Dignity Health
St. Joseph’s Hospital and Medical Center

Community Benefit 2015 Report and 2016 Plan
A message from

Patty White, President and CFO of Dignity Health – St. Joseph’s Hospital and Medical Center and Harry Garrawal, Chair of the Dignity Health – St. Joseph’s Hospital and Medical Center, Community Board.

The Hello humankindness campaign launched by Dignity Health is a movement ignited by and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. Dignity Health’s comprehensive approach to community health improvement includes multi-pronged initiatives directed at significant health needs, partnering with others in the community working to improve health, and investing in efforts that address social determinants of health.

Dignity Health – St. Joseph’s Hospital and Medical Center share a commitment to improve the health of our community, and deliver programs and services to achieve that goal. The Community Benefit 2015 Report and 2016 Plan describes much of this work. This report meets requirements of not-for-profit hospitals in the Patient Protection and Affordable Care Act to adopt a community health implementation strategy at least every three years, and in California state law (Senate Bill 697) to produce an annual community benefit report and plan. Dignity Health complies with both mandates in all of its hospitals, including those in Arizona and Nevada. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2015 (FY15), Dignity Health – St. Joseph’s Hospital and Medical Center provided $195,019,323 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital’s total community benefit expense was $244,356,218.

Dignity Health’s – St. Joseph’s Hospital and Medical Center Board of Directors reviewed approved and adopted the Community Benefit 2015 Report and 2016 Plan at their October 28, 2015 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 602.406.6580.

Patty White
President/COO

Harry Garrawal
Chairperson, Board of Directors
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EXECUTIVE SUMMARY

Located in the heart of Phoenix, Arizona, Dignity Health - St. Joseph’s Hospital and Medical Center (SJHMC) is a 586-bed, not-for-profit hospital that provides a wide range of health, social and support services with special advocacy for the poor and underserved.

SJHMC has 4,780 staff, 200 Research Employees, 183 Employed Faculty Physicians, 1,109 Credentialled Community Physicians, 260 in 20 specialties of Medical Residents, and 813 Volunteers. St. Joseph’s is a nationally recognized center for quality tertiary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute® , the Heart & Lung Institute® , University of Arizona Cancer Center at St. Joseph’s and a Level 1 Trauma Center verified by the American College of Surgeons. The hospital provides care to the State of Arizona, nationally and internationally through its high-level care. SJHMC services Maricopa County and its surrounding areas.

St. Joseph’s Hospital draws approximately 85.7% of its patients from Maricopa County, 10.75% from outside Maricopa County but within Arizona, and 3.52% from outside the state. It is important to understand that 61% of the population of the state of Arizona resides within Maricopa County. The 2013 estimate from the U.S. Census data stated that Arizona has a population of 6,626,624.

Maricopa County has an estimated population of 4,009,412 and is one of the largest counties in the United States. This is an increase of 5% from 2010 to 2013. St. Joseph’s Hospital’s primary service area is within the urban inner city areas, and it also serves the suburban and rural communities for the high-risk services.

The hospital is also a respected center for women’s health, orthopedics and many other medical services. U.S. News & World Report routinely ranks St. Joseph’s among the top hospitals in the United States for neurology and neurosurgery. Founded in 1895 by the Sisters of Mercy, St. Joseph’s was the first hospital in the Phoenix area.

The significant community health needs that form the basis of this report and plan were identified in the hospital’s most recent Community Health Needs Assessment (CHNA), which is publicly available at http://www.dignityhealth.org/stjosephs/about-us/community-benefit/community-benefit-resources/documents/sjchnas-and-ip-2013. Additional detail about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The significant community health needs identified are:
- Access to Care issues
- Obesity
- Diabetes
- Lung Cancer
- Cardiovascular Disease
- Cancer prevention
- Reduction of Injury and Trauma.

In FY15, Dignity Health - St. Joseph’s Hospital and Medical Center took numerous actions to help address identified needs. The following are the key programs within community benefit are for Fiscal Year 2015.
- Healthier Living – Chronic Disease Self-Management and Diabetes Self-Management
- ACTIVATE and ACTIVATE – Prime (Advance Clients’ Transition to Independence with Actions that Empower). and CATCH (Clients Aligned through Community and Hospital)
- Barrow Connect
- Barrow Prevention Programs
  - Helmet your Head
  - Fall Prevention
  - Think First
  - Stroke Prevention
  - Oliver Otter
  - Car Fit
- Ali Cares – Parkinson’s Program
- MOMobile (Maternal Outreach Mobile)
- Women’s Wellness Clinic
- Access to Care Program - Enrollment Assistance Program – Keogh
- Frequent Users Systems Engagement (FUSE) now HOMeVP (Housing/Health of Medically Vulnerable People)
- Children Are Priceless Passengers (CAPP)
- Arizona Communities of Care Network
- Injury and Trauma Prevention Programs

For FY16, the hospital plans to continue these programs and explore new opportunities based on the Community Health Needs Improvement Plan and the Community Health Needs Assessment. We will enhance our work within the Mental and Behavioral Health Services, increase our work within HOMeVP (FUSE) working to house and providing health for homeless individuals who are medically vulnerable, and increase prevention programs for heart and lung disease.

In fiscal year 2015, Dignity Health - St. Joseph’s Hospital and Medical Center provided $195,019,323 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. Including the unreimbursed costs of caring for patients covered by Medicare, the hospital’s total community benefit expense was $244,356,218.

This report and plan is publicly available at http://www.dignityhealth.org/stjosephs/about-us/community-benefit/community-benefit-resources. This report is widely distributed via the Internet using social media – e-mail, Twitter, LinkedIn, and Facebook, as well as printed copies made available to the community. This information is also shared in Newsletter publications.
MISSION, VISION AND VALUES

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:
- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

After more than a century of experience, we’ve learned that modern medicine is more effective when it’s delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word “care” is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.
OUR HOSPITAL AND OUR COMMITMENT

Our Hospital
St. Joseph’s Hospital and Medical Center (SJHMC) was founded in 1895 by the Sisters of Mercy and was the first hospital in the Phoenix area. The hospital is part of Dignity Health, one of the largest healthcare systems in the West with 40 hospitals in Arizona, California and Nevada.

SJHMC has 4,780 staff, 200 Research Employees, 183 Employed Faculty Physicians, 1,109 Credentialed Community Physicians, 260 in 20 specialties of Medical Residents, and 813 Volunteers. St. Joseph’s is a nationally recognized center for quality tertiary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Heart & Lung Institute®, University of Arizona Cancer Center at St. Joseph’s and a Level 1 Trauma Center verified by the American College of Surgeons. The hospital provides care to the State of Arizona, nationally and internationally through its high-level care. SJHMC services Maricopa County and its surrounding areas.

Our Commitment
Since 1895, St. Joseph’s Hospital and Medical Center has delivered high-quality, affordable, health care services in a compassionate environment that meets each patient’s physical, mental and spiritual needs. Upholding the core values of dignity, justice, stewardship, collaboration, and excellence, our healing philosophy serves not just our patients, but our staff, our communities, and our planet.

Rooted in Dignity Health’s mission, vision and values, Dignity Health - St. Joseph’s Hospital and Medical Center is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Health Integration Network (CHIN). The board and its committee on community health and benefit issues are composed of community members who provide stewardship and direction for the hospital as a community resource.

The Community Board and its chairperson, Harry Garwal, Patty White, the hospital’s President and CEO, the Executive Management Team and the community are involved in the Community Health Needs Assessment process, Community Benefit planning process, and the prioritization of the identified unmet health-related needs to inform the development of the programs for each year and how they link to the hospital’s strategic plan. This commitment is reflected in the hospital’s Community Health Integration and Community Benefit programs, which are a demonstration of the hospital’s commitment to improving the lives of the communities within Arizona. The Community Board, leadership and CHIN hold the planning of the community needs, oversee the Community Health Needs Assessment and its adoption through setting the priority for the Community Benefit Plan and approving the strategies for implementing the programs that will work with the community. They will continue to monitor the outcomes of the programs and ensure the appropriate resources are made available to sustain a healthier Arizona.

In the Fiscal Year 2015, the Community Health Integration Network, (CHIN), a committee to the Community Board, and the Community Board of St. Joseph’s Hospital and Medical Center reviewed and approved the 2013-2015 Community Benefit Implementation Plan, addressing the health priorities identified in the 2013 Community Health Needs Assessment conducted by Maricopa County Health Department. The hospital’s Community Board, the hospital’s leadership, CHIN, along with the community, identified key needs from the assessment and developed a strategy to meet those needs. They set the priorities for the hospital and established the priorities within the strategic plan to address the issues outlined by the committees. The goals and priorities outlined in the Community Benefit Plan are linked to the strategic plan of the hospital and focus on the key pillars established in the Horizon 2020 Strategic Plan which include Quality, Growth, Cost, Integration, Connectivity and Leadership. CHIN will continue to use the Hanlon Method, which will determine the population, problem, effective
strategies, and what resources will be needed to accomplish the goals identified by the hospitals leadership and board.

A roster of the Community Board members along with the CHIN Committee members and their affiliations is provided in Appendix A. The key staff positions dedicated to planning and carrying out the community benefit programs include, but are not limited to the following:

- Director of Community Health Integration and Community Benefit provides the leadership, oversight, evaluation, and effectiveness of the community benefit programming for the hospitals and its affiliates.
- Directors of Hospital Service Lines provide oversight of the programs within their departments that are providing community benefit programming to meet the needs within the community.
- Community Benefit Specialists and Program Coordinators provide program coordination, outreach efforts, and community integration. These program coordinators are integrated within the hospital departments delivering the programs.
- Community Benefit Analyst provides oversight of the evaluation and outcomes of the programs to meet the needs within the community.

St. Joseph’s Hospital and Medical Center’s community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report.

In addition, we are investing in community capacity to improve health – including by addressing the social determinants of health – through Dignity Health’s Community Investment Program. In Arizona, $7,450,000 has been invested through Dignity Health Community Investments. The following are the investments made to date:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Community Foundation</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Chandler Christian Community Center</td>
<td>150,000</td>
</tr>
<tr>
<td>Chicanos por la Causa (Prestamos)</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Children’s Museum of Phoenix</td>
<td>500,000</td>
</tr>
<tr>
<td>Children’s Museum of Phoenix</td>
<td>100,000</td>
</tr>
<tr>
<td>First American Credit Union (linked deposit)</td>
<td>100,000</td>
</tr>
<tr>
<td>Native American Connections, Inc.</td>
<td>690,000</td>
</tr>
</tbody>
</table>

$7,450,000

These investments were made to improve the community through social impact funding with the Arizona Community Foundation; improve a local food bank who also provides social supports to the Chandler Community; provide low-interest loans to small, start-up business to minority groups; improve early childhood learning; provide low-interest rates to individuals who are unable to secure loans for homes; and transitional housing for adolescents. All these projects and investments continue to create healthier, safe, communities in Arizona.
DESCRIPTION OF THE COMMUNITY SERVED

A summary description of the community is below and additional community facts and details can be found in the CHNA report online.

Dignity Health policy states that in addition to its immediate geographical areas, a hospital’s definition of community ought to include neighboring areas and populations with disproportionate or unmet health needs. For this report, Maricopa County and the defined service area are considered the community. Community is further defined through geographic primary and secondary borders as well as the demographic data from those patients who enter our doors.

St. Joseph’s Hospital draws approximately 85.7% of its patients from Maricopa County, 10.75% from outside Maricopa County but within Arizona, and 3.52% from outside the state. It is important to understand that 61% of the population of the state of Arizona resides within Maricopa County. The 2014 estimate from the U.S. Census data stated that Arizona has a population of 6,731,484.

Maricopa County has an estimated population of 4,087,191 and is one of the largest counties in the United States. St. Joseph’s Hospital’s primary service area is within the urban inner city areas and it also serves the suburban and rural communities for the high-risk services.

According to the U.S. Census Bureau, Arizona was one of 14 states, along with the District of Columbia, that had more than 30 percent of its population living in poverty. That means that approximately 2 million Arizona residents lived in "poverty areas" in 2010. This represents 33.4 percent of the state's total population and a 9.4 percent increase from 2000 to 2010. The report defines a poverty area as "any census tract with a poverty rate of 20 percent or more," according to the report "Changes in Areas with Concentrated Poverty: 2000 to 2010."

The Median Household Income for all of Maricopa County for 2009-2013 is $54,385 and within the Phoenix boundaries it is $47,866 which includes the suburbs. Arizona has the thirty-first highest per capita income in the United States of America at $25,571.00 per year (2012). Its personal per capita income is $35,979.00 per year (2012). This is an increase in people living in poverty totaled of 17.9% persons in Arizona and 16.7% in Maricopa County, 21.8% in Phoenix. These are ALL increased from last year’s projections and numbers.

Arizona saw a 3.74 percent drop in its uninsured rate over the course of the 2014 open enrollment period. Arizona’s uninsured rate is now estimated at 16.38 percent, placing it above the national average of 14.22 percent. The following data is provided by Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Kaiser Family Foundation estimates based on the Census Bureau's March 2014 Current Population Survey (CPS: Annual Social and Economic Supplements).

<table>
<thead>
<tr>
<th>Location</th>
<th>Employer</th>
<th>Individual</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Other Public</th>
<th>Uninsured</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>41%</td>
<td>5%</td>
<td>19%</td>
<td>14%</td>
<td>N/A</td>
<td>19%</td>
<td>100%</td>
</tr>
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</table>

Arizona is rated 36th by the Scorecard on State Health System Performance 2014, which compares the 50 states and the District of Columbia. Arizona climbed four spots from its ranking in 2009. Highlights for the state include low death rates from cancer or cardiovascular disease, a low rate of work-related deaths, and a low rate of preventable hospitalizations. However, Arizona’s rating remains near the middle of the pack due to low high school graduation rates, significant differences in health status depending on education level, and high rates of drug-related deaths.
SJHMC is the only hospital along the “light rail line” which provides the opportunity for the community to access the health services and community resources offered by the hospital. The community is in the center of Phoenix, but, with the rail service, it provides ready access to services for individuals who have complex health needs. Within Maricopa County, there is a concentration of the minority populations in close proximity to the hospital. Access to affordable health care continues to challenge individuals who do not qualify for Medicaid and Marketplace insurance. Many of these individuals seek care within the Emergency Department and local free clinics. SJHMC provides free health services through the MOMobile for prenatal services, and Women’s Wellness Clinic for free women’s health cancer screenings and partners with nonprofit organizations within the community to assist in providing health services to the community.

Here are some of the demographic indicators using 2010 U.S. Census or current American Community Survey 3-year estimates. According to the 2013 U.S. Census Bureau: State and County “Quick Facts” for Maricopa County and Arizona data is derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits.

<table>
<thead>
<tr>
<th>Maricopa County</th>
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</thead>
<tbody>
<tr>
<td>o Total Population: 4,013,164</td>
</tr>
<tr>
<td>o Hispanic or Latino: 29.1%</td>
</tr>
<tr>
<td>o Race: 56.7: % White, 4.6 % Black/African American, 4.0 % Asian, 2.7% American Indian/Alaska Native, &amp; 0.3% Native Hawaiian or Other Pacific Islander, 0.0% Other, 2.6% Two or More Races</td>
</tr>
<tr>
<td>o Median Income: $53,596</td>
</tr>
<tr>
<td>o Uninsured: 19%</td>
</tr>
<tr>
<td>o Unemployment: 6.0%</td>
</tr>
<tr>
<td>o No HS Diploma: 13.6%</td>
</tr>
<tr>
<td>o CNI Score: 3.9</td>
</tr>
<tr>
<td>o Medicaid Patients: SJHMC 35,773 and SJH West Gate 4,536</td>
</tr>
<tr>
<td>o Other Area Hospitals: 163 in Maricopa County and 221 in Arizona</td>
</tr>
<tr>
<td>o Medically Underserved Areas or Populations: Yes</td>
</tr>
</tbody>
</table>


Last Revised: Wednesday, 30-Sep-2015 11:31:44 EDT
Community Needs Index Map (CNI) – St. Joseph’s Hospital and Medical Center – Phoenix, Arizona

### St. Joseph’s Hospital & Medical Center

![Community Needs Index Map](image)

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>CNI Score</th>
<th>Population</th>
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<tr>
<td>85003</td>
<td>5</td>
<td>10593</td>
</tr>
<tr>
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<table>
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<td>9175</td>
</tr>
<tr>
<td>85048</td>
<td>2</td>
<td>39434</td>
</tr>
</tbody>
</table>

- **1 - 1.7** Lowest
- **1.8 - 2.5** 2nd Lowest
- **2.6 - 3.3** Mid
- **3.4 - 4.1** 2nd Highest
- **4.2 - 5** Highest
Community Needs Index Map (CNI) – St. Joseph’s Westgate – Glendale, Arizona
COMMUNITY BENEFIT PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging Community Health Integration Network (CHIN) and other stakeholders in the development and annual updating of the community benefit plan.

Community Health Needs Assessment Process

This document provides a summary of areas of importance that were identified through the 2012-2013 Maricopa County’s Community Health Assessment completed on June 29, 2012 through the efforts of multiple community partners, hospitals, nonprofit organizations, governmental agencies and community members. The information identified within the Maricopa County Health Assessment reviewed the county’s epidemiologic indicators and qualitative data from the community interviews and focus groups. This 2012 study examined data from local, state, and national sources that provided appropriate comparisons for review and consideration. Maricopa County’s data was identified through a review of the county’s epidemiologic indicators and qualitative data from the community interviews and focus groups.

Specifically, they examined data from local, state and national sources to provide appropriate comparisons:
- REACH Community Survey;
- Maricopa County Department of Public Health (MCDPH) staff survey;
- Maricopa County Health Status Report 2001 – 2010;
- Focus group reports;
- Other relevant data sources (e.g. BRFSS, Healthy People 2010, Kids Count, County Health Rankings, and US Census).

In June 2012, the Maricopa County Department of Public Health and the Arizona Department of Health Services completed the first Comprehensive Health Assessment (CHA) for Maricopa County. This collaborative effort was the culmination of an 18-month engagement process that involved a wide variety of local public health system partners, education and social service agencies, community members, and other stakeholders. Assessments were conducted using a variety of methods from health data analysis to surveys and focus groups with several objectives in mind:

- Ensuring racial and ethnic minority communities’ needs and input was included.
- Ensuring broad representation of underserved populations.
- Including disease surveillance subject matter experts in analysis of health data.

Through this systematic research and data collection process, the team identified five issues as health priorities: Obesity, Diabetes, Lung Cancer, Cardiovascular Disease, and Access to Health Care. These are being addressed in the five-year Community Health Improvement Plan (CHIP) for Maricopa County Department of Public Health and Arizona Department of Health Services. St. Joseph’s Hospital and Medical Center along with Maricopa County will be evaluating the community yearly. The hospital will meet its obligation of a three-year assessment and work in collaboration with the State of Arizona and Maricopa County.

The hospital held a community forum to discuss the findings of the assessment on October 23, 2013 and to also solicit assistance from the community on meeting the diverse issues within the assessment. More than 60 community organizations participate in the presentation and collaborative strategic planning.
session, which resulted in the creation of the “Communities of Care Network” and work being conducted within Community Benefit.

St. Joseph’s Hospital and Medical Center and the Barrow Neurological Institute utilized the information gathered from this community-wide assessment to inform the implementation strategy for the hospital. We share in the vision of our Departments of Public Health and the Arizona Department of Health Services, namely that “Empowered communities working together to reach optimal health and quality of life for all.”

Task forces representing four different sectors of the community—Where We Live (Community), Where We Learn (Education), Where We Work (Worksites), and Where We Receive Care (Healthcare)—have been formed to develop plans with emphasis on utilizing evidence based-strategies and policy, systems, and environmental approaches to impact health priorities. The CHIP will become the strategic blueprint for how public health and community partners will work collectively in making Maricopa County a healthier place to live and work. Data will be reviewed continually over the five-year cycle of the CHIP, both to monitor progress toward identified goals, and to establish new goals and priorities as necessary. The CHNA documents can be accessed at http://www.maricopa.gov/publichealth/Programs/OPI/resources.aspx.

St. Joseph’s Hospital and Medical Center makes ALL of its Community Health Needs Assessments, Community Benefit Plans and Reports available on its website (https://hospitals.dignityhealth.org/stjosephs/Pages/about/community/Community-Benefit-Resources.aspx) provides hard copies to those who request it within the community.

**CHNA Significant Health Needs**

The CHNA takes into consideration the health priorities of the community and the specialty care services St. Joseph’s Hospital and Medical Center provides, in addition to helping address access to care issues, obesity, diabetes, lung cancer, cardiovascular disease, cancer prevention, and the efforts considered for FY2013-FY2015 include education about reducing injuries, trauma and promoting healthy active living. SJHMC has focused its efforts in developing the “Arizona Communities of Care Network,” a collaborative effort with organizations within the community who are working with the hospital and community to directly respond to the ongoing needs outlined with the 2010-2013 Community Health Needs Assessment and the “National Prevention Strategy America’s Plan for Better Health and Wellness” through the “collective impact” strategy. (http://www.healthcare.gov/center/councils/nphpphc).

The hospital will work in collaboration with the community stakeholders and the Departments of Health and Human Services within the State of Arizona and the County of Maricopa to address the following key needs within the community:

- Access to Care issues
- Obesity
- Diabetes
- Lung Cancer
- Cardiovascular Disease
- Cancer prevention
- Reduce Injury and Trauma.

**Priority Not Being Addressed:** As with any healthcare organization, it is not possible to have the resources to meet every need identified in the CHNA. Within the scope of St. Joseph’s Hospital and Medical Center’s adult and infant services, the priority needs not being addressed include children’s health from 1 to 15 years of age. These health issues are being addressed in various ways by several other

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health providers in the community and through our collaboration with Phoenix Children’s Hospital (a joint venture partner).

**Community Benefit Plan Development Process**

The community benefit planning process begins with the review of the community needs assessment. Feedback, recommendations, and concerns were obtained from members of the hospital’s planning committee. Refer to Appendix B for a list of 2015 Community Health Integration Network (CHIN) members.

In addition to the key hospital stakeholders, needs as identified by community constituencies and community partner organizations, the following criteria were used to prioritize the many community needs that were identified:

- The top three most important issues identified by the community.
- Conditions that were responsible for the highest number of years of potential life lost (YPLL); number of inpatient hospital days and emergency room visits.
- Prevalence and trends over a 10 year period from 2001 through 2010.
- Existence of health disparities by racial/ethnic subgroups.

When prioritizing the goals and objectives to be considered for implementation, the Community Board, Community Health Integration Network (CHIN) and the stakeholders take into account high Emergency Room and unnecessary hospital utilization, patients who are uninsured/underinsured and specific populations who are poor and disenfranchised. We evaluate the assets available and commitment from the hospital and its community partners to meet those goals. We solicit assistance from the community through our “Communities of Care Network” meetings and other gatherings throughout the year. SJHMC acts as the “backbone” organization that provides not only technical resources and assistance, but is an active partner in this solution-based method.

SJHMC’s Community Benefit programming addresses vulnerable populations, within demographic populations with the highest need. The programs address individuals with high prevalence and/or severity of the health needs, the programs are addressing them by collaborating with others in the community. The FUSE (Frequent Users of Systems of Emergent) program was created to assist individuals who are homeless and in need of supportive services, including housing. FUSE housed 13 individuals, provided a medical home, and a true continuum of care. To date, 90 percent continue to remain housed, employed, and provided a continuum of care within their medical care.

Community Benefit programs continue to contain the growth of community health care costs by reducing the unnecessary readmissions to the Emergency Room and hospital through its proactive approaches and programs such as the Stroke Prevention Program, Ali Care Parkinson’s Program, Living Well – Chronic Disease Self-Management, Centering Pregnancy, MOMobile (Maternal Outreach Mobile Unit), FUSE, and Diabetes Education programs. These are just a few programs that are reducing the health costs for the hospital and community.

SJHMC works closely with over 135 community organizations, businesses, hospitals, clinics and governmental agencies to meet the needs within the Community Health Needs Assessment. There are needs that are within the assessment that go beyond the hospital’s license and scope of care. The hospital recognizes and partners with these organizations to address who have the capacity to meet the unmet needs.

Community Benefit programs serve to contain the growth of community health care costs by working together within the Arizona Communities of Care Network where each organization works collectively to improve the health and well-being of the community, by sharing costs, services, staff and creating systems changes in care. Together we have developed new ways of delivering care both in the hospital
and in the community, reducing unnecessary readmissions, providing a medical home, integrating health and human services throughout Arizona.

St. Joseph’s Hospital and Medical Center community benefit programs meet the goals and objectives identified in the priority areas. The programs work closely with the community and others organizations within the community to meet those needs that continue to be unmet. The hospital also works closely with our health partners: St. Joseph’s Westgate, Arizona Orthopedic Surgical Hospital, OASIS Hospital, Arizona General Hospitals (Adeptis), United Surgical Partners, and Phoenix Children’s Hospital in providing services, programs and partnering with community organizations in meeting the needs outlined in the 2013 Community Health Needs Assessment. In order to meet the growing needs of the community, St. Joseph’s Hospital and Medical Center created the Arizona Communities of Care Network where organizations come together to develop a common agenda based on a common need, goals, mutually reinforced activities, strategies, objectives and outcomes to meet the needs within the community. This enables the hospital to further maximize the outcomes to improving the health of the community while engaging others in sustainable and long-lasting change.

As a matter of Dignity Health policy, the hospital’s community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- **Disproportionate Unmet Health-Related Needs**: Seek to address the needs of communities with disproportionate unmet health-related needs.
- **Primary Prevention**: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
- **Seamless Continuum of Care**: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
- **Community Capacity**: Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance**: Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

The process that is used to move from an identified significant health need and initiative to a program is a planned, managed and measured organizational approach to meeting identified community health needs through a series of steps. The Hospital Leadership, Hospital Board, Hospital Program Representatives, Community Health Integration Network (CHIN) and the Arizona Community of Care Network (hospital collaborating partners) convened to identify the key priorities within the CHNA and develop an outline for the programs that would meet the areas of need within the community. We worked closely with Maricopa County to integrate the programming from the hospital into the CHIP for the County and State. We continue to collaborate with them on projects and programs that will increase the well-being of our community.

The hospital will develop its work using the “National Prevention Strategy America’s Plan for Better Health and Wellness” (June 16, 2011)\(^3\) in which it identifies a national prevention strategy to increase the number of Americans who are healthy at every stage of life.

The “National Prevention Strategy America’s Plan for Better Health and Wellness” provides a strong foundation for all of the hospital’s prevention efforts and include some core recommendations necessary to build a prevention-oriented community. The Strategy Directions are:

Existing programs with evidence of success and impact are identified within these key strategy areas to meet the community needs identified in the CHNA. Through our work and collaboration with Maricopa County and the State of Arizona’s Department of Health and Human Services, we participate in Maricopa County’s HIPMC (http://www.arizonahealthmatters.org/index.php?module=Tiles&controller=index&action=display&id=3469899365112658) to improve the outcomes for programs that are research and evidence-based, provide outcome based, and sustainable interventions. CHIP objectives are collected on an ongoing basis by the Maricopa County Department of Public Health (MCDPH) from organizations participating in the Health Improvement Partnership of Maricopa County (HIPMC). We work closely with the partners within HIPMC and also contribute through the hospital’s programs to improve the community. We also collaborate with our community partners in the Arizona Communities of Care Network where we use the “collective impact and asset-based” strategies for program development and improvement.

Program measurements and outcomes are measured using SMART goals to address the immediate needs and provide a framework to address the preventive factors or social determinants of health. We do this in collaboration with our partnering service lines within the hospital, community partners, the county and State of Arizona.

Planning for the Uninsured/Underinsured Patient Population

1. In keeping with its mission, the hospital offers patient financial assistance (also called charity care) to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay. The hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. The amount of financial assistance (formerly Charity Care) provided in FY15 ($27,815,579) and is listed in the Economic Value of Community Benefit section of this report.

2. St. Joseph’s Hospital and Medical Center is actively involved in the promotion of the Affordable Healthcare Act and the Marketplace Place through the Cover Arizona Coalition which is the volunteer group that is the backbone of the Affordable Healthcare Act and the Marketplace enrollment efforts. Community Health Integration is actively involved with the Arizona Hospital and Healthcare Association in developing a tool kit for hospitals in Arizona to further implement the elements within the Affordable Healthcare Act. Currently there are over 600 members and a website (www.coveraz.org) that provides assistance to providers, community organizations, businesses, and government organizations to keep informed on the activities taking place in the state related to the ACA efforts.

3. SJHMC is unique in its approach to reviewing Patient Assistance (Charity Care) within the hospital. The hospital uses the Patient Financial Assistance program developed by Dignity Health to determine financial ability. The Patient Assistance Committee (Charity Care) then reviews the patient’s information to include the biological/psychological and social needs of the individuals seeking charity care. There is a multi-disciplinary team that meets on a regular basis to determine the patient’s health needs while in the hospital and at discharge.

4. Information regarding Patient Financial Assistance Policy (Charity Care Policy) is provided for patients at admitting and also is posted throughout the hospital. It is also on the St. Joseph’s website http://www.dignityhealth.org/stjosephs/patients-and-visitor/for-patients/billing-and-payment-information/payment-assistance. Brochures are provided within the outpatient clinic settings as well
as within the community. The hospital also provides patient financial assistance counselors who assist patients with enrollment in state and federal programs.

There is an ongoing assisted in enrollment efforts by the hospital and partners in government health services such as Medicaid, Medicare, Arizona Long Term Care (ALTCS), Pre-existing Coverage Insurance Program (PCIP) and other programs. Ali Cares provided access to medications and healthcare services for with Parkinson’s disease who are uninsured and underinsured. There are multiple programs within the hospital and community to provide free and reduced fee programs for individuals who do not have the ability to get on to Medicaid or private insurance.
2015 REPORT AND 2016 PLAN

This section presents programs and initiatives the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It includes both a report on activities for FY15 and planned programs with measurable objectives for FY16.

SUMMARY

Below are community benefit and community health programs and initiatives operated or substantially supported by the hospital FY15, and those planned to be delivered in FY16. Programs that the hospital plans to deliver in 2016 are denoted by *.

The following is a summary of the key programs and initiatives that have been a major focus of SJHMC’s over the last year to address the identified and prioritized needs of the community. The key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Health Integration Network (CHIN), Executive Leadership, the Community Board and Dignity Health receive quarterly reports regarding the success of the key initiatives and community benefit reports.

Below are the major initiatives and key community based programs operated or substantially supported by St. Joseph’s Hospital and Medical Center’s Community Benefit Plan for 2013-2015.

2015 Community Health Initiatives include the following programs:

**Initiative I: Access to Health Care Services**
- Financial assistance for uninsured/underinsured and low income residents* -- The hospital provides discounted and free health care to qualified individuals, following Dignity Health’s Financial Assistance Policy.
- MOMobile* – Maternal Outreach Mobile – free/low-cost prenatal services
- Ali Cares* – Provides free and reduced Parkinson’s care for uninsured and underinsured individuals within the Mohammed Ali Parkinson’s Center.
- Health professions* community clinical experiences (Adolescent Health Partnership – Florence Crittenton; St. Vincent’s de Paul Clinic – children and adult; CASS – Healthcare for the Homeless Clinic), Circle the City – respite care for homeless, Creighton University Community Outreach efforts
- Enrollment Assistance* – Keogh Health Connections; Patient Financial Advisors; Arizona Department of Economic Security – on sight location for assistance with health, housing and food assistance
- In-Kind Services* to Mission of Mercy (free mobile clinic); St. Vincent’s de Paul Clinic (free health services), Parsons Family Health Center; Neighborhood Christian Clinic
- Dignity Community Grants* – health resources navigation
- **ACTIVATE Resource Room provides assistance to more than 1,000 individuals within the community in navigating health and human services. ACTIVATE and ACTIVATE Prime provides transitional care services within the community for Medicaid and Uninsured individuals such as transportation, disease management, medications, and assistance with other health items.
- Nurse Family Partnership* – Southwest Human Development partnership
- Healthy Families* – Southwest Human Development partnership
- Smooth Way Home* – Collaboration between Southwest Human Development, Feeding Matters,
- “Happy Hearts Happy Hands” *(HHHH) – a community assistance program
**Initiative II: Obesity - Health and Wellness Programs**
- Mohammed Ali Parkinson’s Promotores Program*
- Stroke Prevention and Education*
- Parkinson’s Wellness Classes*
- Group Diabetes Classes for Refugees*
- Congestive Heart Failure Education and Prevention*
- Women Infant and Children (WIC) nutrition and breast feeding program*

**Initiative III: Improving Chronic Health Conditions (Diabetes, Cardiovascular)**
- Healthier Living Chronic Disease Self-Management Program (CDSMP)*
- Healthier Living Diabetes Self-Managemen Program*
- ACTIVATE – disease management program for Medicare/Medicaid patients*
- Parkinson’s Education, Support and Prevention*
- Alzheimer’s Prevention*
- ACTIVATE Prime* – disease management program for Uninsured patients and Medicare/Medicaid
- Transitional Care Clinic* – clinic to manage individuals with congestive heart failure and other chronic diseases. This is open to the public and also for uninsured and under-insured. This program will start in late 2015-2016
- CATCH* - a transitional care program in collaboration with FSL, DUET, Catholic Charities, Keogh and other in the community to provide home visiting and follow up within the community and disease management.
- Mohammed Ali Parkinson’s Center Promotores * Trained and certified volunteers will deliver an in-home educational program to Hispanics living with PD. The program comprises 12 weekly visits and educational material for the families. The entire program is delivered in Spanish.

**Initiative IV: Cancer Prevention (Lung and other cancers)**
- Cancer Prevention Programs and Support*
- Women’s Wellness Clinic*

**Initiative V: Injury and Trauma Prevention**
- Helmet Your Head* – head and spinal cord injury prevention program
- Think First Program* – trauma prevention program
- SMARTR* Program – violence and trauma prevention program
- Oliver Otter* – Water Safety Program for children
- CareFit* - Senior Driving Classes
- Children Are Priceless Passengers* – child passenger safety program
- Fall Prevention* – children, adults and seniors
- Driving to Excel* - driving safety classes for new drivers
- DayS on the Lake – is a watersports program for individuals who were disabled.

**Initiative VI: Behavioral and Mental Health**
- Think First Program* – trauma prevention program
- CATCH*
- Post-Partum Depression support* - Smooth Way Home program
- HOMeVP and FUSE* – provides supports for homeless individuals who are suffering from chronic health conditions, general mental health and homelessness
- Native Collaboration* - provides supports for individuals who are in the Native Community and are in need of mental and behavioral health services, housing, healthcare and job placement.
- Mental Health First Aid Workshops* - These workshops provide an opportunity for the lay person and professional to understand how to deal with mental health issues.
Anticipated Impact

The anticipated impacts of specific program initiatives, including goals and objectives, are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact. The Community Health Integration Network (CHIN), hospital executive leadership, Community Board, and Dignity Health receive and review program updates. In addition, the hospital evaluates impact and sets priorities for its community benefit program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

Since 2012, St. Joseph’s Hospital and Medical Center has engaged the community, nonprofit organizations, businesses, local community members, and governmental agencies in the Arizona Communities of Care Network (AzCCN). The Community Health Integration Network oversees the outcomes and development of these collaborations in partnership with the Department of Community Health Integration. AzCCN is a demonstration in utilizing the “Collective Impact” model and putting it into action. The five elements of Collective Impact are demonstrated within the “Network’s” common agendas, shared measurement systems, the mutually reinforced activities, the continuous communication and identified backbone organizations. The key intent is to foster collaborations borne of shared responsibility among various organizations and agencies to transform health in our community and to engage the hospital and community in meeting the needs of the poor disenfranchised and underserved. The following are the current Communities of Care who are currently collaborating with one another and the hospital in creating healthier communities.

- Native Collaborations – Community of Care
  - This program is collaborative effort between the hospital, Native American Connections, Native Health, and Indian Health Center to meet the needs of displaced native individuals with healthcare, housing, job placement and behavioral health.

- Smooth Way Home – Community of Care
  - This program is collaborative effort between the hospital, Southwest Human Development – Easter Seals, Feeding Matters and Raising Special Kids to assist families who children were in Neo-Intensive Care Units (NICU) and are fragile to re-integrate within the community, assist in mentoring, education and service connectivity.

- CATCH – “Clients Aligned through Community and Hospital” Community of Care
  - This is a program is a collaboration between the Dignity Health Internal Medicine, Catholic Charities, Foundation for Senior Living, DUEt (Parish Nursing), and Keogh Health Connections to assist uninsured and underinsured with home visiting and disease management, enrollment assistance, case management, transportation, food sustainability, and health management.

  - This program is a collaboration between Dignity Health – Barrow Neurological Institute; Arizona Bridge to Independent Living (ABIL); Arizona Spinal Cord Injury (AzSCIA) and the Brain Injury Alliance of Arizona (BIAAZ) The PIE partners will provide services to people with disabilities, and their families, that are transitioning from SJHMC rehabilitation continuum to the community. This population includes people with physical and cognitive disabilities, including spinal cord injury, brain injury, stroke, and those with chronic health conditions.

- HSC Collaborative – Community of Care
  - This program is a collaboration between Dignity Health – St. Joseph’s Hospital and Medical Center Care Management; Human Services Campus LLC (HSC); Lodestar Day Resource
Center (LDRC); Community Bridges (CB). The collaboration serves homeless, chronically homeless and very low income adults accessing services on the Campus or living in the 85007 zip code. The project will specifically address the needs of homeless individuals who are immediate crisis and extremely vulnerable due to poor physical health issues, serious mental illness, behavioral health concerns and chronic substance abuse.

- **SOAR Into Housing – Community of Care**
  - This program is a collaboration between Dignity Health – St. Joseph’s Hospital and Medical Center Care Management and Emergency Services with Human Services Campus (HSC); Circle the City (CTC); and Lodestar Day Resource Center. The focus of SOAR Into Housing is to leverage mainstream resources to assist high acuity individuals experiencing homelessness with appropriate housing resources. To accomplish this, the partners will utilize SSI/SSDI Outreach, Access, and Recovery (SOAR). Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), SOAR is designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring substance use disorder. This includes social security (SSI) and social security disability (SSDI) benefits. Providing a SOAR navigator onsite at CTC will increase the positive housing outcomes of the individuals receiving care and connect them more rapidly with appropriate resources.

- **Welcome Home: Prioritizing Medically Vulnerable Individuals for Housing – Community of Care**
  - This program is a collaboration between Dignity Health – St. Joseph’s Hospital and Medical Center Care Management and Emergency Services with Human Services Campus (HSC); Circle the City (CTC); and Lodestar Day Resource Center. Welcome Home, an outgrowth of the Frequent User Service Enhancement (FUSE) pilot, will develop/implement a process to identify, assess, treat & prioritize medically vulnerable homeless persons for finite SH resources. FUSE successfully engaged, treated, stabilized & housed 15 medically vulnerable homeless persons & resulted in significant reductions in ER & inpatient costs and substantial increases in client self-sufficiency. FUSE participant identification, however, was imprecise & labor intensive, resulting in the need for a system wide methodology to ensure accurate identification & prioritization of the target population for SH.

- **ACTIVATE and ACTIVATE-Prime – Community of Care**
  - This program collaboration is between Dignity Health-St. Joseph’s Hospital and Medical Center, Mercy Care Plan, and multiple community resources and partners. This program a model of transitional care has been designed to combine the proven techniques of RED protocols and software, best practices from the Coleman model and a number of innovative features, including an embedded Transitional Care Nurse managed by Foundation for Senior Living (Community Based Organization); an in-hospital beneficiary I caregiver resource center; a community-based Transitional Care Coach; and a 24x7 nurse call-in service. These additional resources and roles strengthen the significant improvements underway within the hospital processes; apply a more holistic model of beneficiary care, provide a strong array of community supports and promote beneficiary empowerment. These services are provided for the uninsured and underinsured populations.

This community benefit plan specifies significant community health needs that the hospital plans to address in whole or in part, in ways consistent with its mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in other community assets and resources directed to those needs may merit refocusing the hospital’s limited resources to best serve the community.

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report.
### Significant Health Needs Addressed

List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.

- Access to Care
- Obesity
- Diabetes
- Lung Cancer
- Cardiovascular Disease
- Cancer Prevention
- Reduce Injury and Trauma

### Program Emphasis

Select the emphasis(es) of the program from the five core principles below.

- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

### Program Description

Ali Care was created to honor Muhammad and Lonnie Ali's commitment that all people with Parkinson's disease receive care, regardless of ability to pay. Through Ali Care, people with Parkinson's disease who have little or no health care insurance and limited financial resources receive health care and services that enhance quality of life. Multiple services provided to Arizona residents through Ali Care may include assistance in obtaining medications, doctor visits, therapies, & provision of adaptive equipment.

### Planned Collaboration

Discounted medications from Sunwest Pharmacy and McCauley Pharmacy. Assistance from pharmaceutical companies.

### Community Benefit Category

Community Health Improvement Services

### FY 2015 Report

**Program Goal / Anticipated Impact**

Describe the goal or anticipated impact established for FY 2015 in broad terms.

Provide access to medication and medical care to those who are uninsured or underinsured.

**Measurable Objective(s) with Indicator(s)**

Specify one or more measurable objectives with indicators related to the program goal.

Number of persons served 72 people which consisted of 431 encounters

**Baseline / Needs Summary**

There are a percentage of people with PD who have little or no health insurance and are not able to purchase their PD meds or see a movement disorder specialist. Ali Care provides a safety net for these and other services.

**Intervention Actions for Achieving Goal**

Medications and services were provided to people living in the community who would not have received medical treatment otherwise. Others who did not meet criteria were counseled re: other strategies, resources such as pharmaceutical assistance programs to assist.

**Program Performance / Outcome**

72 people received over $95,000.00 of medications, supplies, and/or healthcare services.

**Hospital’s Contribution / Program Expense**

Medications, doctor and therapy visits, staff (Resource Coordinator and Social Worker) to oversee the program.

### FY 2016 Plan

**Program Goal / Anticipated Impact**

Describe the goal or anticipated impact for FY 2016. What will be achieved through this program?

Provide access to medication and medical care to those who are uninsured or underinsured.

**Measurable Objective(s) with Indicator(s)**

Specify one or more measurable objectives with indicators related to the program goal.

Number of persons served. Increase by 5%

**Baseline / Needs Summary**

There are a percentage of people with PD who have little or no health insurance and are not able to purchase their PD meds or see a movement disorder specialist. Ali Care provides a safety net for these and additional services.

**Intervention Actions for Achieving Goal**

Describe the principal program/initiative activities planned for FY 2016.

Provide access to medication and medical care to those who are uninsured or underinsured.
## MOMobile (Maternity Outreach Mobile)

### Significant Health Needs Addressed
List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.
- **Access to Care**
- Obesity
- Diabetes
- Lung Cancer
- Cardiovascular Disease
- Cancer Prevention
- Reduce Injury and Trauma

### Program Emphasis
Select the emphasis (es) of the program from the five core principles below.
- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

### Program Description
Provide prenatal and postpartum care for low-income, uninsured pregnant women in Maricopa County who would otherwise not be able to obtain prenatal care. Mobile clinic (truck/trailer) which travels to 4 different locations within Maricopa County weekly. Supported by SJH, and the OB/GYN Department of SJMG, funded through SJH Foundation which covers all operating costs, including staffing. This program was started in 1995 in collaboration with March of Dimes.

### Planned Collaboration
Currently collaborate with community partners where we locate the MOMobile. St John Vianney Church, First Southern Baptist Church, C.A.R.E. Partnership, Golden Gate Community Center. Our patients also received collaborate services with First Things First, The Nurse Partnership, Southwest Human Development, March of Dimes, Mission of Mercy, and St Vincent de Paul

### Community Benefit Category
Community Health Improvement Services – Community Based Clinical Services – Mobile Unit

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### FY 2015 Report

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Decrease preterm and low birth weight infants in Maricopa County, increase number of mothers receiving adequate prenatal care. Decrease both infant and maternal mortality.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td>Measurements include number patient visits, number of prenatal visits per patient receiving their prenatal care through MOMobile, average birth weight of infants, and outcomes of births – 132 women were served</td>
</tr>
<tr>
<td>Baseline / Needs Summary</td>
<td>Lower than average percentage of women in Maricopa County receiving adequate prenatal care, 76% compared to 78% in state of Arizona, and far less than Healthy People Goal of 2010 ensuring that 90% of all births are to mothers who received prenatal care beginning in first trimester. Also 7.1% of live births in Maricopa County are low birth weight births, again higher than the Healthy People 2010 goal of 5%.</td>
</tr>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>Provide services in areas where zip codes are indicating increased rates of premature birth, low birth weights, and higher infant mortality.</td>
</tr>
<tr>
<td>Program Performance / Outcome</td>
<td>Total number of patient visits 7/1/2014-6/30/2015:1845 (increased from 1673 previous fiscal year). Average number of prenatal visits per patient: 10, average birth weight: 7 lbs. 8.5 oz.</td>
</tr>
<tr>
<td>Hospital’s Contribution / Program Expense</td>
<td>Provides staffing, assistance for patients including physicians for delivery, ultrasounds, co-management of higher risk patients, office space for staff, parking for mobile clinic, supplies for clinic.</td>
</tr>
</tbody>
</table>

### FY 2016 Plan

| Program Goal / Anticipated Impact | Continue providing prenatal care in areas of most need thus improving perinatal outcomes in Maricopa County |
| Measurable Objective(s) with Indicator(s) | Number of prenatal visits, patient visits, and delivery outcomes as compared to state and national average. |
| Baseline / Needs Summary | Limited resources for low income women to obtain prenatal services if they do not qualify for current state plan (AHCCCS). Many of these women do not qualify, due residential status, for state or federal assistance for prenatal care. Thus a higher percentage of women and families residing in Arizona remain uninsured. |
| Intervention Actions for Achieving Goal | Maintain funding so program can continue to provide services to areas of higher need, and continued collaboration with community partners. |
Keogh Health Connection - Enrollment Assistance

**Significant Health Needs Addressed**
List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.
- [x] Access to Care

**Program Emphasis**
Select the emphasis (es) of the program from the five core principles below.
- [x] Disproportionate Unmet Health-Related Needs
- [x] Build Community Capacity
- [x] Collaborative Governance

**Program Description**
St. Joseph's Hospital partner's with Keogh Health Connection to assist uninsured/underinsured patients in applying for government assistance programs. The hospital provides in-kind space for the Keogh representative to have a private office to meet with patients.

**Planned Collaboration**
Keogh Health Connections plans on continuing to work with St. Joseph's Hospital staff that will refer potential applicants for AHCCCS, SNAP (Food Stamps), the Marketplace and other community resources.

**Community Benefit Category**
Community Health Improvement Services – Enrollment Assistance

**FY 2015 Report**

**Program Goal / Anticipated Impact**
Keogh Health Connection plans on connecting community members to programs such as AHCCCS, SNAP, and the Marketplace which will improve their access to care and their quality of life.

**Measurable Objective(s) with Indicator(s)**
Keogh Health Connection will place staff at St. Joseph's Hospital three times a week to provide application assistance for Public Benefits and or the Marketplace. Keogh will submit 200 applications and reach 600 people for fiscal year 2015.

**Baseline / Needs Summary**
Currently there are 120,620 residents in Maricopa County who are uninsured, many who are children who are eligible for AHCCCS but not enrolled.

**Intervention Actions for Achieving Goal**
Keogh connects people who survive on little income, usually women and their children who are seeking healthcare and other resources such as Food Stamps (now called SNAP for Supplemental Food Assistance Program). Keogh collaborates with many agencies that have established a trust relationship with working-poor families. Keogh focuses on agencies that help move families forward towards self-sufficiency, such as Head Start, training, and educational programs. Many nonprofit groups that work with low-income families do not provide counseling and applications assistance for Medicaid (AHCCCS in Arizona), SNAP, and other community resources, or help their clients understand and navigate the often complicated process, requirements and choices that make up the Affordable Care Act Marketplace. Help with these areas is one of the hallmarks of the Keogh Health Connection.

**Program Performance / Outcome**

<table>
<thead>
<tr>
<th>HEALTH plus Applications</th>
<th>Number of People Applying</th>
<th>Number of AHCCCS Applicants</th>
<th>Number of SNAP Applicants</th>
<th>Number of TANF Applicants</th>
<th>Marketplace Application 2</th>
<th>Number of People Applying</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>249</td>
<td>879</td>
<td>586</td>
<td>510</td>
<td>19</td>
<td>9</td>
</tr>
</tbody>
</table>

**Hospital's Contribution / Program Expense**
The hospital provided in-kind space use. The cost is $5,112.

**FY 2016 Plan**

**Program Goal / Anticipated Impact**
To connect community members to Public Benefits and the Marketplace by assisting them with electronic applications. Keogh will also provide advocacy for the applicants with the end goal of having them approved for benefits such as AHCCCS and or the Marketplace.

**Measurable Objective(s) with Indicator(s)**
Keogh will submit 147 applications and connect 441 people to Public and or Marketplace benefits during fiscal year 2016.

**Baseline / Needs Summary**
There continues to be a disproportionate number of people who are uninsured or underinsured within Maricopa County. Currently, Maricopa County has the highest number of uninsured residents within the state. Keogh Health Connection is committed to helping the community navigate and access the various program that are available to the public (AHCCCS, SNAP, Marketplace).

**Intervention Actions for Achieving Goal**
Keogh Health Connection will continue to place staff at St. Joseph's Hospital for once a week to accept appointments and walk-ins for public benefits and or the Marketplace. Keogh Health Connection will also provide outreach and presentations to St. Joseph's Hospital staff on an as needed basis.
### MAPC PROMOTORES

#### Significant Health Needs Addressed
List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.
- Access to Care
- Obesity

#### Program Emphasis
Select the emphasis (es) of the program from the five core principles below.
- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

#### Program Description
Trained and certified volunteers deliver in-home educational program to Hispanics who have barriers to healthcare information living with PD. The program comprises 13 weekly visits and educational material for the families. Families are followed for 6 more monthly visits. The entire program is delivered in Spanish.

#### Planned Collaboration
Promotores HOPE Network (AZ), Creciendos Unidos/Growing Together (AZ)

#### Community Benefit Category
Community Health Education

### FY 2015 Report

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Describe the goal or anticipated impact established for FY 2015 in broad terms. Example: Contribute to increases in physical activity and maintenance or reduction in Body Mass Index among youth aged 7-14.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td>15 families completed the program and/or in the 6 month follow up.</td>
</tr>
<tr>
<td>Baseline / Needs Summary</td>
<td>There are many Hispanics living with PD who lack information about PD and who are unable to access community educational programs and seminars due to many barriers</td>
</tr>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>This year the program included additional volunteer training through an annual conference in CA and two workshops: Motivational Interview and Leadership training.</td>
</tr>
<tr>
<td>Program Performance / Outcome</td>
<td>Fourteen families have benefited from the program and have acquired valuable information and tools to improve their quality of life. Some have joined the MAPC Hispanic programs such as exercise, support groups and/or the choir.</td>
</tr>
<tr>
<td>Hospital’s Contribution / Program Expense</td>
<td>SJHMC staff supervises the program; pays for volunteers’ gas and training, annual conference registration and travel; and space for ongoing meetings</td>
</tr>
</tbody>
</table>

### FY 2016 Plan

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Provide in home education to Hispanics living with Parkinson Disease and their families who experience barriers to health education. The education will help people with chronic disease self-management and connect to MAPC programs for continued outreach support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td>Provide in home education to 10 families for 12 weeks and 6 monthly f/u visits. The trained Promotores will provide training to other community healthcare workers in the community (outside of the MAPC).</td>
</tr>
<tr>
<td>Baseline / Needs Summary</td>
<td>There are many Hispanics living with PD who lack information about PD and who are unable to access community educational programs and seminars due to many barriers. There is also a lack of information in community organizations that serve the Hispanic community.</td>
</tr>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>Promotores volunteers to attend annual national Promotores program and to provide training to other Promotores outside the organization (i.e.: Promotores HOPE Network and the Creciendo Unidos promotores group.</td>
</tr>
</tbody>
</table>
## Barrow Stroke Prevention

### Significant Health Needs Addressed

List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.

- Access to Care
- Obesity
- Cardiovascular Disease

### Program Emphasis

Select the emphasis of the program from the five core principles below.

- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

### Program Description

Health promotion and stroke prevention education for seniors, community and employees that identify cardiovascular risk factors, increase the number of individuals who recognize signs and symptoms of stroke, and increase the number of individuals being referred to appropriate professionals to receive medical care and education needs.

### Planned Collaboration

American/Arizona Heart/Stroke Associations, public, hospital staff, senior residential site coordinators.

### Community Benefit Category

Community Health Education

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### FY 2015 Report

#### Program Goal / Anticipated Impact

Describe the goal or anticipated impact established for FY 2015 in broad terms.

Reduce the incidence of strokes through greater outreach and educational efforts. Increased by 10% stroke outreach, presentations and community blood pressure checks.

#### Measurable Objective(s) with Indicator(s)

Specify one or more measurable objectives with indicators related to the program goal. Identify 2 underserved populations at risk for stroke for intervention.

#### Baseline / Needs Summary

Cardiovascular disease (CVD), which includes heart disease and stroke, is the leading cause of the death both nationally and in Arizona heart disease was the cause of nearly 1 in every 4 deaths. Many of the risk factors for heart disease and stroke, including poor nutrition, physical inactivity and tobacco use, are behaviors that can be modified to prevent or delay the development of CVD. Data from the AZ Dept. of Health shows that 30% of the deaths in AZ are related to CVD. Conditions related to risk factors for CVD correlate to SJHMC ED utilization.

#### Intervention Actions for Achieving Goal

Identified 5 senior residential sites, Casa Pedro Ruiz in Phoenix, 85043, Vista De La Montana, Phoenix, 85042, Paseo Abeytia, Phoenix, 85040, Bill Soltero, Glendale, 85301, Haciendas, Avondale, 85323 to provide stroke prevention education; invited all to attend the free stroke screening on June 5; blood pressure checks done at Casa Pedro Ruiz site.

#### Program Performance / Outcome

Describe the results this program achieved for participants or the broader community, incorporating the measurable objectives/indicators.

Elevated blood pressure found in 10 of the 21 individual tested, referred to physician and given educational resources. In coordination with the residential coordinators, educated 71 individuals on risk factors, warning signs & symptoms of stroke, diet and exercise. Resource material provided in English and Spanish.

#### Hospital’s Contribution / Program Expense

Describe the contribution and resource commitment the hospital provided.

Mileage reimbursement and staff time for Stroke Prevention presentations, health fairs, and Stroke Screening and coalition meetings.

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### FY 2016 Plan

#### Program Goal / Anticipated Impact

Describe the goal or anticipated impact for FY 2016. What will be achieved through this program? Reduce the incidence of strokes through greater outreach and educational efforts. Increased by 10% stroke outreach, presentations and community blood pressure checks.

#### Measurable Objective(s) with Indicator(s)

Specify one or more measurable objectives with indicators related to the program goal. (Measurable objectives and goals can span more than one year.) Identify 2 underserved populations at risk for stroke for intervention.

#### Baseline / Needs Summary

Cardiovascular disease (CVD), which includes heart disease and stroke, is the leading cause of the death both nationally and in Arizona heart disease was the cause of nearly 1 in every 4 deaths. Many of the risk factors for heart disease and stroke, including poor nutrition, physical inactivity and tobacco use, are behaviors that can be modified to prevent or delay the development of CVD. Data from the AZ Dept. of Health shows that 30% of the deaths in AZ are related to CVD. Conditions related to risk factors for CVD correlate to SJHMC ED utilization.

#### Intervention Actions for Achieving Goal

Describe the principal program/initiative activities planned for FY 2016.

1. Provided 7 stroke presentations
2. Provided stroke screening in Phoenix. Individuals will be provided with free blood pressure checks, blood work and screening ultrasound of carotid. Health care providers will be available to provide counseling and give resources for individuals in need.
Barrow Helmet Your Head and ThinkFirst Programs

<table>
<thead>
<tr>
<th>Significant Health Needs Addressed</th>
<th>List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.</th>
<th>✓ Reduce Injury and Trauma</th>
</tr>
</thead>
</table>
| Program Emphasis                  | Select the emphasis(es) of the program from the five core principles below.  | ✓ Disproportionate Unmet Health-Related Needs  
|                                   |                                                                        | ✓ Primary Prevention  
|                                   |                                                                        | ✓ Seamless Continuum of Care  
|                                   |                                                                        | ✓ Build Community Capacity  
|                                   |                                                                        | ✓ Collaborative Governance |
| Program Description               | “Helmet Your Head” (HYH) is a safety program developed by Barrow Neurological Institute. The program focuses on the prevention of head and traumatic brain injuries and promotes the establishment of safe behaviors and helmet use during recreational activities. Target area: State of Arizona. This program provides trainings, fits and distributes helmets to prevent traumatic brain injury. ThinkFirst (TF) is an award winning national program that teaches individuals to “think first” and to use their minds to protect their bodies from serious brain, spinal cord and other traumatic injuries related to car crashes, drug and alcohol use, falls, violence, recreational and water related incidences. Barrow is the state Training Center for ThinkFirst as well as housing the State ThinkFirst Director. The ThinkFirst Director also services on the National ThinkFirst Foundation’s Board of Directors. |
| Planned Collaboration             | Schools, parent groups, cities, other hospitals and professional safety groups. |
| Community Benefit Category        | Community Health Education |

**FY 2015 Report**

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Describe the goal or anticipated impact established for FY 2015 in broad terms. Enhance &amp; expand the HYH and TF injury prevention programs</th>
</tr>
</thead>
</table>
| Measurable Objective(s) with Indicator(s) | Specify one or more measurable objectives with indicators related to the program goal.  
|                                   | a. Create handouts on prescription drugs and marijuana developed for target population  
|                                   | b. Two opportunities/partnerships identified to leverage efforts |
| Baseline / Needs Summary         | The AZ Dept. of Health reports that in 2011, unintentional injuries were the leading cause of death for people between the ages of 1 through 44 and older adults have the highest risk of death than any other age group. |
| Intervention Actions for Achieving Goal | Describe the principal program/initiative activities undertaken in FY 2015.  
|                                   | 1. Barrow Prevention & Outreach Staff have attended 2 RX360 training on prescription drug use and marijuana. Staff also attended an adolescent summit in October to increase their knowledge of this target population and identify other community partners.  
|                                   | 2. Identified parent group partners in the Washington School District and Glendale Community College to provide HYH and TF presentations. |
| Program Performance / Outcome    | Describe the results this program achieved for participants or the broader community, incorporating the measurable objectives/indicators.  
|                                   | Identified parent group partners in the Washington School District and Glendale Community College to provide HYH and TF presentations. Two HYH & TF presentations were given to college classes at Glendale Community reaching 37 students and their instructor. The other partner was the Washington School District. Following a presentation to the Head Start coordinators, case managers and other curriculum staff, we were able to schedule an additional 6 parent presentations, reaching 96 parents and instructors; all were in underserved communities. |
| Hospital's Contribution / Program Expense | Describe the contribution and resource commitment the hospital provided.  
|                                   | Mileage reimbursement and staff time for TF & HYH training, fittings and distribution of helmets, participation in skill-based bike rodeos and coalition meetings. |

**FY 2016 Plan**

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
<th>Describe the goal or anticipated impact for FY 2016. What will be achieved through this program? Reduce the incidence of brain, spinal cord and other traumatic injuries through greater outreach and educational efforts. Enhance &amp; expand the HYH and TF injury prevention programs &amp; training.</th>
</tr>
</thead>
</table>
| Measurable Objective(s) with Indicator(s) | Specify one or more measurable objectives with indicators related to the program goal.  
|                                   | (Measurable objectives and goals can span more than one year.)  
|                                   | Provide training opportunities to two health or safety agencies. |
| Baseline / Needs Summary         | Describe the current situation in the community. Why will you continue doing this program? Injuries to the brain and spinal cord injuries remain the leading causes of long term disabilities and death. |
| Intervention Actions for Achieving Goal | Describe the principal program/initiative activities planned for FY 2016.  
|                                   | 1. Identify and provide 2 training to safety groups or agencies.  
|                                   | 2. Identify targeted parent and teen populations to expand the injury prevention message.  
<p>|                                   | 3. Increase presentations to these populations by 10% |</p>
<table>
<thead>
<tr>
<th><strong>Barrow Fall Prevention</strong></th>
</tr>
</thead>
</table>
| **Significant Health Needs Addressed** | List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.  
☑ Reducing Injury and Trauma |
| **Program Emphasis** | Select the emphasis(es) of the program from the five core principles below.  
☑ Disproportionate Unmet Health-Related Needs  
☑ Primary Prevention  
☑ Seamless Continuum of Care  
☑ Build Community Capacity  
☑ Collaborative Governance |
| **Program Description** | Health promotion and fall prevention education for seniors, community and employees that identifies risk factors for falling, prevention strategies and referrals to appropriate professionals to receive additional services. |
| **Planned Collaboration** | Senior Centers, rehabilitation facilities and older adults as well as city, state and agencies working with older adults such as Rebuilding Together, Valley of the Sun and AZ Falls Prevention Coalition. |
| **Community Benefit Category** | Community Health Education |
| **FY 2015 Report** |
| **Program Goal / Anticipated Impact** | Describe the goal or anticipated impact established for FY 2015 in broad terms. Identify collaboration opportunities with the Dept. of Health Services to grow AZ Falls Prevention Coalition & Barrow Fall Prevention Center state-wide. |
| **Measurable Objective(s) with Indicator(s)** | Specify one or more measurable objectives with indicators related to the program goal.  
1. AZ Falls Coalition identifies 3 partners state-wide  
2. Educate the Dept. of Health and AZ Falls Coalition about the multi-specialty Barrow Fall Prevention Center team approach to assess individuals and train other healthcare professions on fall prevention |
| **Baseline / Needs Summary** | The AZ Department of Health Services Injury Prevention Plan states that “Falls are the leading cause of unintentional injury-related inpatient hospitalizations and emergency department visits. In 2011, falls were the second leading cause of unintentional injury-related death for all age groups and the leading cause of injury-related death among individuals 65 years and older”. |
| **Intervention Actions for Achieving Goal** | Describe the principal program/initiative activities undertaken in FY 2015. Continue serving as a member of the AZ Falls Prevention Steering Committee to develop a strategic plan which included expanding membership statewide. |
| **Program Performance / Outcome** | Describe the results this program achieved for participants or the broader community, incorporating the measurable objectives/indicators.  
1. AZ Falls Prevention Coalition has identified partners in Tucson, Green Valley and Indian Health Services to be a part of the state-wide coalition.  
2. I have introduced Peg McCauley, from the Rene and Bob Parsons Fall Prevention Center of Excellence to the AZ Fall Coalition so she can share updates on research and development that they will be implementing. Invited to serve as the Co-chair of the AZ Falls Prevention Coalition Education Subcommittee. |
| **Hospital's Contribution / Program Expense** | Describe the contribution and resource commitment the hospital provided. Mileage reimbursement and staff time for Fall Prevention presentations & health fairs and coalition meetings. |
| **FY 2016 Plan** |
| **Program Goal / Anticipated Impact** | Describe the goal or anticipated impact for FY 2016. What will be achieved through this program? Reduce the incidence of falls through greater outreach and educational efforts. Identify collaboration opportunities with the Dept. of Health Services to grow AZ Falls Prevention Coalition & Barrow Fall Prevention Center state-wide. |
| **Measurable Objective(s) with Indicator(s)** | Specify one or more measurable objectives with indicators related to the program goal. (Measurable objectives and goals can span more than one year.)  
1. Assist the AZ Falls Coalition in identifying 3 new partners state-wide  
2. Increase fall prevention presentations in the underserved population by 10%. |
| **Baseline / Needs Summary** | Describe the current situation in the community. Why will you continue doing this program? Falls continue to be one of the leading causes of unintentional injury-related inpatient hospitalizations and emergency department visits in AZ and the USA. |
| **Intervention Actions for Achieving Goal** | Describe the principal program/initiative activities planned for FY 2016.  
1. Continue to serve as a member of the AZ Falls Prevention Steering Committee: serve as the Co-Chair of the Education Subcommittee.  
2. Identify two sites to provide Fall Prevention presentations. |
## Significant Health Needs Addressed

List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.
- **Reduce Injury and Trauma**

## Program Emphasis

Select the emphasis(es) of the program from the five core principles below.
- **Disproportionate Unmet Health-Related Needs**
- **Primary Prevention**
- **Seamless Continuum of Care**
- **Build Community Capacity**
- **Collaborative Governance**

## Program Description

CarFit is a free educational program created by the American Society on Aging and developed in collaboration with AAA (American Automobile Association), AARP and the American Occupational Therapy Association. CarFit identifies risk factors, access strategies, provides information and materials on community-specific resources that could enhance the safety for older drivers, and/or increase their mobility in the community. CarFit also provides referrals to appropriate professionals for additional services.

## Planned Collaboration

Local AAA, AARP, Occupational Therapists, City of Phoenix Senior Services, health & safety organizations and governmental agencies. Other partners include Dignity Health hospitals and medical centers and other partner groups.

## Community Benefit Category

Community Health Education

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## FY 2015 Report

### Program Goal / Anticipated Impact

Describe the goal or anticipated impact established for FY 2015 in broad terms. Development of partnerships to train a team of certified technicians, i.e. health professionals, occupational therapists and other community members, to work with older adults to ensure that they "fit" their vehicle properly for maximum comfort and safety and provide information and materials on community-specific resources that could enhance their safety as drivers, and/or increase their mobility in the community.

### Measurable Objective(s) with Indicator(s)

Specify one or more measurable objectives with indicators related to the program goal.
1. Identification of 10 community members or other partners to be trained to become certified CarFit technicians.
2. Identify and train 4 occupational therapists to become certified CarFit technicians.
3. Collaborate with community members and partners to identify a site for seniors to receive this educational assessment program and resources.

### Baseline / Needs Summary

Describe the current situation in the community. What is the evidence of need?

The **AZ 2014 Strategic Highway Safety Plan** states that drivers 65 years and older are the fastest-growing segment of the population. In Arizona, 15 percent of all roadway deaths involved a person 65 years or older. The highest incidence of older driver involved severe crashes take place most often in traffic locations in major urban centers.

### Intervention Actions for Achieving Goal

Describe the principal program/initiative activities undertaken in FY 2015.
1. Identify a funding source to bring 2 trainers to AZ to provide the training and equipment for community members and occupational therapists to become certified CarFit technicians.
2. Identify partners in the community and AZ Service Area facilities to become CarFit technicians and use this knowledge to work with clients in their communities or facilities.
3. Provide CarFit assessment for 15 older adults at 1 or more sites.

### Program Performance / Outcome

Describe the results this program achieved for participants or the broader community, incorporating the measurable objectives/indicators.
1. St. Joseph’s Foundation funded cost to bring 2 CarFit trainers to AZ and paid for adaptive equipment and training and event expenses.
2. Partnered with City of Phoenix Senior Services to identify staff and site for CarFit event and event planning. In addition members from AARP, AAA (American Automobile Association, SCAN and Dignity Health Occupational Therapists (OT) participated in the event planning and CarFit Screening. Twenty eight individuals were trained as certified CarFit technicians including 6 OTs, 4 from St. Joseph’s Hospital and Medical Center, 2 from MGMC/CRMC.
3. Twenty individuals had their car checked and 14 had identified risks and were educated, showed how to fix risk or referred to appropriate organization.

### Hospital's Contribution / Program Expense

Describe the contribution and resource commitment the hospital provided.

St. Joseph’s Foundation provided funding for project. Operational budget provided Manager with resources and time to coordinate project.

---

## FY 2016 Plan

### Program Goal / Anticipated Impact

Describe the goal or anticipated impact for FY 2016. What will be achieved through this program? Continue to develop partnerships to train additional certified CarFit technicians, i.e. health professionals, occupational therapists and other community members to enable us to host another
**CarFit Screening.**

<table>
<thead>
<tr>
<th>Measurable Objective(s) with Indicator(s)</th>
<th>Specify one or more measurable objectives with indicators related to the program goal. (Measurable objectives and goals can span more than one year.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identification of 5 community members or other partners to be trained to become certified CarFit technicians.</td>
<td></td>
</tr>
<tr>
<td>2. Identify and train 2 occupational therapists to become certified CarFit technicians.</td>
<td></td>
</tr>
<tr>
<td>3. Collaborate with community members and partners to identify a site for seniors to receive this educational assessment program and resources.</td>
<td></td>
</tr>
</tbody>
</table>

| Baseline / Needs Summary | Describe the current situation in the community. Why will you continue doing this program? Drivers 65 years and older are the fastest-growing segment of the population. In Arizona, 15 percent of all roadway deaths involved a person 65 years or older. The highest incidence of older driver involved severe crashes take place most often in traffic locations in major urban centers. |

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>Describe the principal program/initiative activities planned for FY 2016.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify a funding source to provide training to become a CarFit trainer and to provide 1 additional training opportunity for partners.</td>
<td></td>
</tr>
<tr>
<td>2. Identify partners in the community and AZ Service Area facilities to become CarFit technicians and use this knowledge to work with clients in their communities or facilities.</td>
<td></td>
</tr>
<tr>
<td>3. Provide CarFit assessment for 15 older adults at 1 or more sites.</td>
<td></td>
</tr>
</tbody>
</table>
### Significant Health Needs Addressed

List the significant health needs in the most recent Community Health Needs Assessment here; check as appropriate for each program described.

- Access to Care
- Obesity
- Diabetes
- Lung Cancer
- Cardiovascular Disease
- Cancer Prevention
- Reduce Injury and Trauma

### Program Emphasis

Select the emphasis(es) of the program from the five core principles below.

- Disproportionate Unmet Health-Related Needs
- Primary Prevention
- Seamless Continuum of Care
- Build Community Capacity
- Collaborative Governance

### Program Description

Healthier Living is a series of classes designed to teach self-management skills that will maximize the health potential and improve the patients’ quality of life. If a patient has a condition such as diabetes, arthritis, cancer, hypertension, heart disease or depression Healthier Living can help them take charge of their life.

HL is run out of the Community Benefit Department and has two master trainers and two lay leaders.

### Planned Collaboration

Collaboration with the Arizona Living Well Institute.

### Community Benefit Category

Community Health Improvement Services

### FY 2015 Report

#### Program Goal / Anticipated Impact

Describe the goal or anticipated impact established for FY 2015 in broad terms.

- Enroll patients with Chronic Diseases in the Healthier Living program.

#### Measurable Objective(s) with Indicator(s)

1. Host 2 Healthier Living Workshops
2. Promote the program to hospital staff and physicians

#### Baseline / Needs Summary

High need of patients seen inpatient and outpatient with chronic health conditions.

#### Intervention Actions for Achieving Goal

In FY 2015 we had a new team member join the team. This team member has gone through the Master & Lay Leader Trainings for Chronic Disease Self-Management and Diabetes Self-Management as well as the Spanish Tomando Control de Su Salud. With this new team member joining the team we can further continue to grow the program and offer more workshops.

#### Program Performance / Outcome

One DSMP workshop has been completed with 5 participants successfully completing the workshop.

#### Hospital’s Contribution / Program Expense

The hospital is providing the staff and space to host the workshops.

### FY 2016 Plan

#### Program Goal / Anticipated Impact

To grow and market the Healthier Living Program within the hospital and establish the program for patients and community members with chronic conditions.

#### Measurable Objective(s) with Indicator(s)

1. Host 4 CDSMP & 4 DSMP Workshops
2. 80 participants will participate and complete a CDSMP or DSMP workshop.

#### Baseline / Needs Summary

High rates of individuals with Chronic Diseases such as: Diabetes, CHF, COPD, High Blood Pressure, Asthma and Arthritis.

#### Intervention Actions for Achieving Goal

Develop a Marketing/Communication Plan to promote and grow the program.

Develop a sustainable referral method from physicians to the program.
## ECONOMIC VALUE OF COMMUNITY BENEFIT

9/24/2015  
500 St. Joseph’s Hospital and Medical Center  
Complete Summary - Classified  
For period from 7/1/2014 through 6/30/2015

<table>
<thead>
<tr>
<th>Benefits for Living in Poverty</th>
<th>Persons</th>
<th>Total Expense</th>
<th>Offsetting Revenue</th>
<th>Net Benefit</th>
<th>% of Organization Expenses</th>
<th>Revenues</th>
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<tbody>
<tr>
<td>Financial Assistance</td>
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<td>27,815,579</td>
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<td>2.9</td>
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<td>Medicaid</td>
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<td>110,719,461</td>
<td>130,580,649</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Community Services</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Community Health Improvement Services</td>
<td>8,779</td>
<td>1,308,618</td>
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<tr>
<td>B - Subsidized Health Services</td>
<td>1,293</td>
<td>214,469</td>
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<td>C - Financial and In-Kind Contributions</td>
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<td>3,220,812</td>
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<td>3,220,812</td>
<td>0.3</td>
<td>0.3</td>
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<td>D - Community Building Activities</td>
<td>132</td>
<td>14,130</td>
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<td>14,130</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>E - Community Benefi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation</td>
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<td>527,924</td>
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<td>527,924</td>
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<td>0.1</td>
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<tr>
<td>Totals for Community Services</td>
<td>18,221</td>
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<td>5,285,953</td>
<td>0.5</td>
<td>0.5</td>
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<tr>
<td>Totals for Living in Poverty</td>
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<td>274,401,642</td>
<td>110,719,461</td>
<td>163,682,181</td>
<td>16.6</td>
<td>16.8</td>
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</table>

<table>
<thead>
<tr>
<th>Benefits for Broader Community</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Community Health Improvement Services</td>
<td>22,481</td>
<td>363,765</td>
<td>28,808</td>
<td>334,957</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>B - Health Professions Education</td>
<td>3,431</td>
<td>21,550,183</td>
<td>165,813</td>
<td>21,384,370</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>C - Subsidized Health Services</td>
<td>0</td>
<td>131,095</td>
<td>0</td>
<td>131,095</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>D - Research</td>
<td>1,522</td>
<td>29,899,507</td>
<td>20,835,851</td>
<td>9,062,656</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td>E - Financial and In-Kind Contributions</td>
<td>15</td>
<td>247,749</td>
<td>0</td>
<td>247,749</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>F - Community Building Activities</td>
<td>385</td>
<td>247,415</td>
<td>41,100</td>
<td>296,315</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Totals for Community Services</td>
<td>27,834</td>
<td>52,498,714</td>
<td>21,072,572</td>
<td>31,327,142</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Totals for Broader Community</td>
<td>27,834</td>
<td>52,498,714</td>
<td>21,072,572</td>
<td>31,327,142</td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Totals - Community Benefit</td>
<td>114,888</td>
<td>326,811,355</td>
<td>131,792,033</td>
<td>195,019,323</td>
<td>19.8</td>
<td>20.0</td>
</tr>
</tbody>
</table>

| Unpaid Cost of Medicare       | 26,233  | 167,878,958   | 138,542,081        | 49,336,895  | 5.0                      | 5.1      |
| Totals including Medicare     | 141,131 | 514,690,312   | 270,334,094        | 244,356,218 | 24.8                     | 25.1     |

Signature of Chief Financial Officer  
Jeffrey P. Jackson  
V.P. of Financial Operations  
Calculation of community benefit expense is derived using a cost accounting methodology.
APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

2015-2016 COMMUNITY BOARD MEMBERS – ST. JOSEPH’S HOSPITAL AND MEDICAL CENTER AND ST. JOSEPH’S WESTGATE MEDICAL CENTER

- Aking, MD, Rodd, Family Medicine Physician, Trinity Adult Medicine
- Bayless, Justin, CEO of Bayless Healthcare Group
- Collum, MD, Earle “Smitty” (ex-officio member), Chief of Medical Staff, Medical Director of Department of Pathology, St. Joseph’s Hospital and Medical Center
- Davis, J.D. Helen (ex-officio representative from East Valley Hospitals Community Board) Family law attorney; The Cavanagh Law Firm, P.A.
- Dolan, R.S.M. Sister Sherry, Sister of Mercy
- Egbo, M.D. Obinna, Physician President/CEO of Zion Medical Group, PPLC
- Garewal, Jr. Harry (Board Chair), Healthcare and business consultant; CEO of Trin and Associates, LLC
- Gentry, Patti (Board Vice Chair) Commercial real estate broker, Arizona Commercial Advisors
- Hatfield, James, Executive VP/CFO, Arizona Public Service Co./Pinnacle West Capital Corp. (public utility company)
- Heredia, Carmen, Chief of Arizona Operations, Valle del Sol (non-profit organization)
- Horn, Rick, Independent financial and retail advisor
- Hughes, R.S.M., Sister Phyllis, Sister of Mercy, healthcare consultant
- Hunt, Linda (ex-officio member), President/CEO, Dignity Health in Arizona
- Little, M.D. Andrew, Co-Director, Barrow Interdisciplinary Skull Base Program: Co-Director, Barrow Pituitary Center, Barrow Neurosurgical Associates
- Mason-Motz, Cassandra (Secretary of the Board), Retired from City of Phoenix Police
- Million, Jean-Pierre, “J.P.” Director, CVS Caremark (bioscience and pharmaceuticals)
- Perlick, R.S.M.: Sister Nancy, Sisters of Mercy, Associate Director, Activities/Athletics; Xavier College Prep
- Schembs, Jim, Retired corporate CEO
- Silva, Margarita, Immigration attorney; M.Silva Law Firm, PC
- Simkin, Gayle, Infection Control Preventionist, Kindred Hospital
- Stoup, David, Co-Chairman/CEO, Healthy Lifestyle Brands (healthcare products and services)
- Tierney, David, (Chair – Community Health Integration Network – CHIN) Construction law attorney; Sacks, Tierney, P.A.
- White, Patty, (ex-officio member) President/CEO, St. Joseph’s Hospital and Medical Center
- Yazzie-Devine, Diana, President/CEO, Native American Connections (non-profit organization)
2015-2016 COMMUNITY HEALTH INTEGRATION NETWORK (CHIN) MEMBERS –
ST. JOSEPH’S HOSPITAL AND MEDICAL CENTER AND ST. JOSEPH’S WESTGATE
MEDICAL CENTER

- **Alonzo, Anna**, Office Chief Chronic Disease Prevention Programs Arizona Department of Health Services/Bureau of Tobacco and Chronic Disease
- **Battis, Eric**, Chief Operations Officer Adelante Healthcare
- **Bauer, John**, Director of Finance at St. Joseph’s Hospital and Medical Center
- **Brewer, DeeAnn**, Grants Manager Esperanca
- **Brown, Gail**, Nurse Practitioner St. Joseph’s Hospital and Medical Center
- **Brucato-Day, Tina**, Hospital Administrator at St. Joseph’s Westgate Hospital
- **Dal Pra, Marilee**, VP of Programs at Virginia G. Piper Charitable Trust
- **Flaherty, Charlene**, Director of Southwest-Arizona/Nevada Cooperation for Supportive Housing
- **Garganta, Marisue**, Director of Community Health Integration & Community Benefit at St. Joseph’s Hospital and Medical Center
- **Hager, CJ**, Director Community Health Policy, St. Luke’s Health Initiatives
- **Heredia, Carmen**, Chief of Arizona Operations - Valle Del Sol (St. Joseph’s Hospital Community Board Member)
- **Hesse, Maria**, Vice Provost for Academic Partnerships – ASU
- **Hoffman, Terri**, Vice President of Development for St. Joseph’s Foundations
- **Jewett, Matt**, Grants Manager at Mountain Park Health Center
- **Mascaro, CarrieLynn**, Sr. Director of Programs – Catholic Charities
- **Mason-Motz, Cassandra**, Retired (St. Joseph’s Hospital Community Board Member)
- **McBride, Sr. Margaret**, VP Organizational Outreach at St. Joseph’s Hospital & Medical Center
- **Mezey, Mary**, Manager, Office of Community Empowerment at Maricopa County Dept. of Public Health
- **Mitros, Melanie**, Director, Strategic Community Partnerships at St. Luke’s Health Initiatives (SLHI)
- **Pena, Sara, MD, MPH**, Associate clinical professor, Department of Family Medicine at the University of Arizona College of Medicine and assistant professor/affiliated faculty of Department of Family Medicine at the Creighton College of Medicine at St. Joseph’s Hospital and Medical Center
- **Ranus, Lucy**, Program Manager - Barrow Prevention & Outreach – Barrow Neurological Institute
- **Robinson, Kristina**, Community Benefit Specialist at St. Joseph’s Hospital and Medical Center
- **Simkin, Gail**, Kindred Hospital (St. Joseph’s Hospital Community Board Member)
- **Smith, Carrie**, Chief Operating Officer Foundation for Senior Living (FSL)
- **Stutz, Linda**, Vice President Care Management at Dignity Health
- **Tierney David**, Trial Lawyer Sacks Tierney P.A. (St. Joseph’s Hospital Community Board Member and Chair for CHIN)
- **VanMaanen, Pat**, Health Consultant at PV Health Solutions
- **Vasquez, Berenise**, Community Benefit Specialist – St. Joseph’s Hospital
- **Whitaker, Ph.D, Matthew.,** ASU Foundation Professor of History – ASU
APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital’s mission and its commitment to improving community health and well-being.

St. Joseph’s Hospital and Medical Center, has three pillars: patient care, medical education and research. Physicians and researchers at St. Joseph's are dedicated to investigating and discovering new and powerful therapies with one ultimate goal - to enhance patient care. With both basic research laboratories as well as hundreds of clinical trials, patients have access to state-of-the-art treatments.

Medical education at St. Joseph's includes both educations for medical students through our partnership with Creighton University School of Medicine as well as post-medical school training through residency and fellowship programs. Medical education at St. Joseph's includes both education for medical students through our partnership with Creighton University School of Medicine as well as post-medical school training through residency and fellowship programs. The faculty is training future physicians, today.

Ecology Report FY 2015

Community Health

St. Joseph’s Hospital and Medical Center (SJHMC) also conducted efforts to ensure environmental improvement through the Ecology or “Go Green” initiatives implemented throughout our facility. We identified our waste stream to consist of the following in fiscal year 2015 (FY15):

<table>
<thead>
<tr>
<th>Type of Waste</th>
<th>Percent of Waste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Municipal Solid Waste (MSW)</td>
<td>79%</td>
</tr>
<tr>
<td>Recycling</td>
<td>14%</td>
</tr>
<tr>
<td>Regulated Medical Waste (RMW)</td>
<td>6%</td>
</tr>
<tr>
<td>Pharmaceutical Waste</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

The Practice Green Health industry benchmarks established a goal of 60% municipal solid waste and 10% regulated medical waste. SJHMC is exceeding the industry benchmark for regulated medical waste, and our recycling efforts have continued to reduce the amount of material being land-filled as municipal solid waste. We continue to expand our recycling program and educate our staff about the types of materials that can be diverted from the landfill.

In FY15, we land-filled 29 pounds of waste (per adjusted patient day) with a 14% recycling rate. This compares to 21.8 lbs./apd and a 15% recycling rate in FY14. This is not at the Dignity Health system-wide goal (15lbs/apd), and represents that there are opportunities for education and improvement. This calculated recycling rate only represents the data provided from our recycling vendors, and does not include all recycling and “Go Green” activities conducted by the various departments as described below.

- Energy efficient lighting retrofits in several departments;
- Use of Grainger “KeepStock” inventory management system to better track the amounts of supplies ordered throughout the hospital;
- Incorporated green practices in various remodel projects, including reuse of existing materials when possible, and recycling of generated construction materials and metals;
- Maintained 1,200 sq. ft. or artificial turf in place of grass;
- Recycling of kitchen grease and oils; and
- Reduced use of bottled water and purchase of some locally grown produce.
The “Go Green” team at SJHMC remains committed to sustainability efforts at our campus. Examples of materials that are recycled at SJHMC include: cardboard, HIPAA confidential documents, plastics, metals, oil, and universal waste (mercury, batteries, light ballasts, etc.). We also participate in food donations on a monthly basis.

I. Shipping and Receiving / Materials Management
SJHMC Materials Management continues to conduct the following “Go Green” initiatives at the Shipping/Receiving Dock:
1. Recycle packing materials (bubble wrap, Styrofoam popcorn and packing paper).
2. Reuse shipping boxes from incoming packages.
3. Use internal package tracking system that eliminates half of previous printing activities.

Materials Management estimated that this recycling and reuse activity resulted in 500 to 1,000 pounds of recycled boxes and packing material for FY15.

II. Food & Nutrition Services
Food and Nutrition Services (FNS) is committed to finding innovative and environmentally friendly methods to provide quality products to the facility. The following represent the “Go Green” initiatives for FNS:
1. Grease/Cooking Oil Recycling – 12,269 Gallons in FY15. This recycling activity resulted in a total payment of $134.03 for FY15 to the hospital. The grease/cooking oil recycling vendor was changed in November 2014 to Filta/Eco-Kitchen Solutions, who provides a more comprehensive Environmental Impact Report for the services conducted at SJHMC.
   a. In the fourth quarter of FY15, SJHMC was provided with the following data from Filta:
      i. 2,935 pounds of oil saved with FiltaFry service
      ii. 2,015 pounds of waste oil collected and recycled with FiltaBio service
      iii. The waste oil is recycled into biodiesel, which is estimated to have a carbon offset/savings equivalent to planting 367 trees and a reduction in greenhouse gases equivalent to 7,362 pounds.
   2. Recycling of cans, paper, and plastics
      a. Collection bins were placed in the Cafeteria and Kitchen
      b. Kitchen collection bin averages 260 #10 cans per day – 94,900 annually
   3. Solid waste reduction activities
      a. Cafeteria food waste is monitored and production volumes are adjusted to minimize food waste.
      b. Estimated 42 pounds per day of reduced solid waste from food – 15,330 pounds annually

FNS also participates in various food donation activities estimated to account for 15,600 pounds of donated food for FY15.

III. Clinical Activities
Dignity Health has set a 75% total overall reprocessing savings goal for FY15. Program savings are a guide to help get the facility to the overall saving goal. Dignity provides Stryker Sustainability with each facility’s device usage every 6 months. Savings are realized in the form of cost diversion/avoidance each time a Stryker device is purchased instead of a full-priced OM (Original Manufacturer) device. The corporate sustainability initiatives associated with Stryker Sustainability Solutions device reprocessing data for FY15 showed a fiscal year to date cost avoidance of $604,833.00 for SJHMC. This cost avoidance estimate includes data from June 2014 to March 2015.
Arizona Service Area
Public Policy and Advocacy

Delivery System Redesign - Advocated for a highly-integrated, sustainable and just health care delivery system as follows:

- Supported our hospital CEOs, policy advocacy liaisons, and other hospital executives as they sought opportunities and demonstrate leadership to refine the community’s experience with ACA implementation.
- Continued development of community partnerships, both existing and new, to further define and advance population health.
- Actively influenced state and local Chambers of Commerce’s position and education around the ACA implementation process.
- Advocated for the transfer the Arizona Division of Behavioral Health Services (Division) out of the Department of Health Services into the Arizona Health Care Cost Containment System. The Division is the permanent authority for publicly funded behavioral health services in Arizona. Consistent with Dignity Health’s efforts to integrate behavioral health and acute care health into our healthcare delivery model to improve the overall quality of care for patients. Integrating the administration and regulatory functions will optimize resources achieving more efficiency with our partners Mercy Care Health Plan and our Mercy Maricopa Integrated Care.
- Participated in an Arizona coalition that successfully advocated a change in licensure for outpatient behavioral health treatment facilities to collocate (inside) a licensed behavioral health or acute care facilities. This measure improves the care coordination across the spectrum by integrating lower level clinical behavioral health needs with more acute care services.

Medicare & Medicaid - Protected the integrity of the Medicare and Medicaid programs while advocating for adequate provider payments in the following ways:

- Successfully established an educational platform to inform healthcare providers, payors, business executives, advocates, community leaders, members of the media and elected officials, about the potential state-level consequences of King v. Burwell.
- Advocated for protecting Arizona’s Medicaid expansion by providing support and information to advocates involved in the Medicaid Restoration lawsuit. Held meetings with legislators and stakeholders to clarify the purpose of the assessment and its impact on Arizona’s health.
- Advocated to block the implementation of the legislatively passed 5% rate cut to AHCCCS providers. Dignity Health along with 144 other AHCCCS providers wrote comment letters to the AHCCCS Director detailing the serious threat the 5% cuts will have on the integrity of network if fully implemented. The halt to the policy saved an estimated $7.5 million in cuts to the Dignity Health Arizona Service Area.
- Actively engaged in two separate work groups to provide input into the development of Arizona next 1115 Waiver proposal to ensure mandatory co-pays and other cost sharing proposals are effective yet do not negatively affect current rate methodologies to Dignity Health. The current waiver expires in 2016.
- Monitored the outcome of Biggs v Betlach in the AZ Supreme Court and provided additional legal support including amicus briefs in support of Medicaid Expansion and Restoration. Met with legislators and the media to educate them on the need for the program and articulating how the assessment has no impact on the State general fund or taxpayers.
Financing & Operations - Advoacted for sustainable health care financing in support of resilient hospital infrastructure, operations and service line growth as follows:

- Partnered with AZ Congresswoman Kyrsten Sinema to hand-deliver a Dignity Health letter directly to VA Secretary McDonald detailing more than $19 million in outstanding VA claims due to Dignity Health and explaining the complex billing problems within the VA.
- Submitted a Comment letter to VA Secretary McDonald regarding regulations to the expanded access to care to non-VA care through the Veterans Choice Program. Recommendations were provided that sought to improve the VA Choice program with respect to the mileage requirement, timely payment of claims and contracting to provide care. Dignity Health was successful in getting the 40-mile criteria adjusted to allow for a more flexible measurement of mileage based on the veteran’s home and road geography.
- Created a VA claims process flow chart which illustrates the complex, obsolete and inefficient processes that contributes greatly to delayed payments or no payment to Dignity Health. The flow chart helped identify key pinch points in the VA system that creates the bottlenecks for claims processing. The flow chart has been used in discussions with the VA and will ultimately be shared with members of Congress to advocate for significant policy changes in the VA.
- Influenced key members of Congress to oppose reforms to the 340B program. Engaged Dignity Health 340B Pharmacists and Hospital leadership in the efforts to protect the 340B program as key Congressional Committees considered language to change the 340B program. This advocacy lead to preventing the inclusion of an amendment to the 21st Century Cures bill. The 340B program provides Dignity Health $45 million in savings annually.

Health IT, Privacy & Security - Improve provider and patient connectivity while maintaining the safety and security of medical information.

- Advocated to delay and modify Meaningful Use Stage 2 requirements and extended time to attest.
- Participated in advocacy efforts to expanded scope of practice for dental hygienists to include teledentistry and to have services covered AHCCCS for enrolled members under the age of 21.

Access/Community Health - Advocated for health care access for all, while improving overall health of communities, with special attention to the poor, vulnerable and disenfranchised by:

- Advocating and supporting legislation with community health providers in Arizona to expand the types of medical professions that can participate in the Primary Care Provider Loan Repayment Program and the Rural Private Primary Care Provider Loan Repayment Program adding: pharmacists, advance practice providers and behavioral health providers.
- Provided advocacy strategy support and prevented many onerous and unnecessary regulatory requirements around emerging public health issues, including Ebola.
- Worked collaboratively with stakeholders for compassionate laws in Arizona for victims of human trafficking with the passage of a provision that allows a person convicted of prostitution prior to July 24, 2014 to apply to the court to vacate the person’s conviction if the court finds by clear and convincing evidence that the person’s participation in the offense was a direct result of being a victim of sex trafficking.
Selected Highlights of the Social Impact of Dignity Health Investments – Phoenix Service Area:

Dignity Health investments support nonprofit organizations that deliver an array of services to low-income communities surrounding St. Joseph’s, Mercy Gilbert, and Chandler Medical Centers.

- **Chandler Christian Community Center**
  In 2012, the Chandler Christian Community Center (CCCC) used their loan from Dignity Health to renovate and expand their center in Chandler, Arizona. The construction was completed and ribbon cutting took place in March 2015. CCCC provides emergency food services, home-delivered meals to seniors, ESL classes, income tax assistance, and 12-step support groups to adults and children. As a Family Resource Center, they also offer programs to help individuals and families combat conditions that exacerbate poverty, such as early literacy education and health and wellness services.

- **Native American Connections, HomeBase Youth Services**
  Native American Connections (NAC) is a non-profit dedicated to serve and provide affordable housing to Native American men in recovery from substance abuse. HomeBase Youth Services, a program within Native American Connections, Inc., continues to offer 25 units of housing – financed originally by Dignity Health – along with wrap-around support such as GED/college readiness, employment and life skills courses, financial literacy, and wellness resources to homeless youth ages 18-24.

- **Prestamos Community Development Financial Institution (CDFI), LLC**
  Dignity Health has been a partner with Prestamos CDFI since 2008. Dignity Health’s investment in Prestamos has enabled Prestamos to grow in its impact on job development and growth in the disadvantaged communities of Arizona.

  Prestamos CDFI provides lending programs for small businesses located in both rural and urban communities in Arizona, and to provide training and technical assistance to economically disadvantaged individuals and underserved communities that enable them to effectively use credit and capital.

- **Arizona Community Foundation**
  Dignity Health has loaned funds to the Arizona Community Foundation, which in turn provides loans to build the capacity of nonprofit community-based organizations in Arizona.