Dignity Health

A message from

Tim Bricker, President and CEO of Chandler Regional Medical Center, and Terry Miller, Chair of the East Valley 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.

Chandler Regional Medical Center shares a commitment to improve the health of our community, and delivers 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), Chandler Regional Medical Center provided $37,088,763 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 $48,969,960.

Dignity Health’s Chandler Regional Medical Center Board of Directors reviewed, approved, and adopted the Community Benefit 2015 Report and 2016 Plan at its November 17, 2015 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (480) 728-3458.

Tim Bricker, President/CEO

Terry Miller, Chairperson, Board of Directors
# Table of Contents

**Executive Summary** 3

**Mission, Vision, and Values** 5

**Our Hospital and Our Commitment** 6

**Description of the Community Served** 8

**Community Benefit Planning Process**
- Community Health Needs Assessment Process 10
- CHNA Significant Health Needs 10
- Community Benefit Plan Development Process 11
- Planning for the Uninsured/Underinsured Patient Population 13

**2015 Report and 2016 Plan**
- Summary, Anticipated Impact, and Planned Collaboration 14
- Program Digests 17

**Economic Value of Community Benefit** 37

**Appendices**
- Appendix A: Community Board and Committee Rosters 38
- Appendix B: Other Programs and Non-Quantifiable Benefits 41
EXECUTIVE SUMMARY

The City of Chandler is a growing and diverse city in Maricopa County, Arizona with nearly 250,000 residents of many ethnicities, and income and education levels. Surrounding communities include Gilbert, Mesa, Tempe, Awhatukee, Sacaton, Apache Junction, Casa Grande, Pinal County, Gila River Indian Reservation, and Guadalupe. Chandler is home to several major industrial firms that include Intel, Microchip and Orbital. However, despite strong economic growth, there continue to be many factors and social determinants of health in the suburban Chandler communities that need to be addressed in order to improve the health and wellbeing for the broader community, and the underserved. According to the Community Need Index (CNI), Chandler includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85122, 85128, 85139, 85202, 85283, and 85225.

According to research findings from the most recently completed Community Health Needs Assessment (CHNA) conducted in 2012, individuals lacking health insurance, whether chronically uninsured or experiencing gaps in insurance, avoid seeking care for conditions until the condition worsens to an unmanageable state. Strategies need to continue with a proactive focus on chronic disease management and access to health education and services. In addition, continuum of care initiatives should be encouraged that that will improve quality of life and decrease the need for extensive healthcare utilization.

The significant community health needs that form the basis of this report and plan were identified in the hospitals most recent Community Health Needs Assessment which is publicly available at http://www.dignityhealth.org/chandlerregional/. 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:

1. Infant mortality
2. Children emergency room visits and mortality
3. Adolescent pregnancy and risk behaviors
4. Injuries
5. Mental Health
6. Chronic Disease
7. Asthma
8. High blood pressure
9. Stroke
10. Chest Pain
11. Congestive Heart Failure
12. Cancer

After thorough review and analysis of the identified needs from the CHNA, Chandler Regional Medical Center has selected the health priorities listed below. The health priorities became the framework for the next step in the CHNA process, the implementation strategy, and associated goals, activities, and outcomes. The process for determining health priorities included review of primary and secondary data, feedback from internal and external stakeholders, and recommendations from the hospital’s Community Benefit Committee. Additional considerations included hospital and community assets, resources, and capabilities.
1. Chronic Disease (diabetes, heart disease, asthma, congestive heart failure)
   - Disease Management
   - Reduction in admission
   - Reduction in readmission
2. Access to medical primary and secondary prevention, health education, intervention, and treatment
3. Oral Health
4. Mental Health
5. Obesity
6. Transition Care: Hospital to home
7. Continuum of Care

In FY15, Chandler Regional Medical Center took numerous actions to help address identified needs. These included:

1. --Dignity Health Community Grants Program
   - Senior Community Wellness
   - I-Help
   - Partnership to Build Resilient Families
2. Center for Diabetes Management
3. Mission of Mercy
4. Early Childhood Oral Health Program
5. Dignity Health Children’s Dental Clinic
6. Immunization Program
7. Building Blocks for Children Hearing and Vision Screening
8. Community Education and Support groups
9. Teen Pregnant and Parenting Program
10. Injury Prevention Program
11. Lactation Services
12. Center for Faith Health Ministry
13. Discharge Call Center
14. Circle the City
15. Chronic Disease Self-Management

For FY16, the hospital plans to continue the FY15 programs, and expand in the following areas:

1. Dignity Health Children’s Dental Clinic
2. Vision screening for children 0-3
3. Fall prevention program (Community Grant Program)
4. Senior Car Fit Program
5. Prescription Misuse Prevention

The economic value of community benefit provided by Chandler Regional Medical Center in FY15 was $37,088,763, excluding unpaid costs of Medicare in the amount of $11,881,197.

The Community Benefit Report and Plan is available upon request, distributed to key community partners, board members and constituents, and is on the Chandler Regional Medical Center and Dignity Health websites at http://www.dignityhealth.org/cm/content/pages/Community-Benefit.asp http://www.dignityhealth.org/chandlerregional/about-us/community-benefit-and-outreach.
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

HOSPITAL DESCRIPTION

Chandler Regional Medical Center (CRMC), a member of Dignity Health, is the longest established hospital in the southeast valley, providing more than 50 years of service to the community. Since the beginning, our commitment to quality patient care and service to our community has been the focus. Established as a small community hospital with 40 beds and 25 employees, Chandler Regional Medical Center has grown into a comprehensive acute-care hospital that provides a full spectrum of services including a Level I Trauma Center, open heart surgery program, neurosurgery, orthopedics, and high risk obstetrics and newborn services. With 338 acute-care licensed beds, more than 1,600 employees and 928 physicians representing all major specialties, Chandler Regional Medical Center provides comprehensive care, from routine check-ups and diagnostic services to a wide range of specialties including advanced diagnostic, surgical, robotics and intensive care services.

OUR COMMITMENT

Rooted in Dignity Health’s mission, vision and values, Chandler Regional Medical Center is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

Chandler Regional Medical Center is committed to meeting the health needs of the community by ensuring implementation of successful programs that meet the specific needs of the people it serves. Success is achieved through assessment of community needs, involvement of key hospital leaders, and implementation of community benefit activities. Organizational and community commitment includes:

Executive Leadership Team: The Chandler Regional Medical Center Executive Leadership Team is responsible for reviewing the Community Benefit Report and Plan prior to presentation and approval by the Community Board. The Executive Leadership Team’s contribution to the community benefit plan includes reviewing alignment of the Community Benefit Plan with the CHNA, the hospital’s overall strategic plan, and budgeting for resources.

Community Benefit Committee: The Community Benefit Committee (CBC), chaired by a board member, assists the community board in meeting its obligations by reviewing community needs identified in CHNA, recommending health priorities, recommending implementation strategies, presenting the hospital’s annual Community Benefit Report and Plan, presenting the hospitals CHNA Implementation Strategy, and monitoring progress. Refer to Appendix A for a listing of the CBC members.

Community Board: The Community Board is responsible for oversight and adoption of the CHNA and Implementation Strategy, approval of the Community Benefit Report and Plan, and program monitoring. Throughout the fiscal year the community board receives reports on community benefit programs. The chair of the Community Benefit Committee reports to the board regarding strategies, programs, and outcomes. Refer to Appendix B for a complete listing of current board members.
Community Benefit Department: The Community Benefit Department, under the Vice President of Mission Integration, is accountable for planning, implementing, evaluating, reporting, and ultimately for the success of designated programs. The Community Benefit Department is directly responsible for the CHNA and Implementation Strategy, Community Benefit Report and Plan, Dignity Health Community Grants committee, program implementation, evaluation, and monitoring, community collaboration, and reporting of community benefit activities. Key staff positions include: Director of Community Integration, Senior Coordinator for Community Benefit, Manager of Center for Diabetes Management, Manager of Community Education, Manager of Oral Health Program, Manager of Community Wellness, and Charge Nurse of Lactation Services.

Chandler Regional 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, examples Include:

ICAN
ICAN is a free, family-centered youth service in the East Valley providing a full complement of programs proven effective in equipping youth to achieve personal and academic success by tackling substance abuse, gang involvement and juvenile delinquency.

In 2010, ICAN received a $1,200,000 loan from Dignity Health. The loan was part of a $5 million campaign to build a new center in Chandler to deliver services to more at-risk children. The new center opened in 2012, serving over 350 more children with services that include after-school meals, tutoring, and physical fitness activities. Through ICAN services, fewer children engage in risky behaviors, gang activity, alcohol, and drug abuse. The loan was fully reimbursed to Dignity Health.

Chandler Christian Community Center
In 2012, the Chandler Christian Community Center (CCCC) used its $150,000 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, English as a Second Language 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. Payments are being made on time and there is a current outstanding balance due of $65,642.
DESCRIPTION OF THE COMMUNITY SERVED

Description of Community

According to City of Chandler Profile (2015), Chandler is a growing and diverse city in Maricopa County, Arizona with nearly 250,000 residents. When taking into consideration the total Primary Service Area (PSA) being served by Chandler Regional Medical Center, the community population is 792,009 (INTELLIMED, 2015). The growing population includes people of many ethnicities, income, and education levels. Key statistics include:

| Total PSA Population: 792,009 | Unemployment: 4.9 % * |
| White: 58.44% | Uninsured: 7.09% |
| Black/African American: 4.87% | Less than High School Diploma: 4.0% |
| Asian: 5.75% | Some high school: 5.5% |
| American Indian/Alaska Native: 2.98% | Medicaid: 13.07% |
| Native Hawaiian or Other Pacific Islander: 0.24% | Other area hospitals: Yes |
| Other Race: 0.14 % | Medically underserved areas: Yes |
| Two or More Races: 2.53% | |
| Hispanic or Latino: 25.05% | |
| Average Household Income: $81,496 | |

The City of Chandler is primarily served by Chandler Regional Medical Center for acute care and trauma services. Surrounding communities also being served by Chandler Regional Medical Center include Gilbert, Mesa, Tempe, Awhatukee, Sacaton, Apache Junction, Casa Grande, Pinal County, Gila River Indian Reservation, and Guadalupe. Chandler is home to several major industrial firms that include Intel, Microchip and Orbital. Despite strong economic growth, there continue to be many factors and social determinants of health in the suburban Chandler community that needs to be addressed in order to improve the health and wellbeing for the broader community, and the underserved. Challenges for the community include high rates of poverty, violence-associated injuries, a large non-English speaking population, and low education attainment, all of which create barriers to access. Downtown Chandler has a significant population of uninsured and underinsured non-English speaking persons of all age groups. A large majority of this population is also indigent with their primary source of income through day labor and seasonal work.

According to the Community Need Index illustrated below, Chandler has a mean CNI score of 3.1 and includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85122, 85128, 85139, 85202, 85283, and 85225. According to research findings from the most recently completed Community Health Needs Assessment conducted in 2012, individuals lacking health insurance, whether chronically uninsured or experiencing gaps in insurance, avoid seeking care for conditions until the condition worsens to an unmanageable state. For chronic conditions such as diabetes, asthma, or mental health, adults often skip medications or avoid filling prescriptions and subsequently visit the emergency department or are admitted to the hospital. Uninsured/underinsured individuals are less likely to receive preventive care and more likely to receive duplicate tests.
Strategies need to continue with a proactive focus on chronic disease management and access to health education and services. In addition, continuum of care initiatives should be encouraged that will improve quality of life and decrease the need for extensive healthcare utilization.

Community Need Index
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 the Community Benefit Committee and other stakeholders in the development and annual updating of the community benefit plan.

Community Health Needs Assessment Process

The most recently completed Community Health Needs Assessment for Chandler Regional Medical Center was adopted in November 2012. The Community Health Needs Assessment for the Chandler Regional Medical Center service area is the result of collaboration between CRMC and the Arizona State University Center for Health Information and Research (CHIR). Key stakeholders determined relevant indicators and assisted in the identification of data sources to be used. CHIR uses the Arizona Health Query (AZHQ) data system, which involves voluntary participation of healthcare organizations to track demographic information on more than four million persons. The AZHQ data used for this report include primary quantitative data submitted by Chandler Regional Medical Center as well as all Arizona medical data submitted by the Arizona Healthcare Cost Containment System (AHCCCS).

Indicators of a broad array of relevant factors in the social and economic environments, as well as traditional medical/physical indicators of community health, were analyzed. These data sources employed utilize different methods of data collection and help ensure that the perspectives of residents, community-based providers, and non-health sectors are included. A combination of qualitative information (e.g. survey results) and quantitative information (e.g. AZHG administrative health data) was included to provide the best picture of the community’s health. Secondary data were obtained from the (CNI), the U.S. Census Bureau, and Arizona Department of Public Health, Center for Disease Control and Preventions (CDC), and Behavioral Risk Factor Surveillance System (BRFSS).

The CHNA report was distributed to community partners, is available upon request, and is posted on both the Chandler Regional Medical Center hospital and Dignity Health websites. The CHNA is available on the Chandler Regional Medical Center website at http://www.dignityhealth.org/chandlerregional/about-us/community-benefit-and-outreach.

CHNA Significant Health Needs

A summary of key CHNA findings is below, including areas of priority for Chandler Regional Medical Center.

- **Maternal and Child Health:**
  Chandler has a high proportion of young families. Nearly three quarters of the population is under the age of 45. In addition, Chandler Regional Medical Center has a higher proportion of minority births than the Primary Service Area.
Pediatrics:
The most frequent diagnoses for emergency room visits by children at Chandler Regional Medical Center were related to injuries and poisonings.

Adolescent Risk Behaviors:
Adolescents in Arizona were more likely to engage in risk behaviors involving weapons, injuries, sexual behaviors, alcohol, drugs, and violence than the PSA or Maricopa County. Adolescent deaths were frequently related to suicide, motor vehicle accidents, homicide, firearms, drugs and alcohol.

Adult and Mental Health
Along with the rest of the nation the Maricopa County is experiencing an aging population. According to the Community Health Needs Assessment, adults (and particularly the senior population) are experiencing high rates of mental health issues. The majority of visits at Chandler Regional Medical Center related to mental health were individuals over the age of 45.

Chronic disease
Increasing numbers of adults and seniors living in Chandler suffer from chronic diseases that include diabetes, asthma, high blood pressure, and congestive heart failure. Chandler Regional Medical Center is experiencing readmissions related to poor transition, poor disease management, and lack of availability of post discharge resources for patients suffering from chronic disease.

Underserved:
The city of Chandler has a strong Hispanic and underserved migrant population. In addition, Chandler has a growing minority population of Asian and African Americans. According to the Chandler Regional Medical Center’s Community Health Needs Assessment, Chandler Regional Medical Center was more likely to have uninsured visits than the Primary Service Area or Maricopa County by over 4%. Planning for health care services to the disenfranchised populations must focus on prevention and partnership with community-based organizations. By leveraging the collective resources and talents of healthcare organizations, community organizations, governmental agencies, and faith communities, the health needs of underserved people can more effectively be met.

Asset Assessment
Within the Chandler service area, government and community based clinics exist including; Mission of Mercy, Chandler Care Center, and Chandler Christian Community Center that offer financial screening and free or low cost medical care. Organizations such as About Care, Neighbors Who Care, and Ahwatukee YMCA provide transportation and home visits to the elderly. Four food banks are dispersed throughout the service area, and refuge housing exists for the homeless. In addition, other hospital systems including Mercy Gilbert Medical Center (Gilbert), Banner Desert Medical Center (Mesa), Tempe St. Luke’s Medical Center (Tempe), Honor Health (Scottsdale), and IASIS Healthcare provide service.

Community Benefit Plan Development Process
The community benefit planning process begins with the review of the CHNA. Feedback, recommendations, and concerns are obtained from Dignity Health executive leadership, Community Benefit Committee, and East Valley Board members. In addition to Chandler Regional Medical Center internal stakeholders, needs
are identified by community constituencies, community partner organizations, and community leaders. Criteria used to prioritize the many identified community needs include demographic and statistical data obtained from the CHNA, patient utilization data, Chandler Regional Medical Center Strategic Plan, availability of resources (staff, time, expertise) funding, grants, CNI, and availability of existing community services.

As directed by the Dignity Health Mission Integration standard #7, 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 community benefit planning process also includes a review of all current and potential community benefit programs. Each program is evaluated for effectiveness, the need for continuation, discontinuation, or the need for enhancement. Of key consideration is the program’s ability to serve the disenfranchised (vulnerable populations) in the Chandler service area. When the CHNA Implementation Strategy is completed, it is presented for review and adoption by the Chandler Regional Medical Center’s Community Board. In addition, the Community Benefit Plan is presented to the board annually for review and approval.

Chandler Regional Medical Center uses the Community Health Needs Assessment, CNI, committee feedback, and constituency feedback to identify specific areas of needs within the service area that will be addressed by the hospital. Identified priorities include:

1. Chronic Disease (diabetes, heart disease, asthma, congestive heart failure)
   - Disease Management
   - Reduction in admission
   - Reduction in readmission
2. Access to medical primary and secondary prevention, health education, intervention, and treatment
3. Oral Health
4. Mental Health
5. Obesity
6. Transition Care: Hospital to home
7. Continuum of Care

As with any healthcare organization, it is not possible to have the resources to meet every need identified in the Community Health Needs Assessment. To address needs not specifically met by Chandler Regional Medical Center, strong and effective community partnerships ensure the community has access to care,
regardless of the need. Services not provided by Chandler Regional Medical Center include outpatient cancer treatment services, burn treatment, and in-patient pediatrics. These services, while not met by Chandler Regional Medical Center, are met by other health care facilities or partners in the service area. Organizations addressing the identified need not met by Chandler Regional Medical Center include Mercy Gilbert Medical Center, Ironwood Cancer and Research Center, Banner Health Care, Phoenix Children’s Hospital, Valley Hospital, Megellan Mental Health Services for inpatient and outpatient services, and Honor Health.

Planning for the Uninsured/Underinsured Patient Population

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 provided in FY15 is listed in the Economic Value of Community Benefit section of this report.

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for government programs, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health’s procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

In addition to staff awareness and education, the community is made aware of the Patient Financial Assistance Policy, including postings throughout the hospital that financial assistance is available. Specifically, signage is in English and Spanish in both the admitting areas and the emergency room, at urgent care, and other outpatient centers. Additionally, the Patient Financial Assistance Policy is posted on the Chandler Regional Medical Center website.

The patient financial services staff works diligently to ensure every underinsured or uninsured patient has the opportunity to apply for financial assistance (AHCCCS, Kidcare, Emergency AHCCCS, and Dignity Health packages).
2015 REPORT AND 2016 PLAN

SUMMARY

Chandler Regional Medical Center provides community outreach services to address many unmet needs of the disenfranchised population. Programs include immunizations, children’s hearing, vision, and oral screening, oral health services, community education, and chronic disease management. In addition, through Chandler Regional Medical Center’s Community Investment and Community Grants Program funding is provided to improve access to health care to underserved populations for identified and prioritized unmet needs. Service delivery is provided in a manner the offers dignity, respect, and human kindness.

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 *

Chronic Disease Management/Obesity: Reduction of Admission/Re-Admission

1. **Center for Diabetes Management:**
   a. Classes: Type 1, Type 2, Pre-diabetes, and Gestational diabetes.
   b. Collaboration with community based agencies, clinics and churches.
   c. Insulin pump starts, continuous glucose monitoring, and monthly support group.

2. **Chronic Disease Self-Management Program:**
   a. The Stanford University evidence-based program consisting of a workshop once a week, for six weeks, in community settings with an expected outcome of increasing participant’s ability to successfully manage chronic disease.
   b. In conjunction with community partners, workshops offered two to four times per year.

3. **Discharge Call Center:**
   100% of discharged patients receive a call to address questions or needs.

4. **Center for Faith Health Ministries**
   Covenant partnership agreements with faith community to offer education, support, and resources for congregational members, including support after discharge from the hospital.

Access to Care

1. **Immunization Program**
   a. Infant, children, adult, college age and senior focused immunization program.
   b. Largest health care organization providing immunizations for the state’s Vaccine for Children program.

2. **Building Blocks for Children Program**
   a. Hearing Screening and referrals. (Grant funded)
   b. Vision Screening and referrals. (Grant Funded)

3. **Dignity Health Community Grants Program**
   The Dignity Health Community of Care program funds Community of Care initiatives in which three or more agencies work collaborative to address community health needs and social determinants
of health. The health priorities identified include access to health care, chronic disease, mental health, and obesity.

a. **I-Help**: Shelter, case management (including mental health) for homeless population.

b. **Senior community Wellness**: Transportation, chronic disease management, and case management for at-risk population.

c. **Partnership to Build Resilient Families**: Mental Health, alcohol and substance abuse prevention through teen and parent education and support. The program in FY16 will include YMCA membership for health and fitness.

d. **Safe at Home**: Falls prevention and Chronic disease management.*

4. **Injury Prevention**

a. **Safe Sitter**: National recognized curriculum.

b. **Think First for Kids**: National brain and spinal cord injury prevention program taken into elementary schools and after school centers within the community. (Grant Funded)

c. **Senior car fit program**.

d. **Falls prevention.**

e. **Prescription drug misuse prevention.**

5. **Support Groups**

a. Free weekly breastfeeding support group.

b. Free weekly postpartum support group.

6. **Improving Birth Outcomes**

a. **Prenatal Classes**.

b. **Teen Pregnancy and Parenting Program.** (Grant Funded)

7. **Transition Care Program**

a. **Mission of Mercy**: Un-insured high-risk patient referrals to community based medical home.

b. **ACTIVATE Transitional Care Program**: Program is for high-risk patients and includes an embedded nurse in the hospital to ensure readiness for discharge and a Community Health Coach to visit the patient after discharge to improve continuum of care.

c. **Circle the City**: Transition care for homeless population requiring additional medical management.

**Oral Health Program**

1. **Dignity Health Children’s Dental Clinic (Grant Funded)**

a. Preventive dental services for children who face barriers to accessing dental care

b. Education, prophylaxis, sealants, fluoride varnish applications, x-rays provided by Affiliated Practice dental hygienists.

c. Community education for children/parents/pregnant women at schools and community partner sites.

2. **Early Childhood Oral Health Prevention Program (Grant Funded)**

a. Oral Health education, screening, fluoride varnish application and referrals for children ages 0-5 provided at community locations including WIC offices, immunization clinics, family resource centers, preschools and childcare centers.
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 Chandler Regional Medical Center Community Benefit Committee, 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 programs by conducting Community Health Needs Assessments every three years.

Planned Collaboration in place and/or Anticipated during FY16

1. **Maricopa County Department of Public Health (MCDPH):** MCDPH is conducting Dignity Health Arizona’s 2016 CHNA. In addition, Dignity Health Arizona is part of the Collaborative Community Health Needs Assessment (CCHNA) with other health systems for the 2017 Maricopa County, AZ CHNA.

2. **Town of Gilbert:** Dignity Health is a lead collaborator with the Town of Gilbert, along with several nonprofit agencies, collaborating to implement the Gilbert Wellness and Resource Center to improve access to care and availability of resources. Additionally, during FY16, Dignity Health will participate in the Town of Gilbert Behavior Health/Mental Health Task Force.

3. **City of Maricopa:** Dignity Health is a lead collaborator with the City of Maricopa, along with several nonprofit agencies, in the City of Maricopa to plan a coalition that will plan and open a crisis intervention center to increase resources related to suicide, domestic violence, rape, and substance abuse of Chandler.

4. **City of Chandler Prescription Medication Misuse and Abuse Task Force:** Dignity Health is in partnership with the City of Chandler and the ICAN organization to implement prevention initiatives that will reduce misuse of prescription drugs and drug abuse.

5. **Oral Health Collaborations:** Dignity Health is a member of the Arizona Oral Health Task Force sponsored by Senator Bradley to support legislation and policy change that will improve access to oral health, reimbursement, education, and innovation. In addition, Dignity Health participates in the state’s First Things First Oral Health Coalition to improve oral health for children.

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.
## PROGRAM DIGESTS

### Dignity Health Community Grants Program

| Significant Health Needs Addressed | ❑ X  Chronic Disease Management  
| ❑ X  Access to Care, including education, prevention, and intervention  
| ❑ X  Oral Health  
| ❑ X  Obesity  
| ❑ X  Mental Health |

| Program Emphasis | ❑ X  Disproportionate Unmet Health-Related Needs  
| ❑ X  Primary Prevention  
| ❑ X  Seamless Continuum of Care  
| ❑ X  Build Community Capacity  
| ❑ X  Collaborative Governance |

| Program Description | Each year the hospital allocates a percentage (0.05) of the previous year’s expenses to support the efforts of other not-for-profit organizations in the local communities. An objective of the Community Grants Program is to award grants to nonprofit organizations whose proposals respond to identified priorities in the Community Health Needs Assessment and initiative. Additionally, it is required that a minimum of three organizations work together in a Community of Care to address an identified health priority. |

| Planned Collaboration | Through the grant awards, Dignity Health becomes a collaborative partner with each Community of Care, and associated agencies. To ensure success of the program. Specific planned collaborations include: About Care, Neighbors Who Care, Valley of the Sun YMCA/Ahwatukee, Christian Community Center, Lutheran Social Services of the Southwest, Tempe Community in Action, Chandler Education Foundation, ICAN, My Sister’s Place. |

| Community Benefit Category | E2-a Grants: Community Grants Program |

### FY 2015 Report

| Program Goal / Anticipated Impact | 1. To award funds to nonprofit organizations whose proposals respond to the priorities identified in the CHNA and/or Community Benefit plan.  
| 2. Fund proposals that best align with the community benefit core principle a) disenfranchised populations with unmet health needs b) primary prevention c) continuum of care d) capacity building e) collaborative governance.  
| 3. Fund Communities of Care initiatives that best address identified needs and provide a more integrated approach and a collective impact on improving health. Specifically to address health priorities of chronic disease, access to health, oral health, mental health, and obesity.  
| 4. Increase community membership in Committee.  
| 5. Make program improvements based on committee and agency feedback, including LOI, FP forms and processes.  
| 6. Support success of initiatives through site visits, six month reports, annual report, workshops, and networking. |

| Measurable Objective(s) with Indicator(s) | 1. 100% of agencies awarded a community grant will be addressing an identified need as stated in the initiative, CHNA, and community benefit plan.  
| 2. 100% of the agencies awarded a community grant will be providing services to underserved/disenfranchised populations and align with the majority of Community Benefit Core Principles.  
| 3. 100% of the agencies funded will be part of a Community of Care whereas three or more agencies work collaboratively to address an identified need.  
| 4. New members will be added to the community grants committee.  
| 5. The Community Grants Committee will conduct annual committee and agency surveys, and make changes to program and forms based on feedback, and needs.  
<p>| 6. Committee will conduct site visits, collect and review six month reports, and prepare two workshops. |</p>
<table>
<thead>
<tr>
<th>Baseline / Needs Summary</th>
<th>It is core to the mission of Dignity Health to advocate for “our brothers and sisters who are poor and disenfranchised.” Additionally, the mission of Dignity Health states the importance of partnering with the community to improve health. Through the Community Grants program, community-based agencies work collaboratively to meet the needs of underserved populations. Dignity Health also recognizes that patients discharged from the hospital or emergency rooms often lack needed resources to fully recover and improve their health. This is particularly true for disenfranchised and underserved populations with significant barriers to accessing health care. Social determinants of health affect one’s access to needed post discharge services. Furthermore, there are limited community-based resources for education, intervention, and treatment for prevalent conditions that if left untreated, lead to decreased quality of life, frequent readmissions, and higher costs for patients and hospitals. Dignity Health seeks to collaborate and fund nonprofit organizations that formally and strategically work together with other nonprofit organizations in “Communities of Care” projects that address identified unmet health needs for underserved populations. According to the Community Needs Index Chandler has a mean CNI score of 3.1 and includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85122, 85128, 85139, 85202, 85283, and 85225. According to research findings from the most recently completed Community Health Needs Assessment (CHNA) conducted in 2012, individuals lacking health insurance, whether chronically uninsured or experiencing gaps in insurance, avoid seeking care for conditions until the condition worsens to an unmanageable state. For chronic conditions such as diabetes, asthma, or mental health, adults often skip medications or avoid filling prescriptions and subsequently visit the emergency department or are admitted to the hospital. Uninsured/underinsured individuals are less likely to receive preventive care and more likely to receive duplicate tests.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>Using a Request for Proposal (RFP) process, Community of Care agencies are invited to submit a Letter of Intent. The Community Grants Committee will review and invite selected agencies to submit a Full Proposal. The committee will review Full Proposals, participate in agency site visit, and attend agency presentations. The Committee will then discuss and vote on funding recommendations for approved Communities of Care. Final recommendations will be submitted to the system office for approval. In January, awarded agencies will receive funding. In addition the agencies will receive reporting expectations and a listing of workshops, meetings, and conferences.</td>
</tr>
<tr>
<td>Program Performance / Outcome</td>
<td>100% of stated objectives for the Community Grants Program were met during FY15: The Community Grants Committee awarded $240,002 for Dignity Health East Valley, and $141,882 for Chandler Regional Medical Center. Three Community of Care initiatives were awarded: <strong>Senior Community Wellness:</strong> $87,200 Transportation, support and case management for high risk Senior population admitted to Dignity Health hospital. <strong>I-Help:</strong> $100,000 Shelter, wrap around services, and case management for homeless population. <strong>Partnership to Build Resilient Families:</strong> $52,802 Education for at risk youth and parents for reduction in drug abuse.</td>
</tr>
<tr>
<td>Hospital's Contribution / Program Expense</td>
<td>$146,226, for program awards and program costs.</td>
</tr>
<tr>
<td>FY 2016 Plan</td>
<td>1. To award funds to nonprofit organizations whose proposals respond to the priorities identified in the CHNA and/or Community Benefit plan. 2. Fund proposals that best align with the community benefit core principle a) disenfranchised populations with unmet health needs b) primary prevention c) continuum of care d) capacity building e) collaborative governance.</td>
</tr>
</tbody>
</table>

Chandler Regional Medical Center
Community Benefit FY 2015 Report and FY 2016 Plan

18
3. Fund Communities of Care initiatives to address identified needs and provide a more integrated approach and a collective impact on improving health. Specifically to address health priorities of chronic disease, access to health, oral health, mental health, and obesity.
4. Increase membership of community based partners by at least one.
5. Conduct committee and agency survey and consider changes to improve program, including forms and process.
6. Monitor funded initiatives through site visits, six month report, and Dignity Health sponsored networking/workshops.

### Measurable Objective(s) with Indicator(s)
1. 100% of agencies awarded a community grant will be addressing an identified need as stated in the initiative, CHNA, and community benefit plan.
2. 100% of the agencies awarded a community grant will be providing services to underserved/disenfranchised populations and align with the majority of Community Benefit Core Principles.
3. 100% of the agencies funded will be part of a Community of Care whereas three or more agencies working collaboratively to address an identified need.
4. One to two new members will be added to the community grants committee.
5. Survey completed, and at least one program improvement made as a response to survey.
6. Committee members will complete site visits for 100% of awarded agencies, 100% of six month reports will be submitted and reviewed, and Dignity Health will sponsor at least one workshop.

### Baseline / Needs Summary
The Community of Care Grants program is an expectation of Dignity Health. However, more importantly, the program demonstrates Dignity Health’s commitment to a mission of advocacy and partnership to address underlying causes and social determinants of health. The Community Grants Program continues to demonstrate great collective impact on the most vulnerable in our society through access to needed services. There is also a quantifiable benefit associated with many funded programs for reduction in readmission, use of the emergency room for medical home, and improved continuum of care.

### Intervention Actions for Achieving Goal
1. Use the Request for Proposal (RFP) process to fund Communities of Care that address identified needs, align with core community benefit principles, and result in a collective impact.
2. Meet and recruit community leaders to participate in the Committee.
3. Monitor and support funded agencies through reporting, site visits, and one: one workshops, and connection to needed resources.

### Chandler Children’s Dental Clinic

#### Significant Health Needs Addressed
- Chronic Disease Self-Management
- Access to care
- Obesity
- Mental Health
- Oral Health

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

#### Program Description
The Children’s Dental Clinic utilizes Affiliated Practice Dental Hygienists to provide comprehensive preventive dental care to low-income and uninsured children. Services include dental exams, professional cleanings, radiographic imaging, sealants, fluoride varnish treatments, oral health education, nutrition education and referrals. Located at a school-based family resource center, the clinic is perceived as a safe-haven, where individuals can seek compassionate, culturally sensitive care. While clinic services are important, behavior change is a critical component of oral health. The dental clinic’s bilingual Oral Health Liaison strengthens the clinic’s connection with the community and instructs children, parents and caregivers on oral health care. The clinic is grant-funded with additional financial and operational support from Chandler Regional Medical Center.
| Planned Collaboration | The Chandler Children’s Dental clinic relies on collaborations to improve access to care and continuum of care. The clinic is located at the Chandler CARE Center, a program of the Chandler Unified School District (CUSD). The St. Vincent de Paul Dental Clinic provides restorative dental services at the same location, providing a direct link to services for patients.

Additional partnerships with a variety of dental professionals ensure that children in need of restorative care are treated appropriately. In addition to the St. Vincent de Paul clinic, children are referred to local dental clinics or private dental practices. Children in urgent need of restorative care with no means to pay are referred to partnering dentists who have agreed to provide free care to a limited number of children.

Dental Hygiene students from Mesa Community College Dental Hygiene School have regular rotations through the clinic. The students gain community and public health dental experience and increase the capacity of the clinic, enabling more children to be seen.

Through a partnership with Maricopa County Department of Public Health, the clinic educator provides education at schools in four Phoenix East Valley school districts which are scheduled with the School-Based Dental Sealant Program. |
| Community Benefit Category | A2b Community Based clinical services |
| **FY 2015 Report** | |
| Program Goal / Anticipated Impact | The Children’s Dental Clinic will improve the oral health of children ages 0 to 18 by reducing barriers to care and increasing awareness of the importance or oral health. |
| Measurable Objective(s) with Indicator(s) | 1. Number of children receiving full preventative dental services.
2. Percent of patients with “no new decay” at subsequent clinic appointments.
3. Number of children, pregnant teens, parents, educators, and community leaders who received comprehensive oral health education. |
| Baseline / Needs Summary | Oral health issues impact the overall well-being of children and Arizona children fall well below the national average. By third grade, Arizona children have the highest rate of cavities in the U.S. (75%) of which 40% is untreated (AZ Dept of Oral Health). More than 50% of children from low-income households have untreated decay and 22% have never seen a dentist. Lack of dental insurance is another risk factor for tooth decay with uninsured children having a greater incidence of untreated decay (47%) than their insured counterparts (27%). Because decay in primary teeth can affect the permanent teeth forming beneath the gums, children with poor oral health often become adults with poor oral health which can have serious health and social complications. |
| Intervention Actions for Achieving Goal | The Dignity Health Children’s Dental Clinic uses education and clinical prevention services to address oral health disparities. Reduced plaque scores and decreased decay indicate that children are incorporating healthy oral health habits at home. These behavior changes along with restorative care to alleviate pain have long-lasting impacts on children. Better nutrition and sleep lead to decreased absenteeism and increased attention in school. A positive dental experience for children increases the likelihood of continuing regular dental care which will carry into adulthood. |
| Program Performance / Outcome | 1. 972 children received full preventative dental services at 998 appointments.
2. 71% of patients had “no new decay” at subsequent clinic appointments.
3. 5581 children, pregnant teens, parents, educators, and community leaders received oral health education in the clinic and the community. |
| Hospital’s Contribution / Program Expense | Total FY15 program expenses were $201,837. Grants contributions totaled $139,091. The remaining $62,746 was contributed by the Dignity Health East Valley Foundation and Chandler Regional Medical Center. |
| **FY 2016 Plan** | |
| Program Goal / Anticipated Impact | The Children’s Dental Clinic will improve the oral health of children ages 0 to 18 by reducing barriers to care and increasing awareness of the importance or oral health. |
| Measurable Objective(s) with Indicator(s) | 1. Number of children receiving full preventative dental services
2. Percent of patients with “no new decay” at subsequent clinic appointments.
3. Number of children, pregnant teens, parents, educators, and community leaders who... |
received comprehensive oral health education.

<table>
<thead>
<tr>
<th>Baseline / Needs Summary</th>
<th>The Children's Dental Clinic serves as a dental home for children who otherwise might not otherwise have regular dental visits. Clinic patients face barriers to care including transportation and language. Oral health issues impact the overall well-being of children and Arizona children fall well below the national average. By third grade, Arizona children have the highest rate of cavities in the U.S. (75%) of which 40% is untreated (AZ Dept of Oral Health). More than 50% of children from low-income households have untreated decay and 22% have never seen a dentist. Lack of dental insurance is another risk factor for tooth decay with uninsured children having a greater incidence of untreated decay (47%) than their insured counterparts (27%).</th>
</tr>
</thead>
</table>
| Intervention Actions for Achieving Goal | 1. Provide preventive dental health services including dental exams, professional cleanings, radiographic imaging, sealants, fluoride varnish treatments, oral health education, nutrition education and referrals.  
2. Provide referrals to 100% of children in need of restorative dental care. Referral list of low-cost dental clinics provided to children with dental caries/dental needs  
3. Increase awareness and improve children’s oral and overall health through education for children and parents.  
4. Provide dental supplies to children at the clinic and in the community. |

<table>
<thead>
<tr>
<th>First Teeth First</th>
</tr>
</thead>
</table>
| Significant Health Needs Addressed | Chronic Disease Self-Management  
Access to care  
Obesity  
Mental Health  
X Oral Health |
| Program Emphasis | Disproportionate Unmet Health-Related Needs  
X Primary Prevention  
Seamless Continuum of Care  
X Build Community Capacity  
Collaborative Governance |
| Program Description | First Teeth First provides oral health education to expectant women and children 0-5 and their families, oral health screening and fluoride varnish treatment to children 0 – 5, and best practice oral health education to dentists, pediatricians, and other early childhood professionals. First Teeth First is funded primarily through First Things First (Arizona Early Childhood Development and Health Board). Chandler Regional Medical Center supports the program with administrative functions. |
| Planned Collaboration | Collaboration with community partners is key to the success of First Teeth First. Dignity Health has developed partnerships with more than 140 unique agencies throughout the Phoenix East Valley. Including WIC offices, Family Resource Centers, childcare centers, and preschools. Our collaboration with the Mesa Community College Dental Hygiene program provides an opportunity to engage future dental professionals. First and second year students participate in First Teeth First clinics as part of their community dental health rotations. |
| Community Benefit Category | A2-b Community-based clinical services |

<table>
<thead>
<tr>
<th>FY 2015 Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Goal / Anticipated Impact</td>
</tr>
</tbody>
</table>
| Measurable Objective(s) with Indicator(s) | 3000 children will receive fluoride varnish applications.  
3000 children will receive oral health screenings.  
3000 children will receive oral health education.  
4500 adults will receive oral health education.  
370 dental, medical and other professionals will receive best practice oral health information. |
| Baseline / Needs Summary | 30% of Arizona children ages 2 – 4 have untreated tooth decay (compared to 16% nationally) and 4 out of 10 four year olds have early or urgent treatment needs. Studies show that there are oral health benefits from applying fluoride varnish. The ADA recommends that children under age 6 in a high-risk category receive fluoride varnish application at 3-month intervals. |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------
<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>women and children age 0-5 and their families.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Children age 0–5 will be screened for oral health status and provided with fluoride varnish when appropriate.</td>
<td></td>
</tr>
<tr>
<td>3. All children receiving services will receive a toothbrush, toothpaste, floss, and educational materials.</td>
<td></td>
</tr>
<tr>
<td>4. Referrals to dental providers will be made to when appropriate.</td>
<td></td>
</tr>
<tr>
<td>5. Clinics will be scheduled at community locations including public school and private preschool programs, childcare centers, WIC offices, immunization clinics, Community Resource Centers, health fairs, Boys &amp; Girls Clubs, YMCA.</td>
<td></td>
</tr>
<tr>
<td>6. Bilingual staff will provide oral health education in Spanish when appropriate. Other language translation services will be available by phone if needed.</td>
<td></td>
</tr>
<tr>
<td>7. Mid-level providers including school nurses, home visitors, care coordinators, family resource coordinators, etc. will be provided with basic oral health education so they can inform, provide resources, and advocate for the families they serve.</td>
<td></td>
</tr>
<tr>
<td>8. Staff at pediatric medical offices will be provided with strategies to identify children at risk for tooth decay and encourage establishment of a Dental Home at age one.</td>
<td></td>
</tr>
<tr>
<td>9. Staff at general dental practices will be provided with strategies for working with young children and developing the practice as a dental home for children beginning at age one.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Health Needs Addressed</th>
<th>☑ Chronic Disease Self-Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>✕ Access to care</td>
<td></td>
</tr>
<tr>
<td>☑ Obesity</td>
<td></td>
</tr>
<tr>
<td>☑ Mental Health</td>
<td></td>
</tr>
<tr>
<td>☑ Oral Health</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Emphasis</th>
<th>✕ Disproportionate Unmet Health-Related Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>✕ Primary Prevention</td>
<td></td>
</tr>
<tr>
<td>✕ Seamless Continuum of Care</td>
<td></td>
</tr>
<tr>
<td>✕ Build Community Capacity</td>
<td></td>
</tr>
<tr>
<td>☑ Collaborative Governance</td>
<td></td>
</tr>
</tbody>
</table>

| Program Description | The Center for Faith Health Ministries is a relationship driven, presence building effort to strategically strengthen the bonds between the faith and healthcare communities. The Center works with 20+ faith communities providing: coordination for a valley-wide Faith Health Ministry Network; professional support and program development resources for Faith Community Nurses, Lay Health Leaders, and Faith Health Ministries; and works to build a collaborative relationship between Faith Health Ministries and Dignity Health. |

| Planned Collaboration | The Center has active Faith Health Ministries with 15 congregations; is cultivating new ministries with 5 more congregations; and has additional congregations searching for nurses and/or considering partnering with Dignity Health. |

| Community Benefit Category | A1 Community Health Education |

<table>
<thead>
<tr>
<th>FY 2015 Report</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Goal / Anticipated Impact</td>
<td>In FY15, Center suspended regular activity to conduct an extensive listening tour to determine how to better connect with and increase reporting from congregations served by the Center.</td>
</tr>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td>Increase the number of congregations submitting monthly activity reports to the Center.</td>
</tr>
</tbody>
</table>

| Baseline / Needs Summary | Baseline – Program: December of 2014, Center had only 1 congregation regularly reporting. Baseline/Need – Community: the Center provides vital links to health services & resources to: o 40% of CRMC’s immediate geographical area that exceeds the median CNI score of 3 o and outreach to 2 neighboring areas in Tempe & Maricopa. o 75% of MGMC’s immediate geographical area that exceeds the median CNI score of 2.6 o and outreach to 3 neighboring areas Gilbert & Queen Creek; and 2 additional areas in Mesa and Florence. |

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>1. Hire Field Coordinator to provide regular field support to active Faith Health Ministries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Hire Office Coordinator to overhaul Faith Ministry reporting tool and manage reporting.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Program Performance / Outcome | 1. From Jan – May of 2015, the Center regularly received reports from 7-13 congregations. |</p>
<table>
<thead>
<tr>
<th>Hospital's Contribution / Program Expense</th>
<th>$43,980</th>
</tr>
</thead>
</table>

**FY 2016 Plan**

**Program Goal / Anticipated Impact**

1. Coordinate and facilitate Faith Health Ministry Networking meetings/trainings to provide a forum for the exchange of best practices and ongoing faith-health education.
2. Build two-way communication channels between Dignity Health and Faith Health Ministries.

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

Goal 1 – by June 30, 2016:
- Conduct a minimum of 10 meetings/training

Goal 2
- Create a newsletter for distribution within CRMC and MGMC to build program awareness and partnership potential within the East Valley
- Distribute health-related information to Faith Health Ministries to meet their health needs

Goal 3
- Document number of congregants impacted by active Faith Health Ministries
- Track number of congregants receiving Dignity-Health branded health/wellness materials

**Baseline / Needs Summary**

The Center provides vital links to health services & resources to:
- 40% of CRMC's immediate geographical area that exceeds the median CNI score of 3
  - and outreach to 2 neighboring areas in Tempe & Maricopa.
- 75% of MGMC's immediate geographical area that exceeds the median CNI score of 2.6
  - and outreach to 3 neighboring areas Gilbert & Queen Creek; and 2 additional areas in Mesa and Florence.

Building human connections between the faith and healthcare communities is consistent with the “humankindness” campaign based on the idea that human connection leads to better health.

**Intervention Actions for Achieving Goal**

Goal 1
- Coordinate monthly networking & education meetings; plan trainings, as requested, to prepare Lay Health Ministers and review program basics with interested congregations.

Goal 2
- Publish Community Connections, on a quarterly basis, introducing East Valley staff and departments to Faith Health Ministries, and explaining opportunities to partner.
- Provide access to health/wellness materials, as requested by Faith Health partners.

Goal 3
- Provide on-going coaching and assistance to support Faith Health Ministries in becoming active and on how to report on the impact of their work with their congregation.
- Reach out to “centers of expertise” within Dignity Health, to connect our hospitals’ resources with the faith communities in our service area.

**Think First for Kids**

**Significant Health Needs Addressed**

- Chronic Disease Self-Management
- Access to care includes education, prevention and intervention
- Obesiy
- Mental Health
- Oral Health

**Program Emphasis**

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

**Program Description**

The *ThinkFirst for Kids Program* was developed by the ThinkFirst National Injury Prevention Foundation to increase awareness and knowledge among children about the risks of brain and spinal cord injury, and the use of good safety habits. The program is designed to enhance...
Intervention
Baseline
Anticipated
Program
Planned

25
Community Benefit FY 2015 Report and FY 2016 Plan

The Think First for Kids Program’s goal is to help students (grade 1-3) develop safety habits that will minimize their risks of sustaining a brain or spinal cord injury. This is done in a fun but meaningful way, which also involves teachers, parents and the community.

Planned Collaboration

The ThinkFirst for Kids collaborates with Barrow’s Injury Prevention Department, Chandler Regional Medical Center’s Trauma Department, Gilbert Public Schools and the Maricopa Unified School District #20. The program received a $3000 grant in December of 2014 from the Arizona Cardinals but does not have any other funding.

Community Benefit Category

A 1 Community Health Education

FY 2015 Report

Program Goal / Anticipated Impact

1. Secure funding to continue the program in Maricopa School District #20 and expand to at least 2 other Gilbert/Chandler school.
2. Secure a medical director for the program (preferably a pediatric neurologist or trauma surgeon)
3. Provide injury prevention education to a minimum of 450 third-grade children.
4. Enhanced collaboration with St. Joseph’s Hospital and Medical Center (SJHMC)/Barrows Neurological Institute (BNI), Chandler Regional Trauma Department Services, Community Education Team and Maricopa Unified School District #20 and the RX360 Initiative.

Measurable Objective(s) with Indicator(s)

1. Number of grant applications submitted; amount received
2. Medical director secured for program
3. Educational sessions provided to children and positive change in children’s safety attitude will be measured and documented through pre and posttest surveys and teacher evaluations
4. Increased number of collaborative events held with SJHMC/BNI and CRMC Trauma Services
5. Number of people served

Baseline / Needs Summary

Between January 1, 2015 and September 30, 2015, Maricopa and Pinal Counties have reported 133 water related incidents. Of those incidents: 37 were deaths of children five years old and under, 1 for a child between the ages of 6 and 12, 2 were for teens age 13-17, and 23 were adults 18 years and older (http://www.childrensafetyzone.com/go/articles.php?category_id=36).

Education and prevention is the key to decreasing these deaths.

In 2014, 61 children died by being backed over and 41 were run over. While the children were not driving these vehicles, teaching them that they can’t be seen in front of a vehicle can help prevent both backovers and frontovers.

In 2013 44 children were left in hot cars and died from Heatstroke. Teaching brothers and sisters to help remember to check everyone is out of the vehicle can also help decrease this statistic (http://www.kidsandcars.org/Statistics.html).

In 2011 there were 42 Arizona children killed due to homicide. It is essential in today’s world that we teach children how to handle their feelings and not resort to using a weapon on others or themselves. This is a critical prevention step for the safety of both children and adults in our community.

From 2006-2010 Unintentional injury was the third leading cause of death for all age groups and the leading cause of death for 1-4 year olds in Arizona (Arizona Injury Prevention Plan, by Brenna V. Rabel, MPH, Office of Injury Prevention, AZ Dept. of Health Services,2012Phoenix,AZ.

Intervention Actions for Achieving Goal

The Think First for Kids Program’s goal is to help students (grade 1-3) develop safety habits that will minimize their risks of sustaining a brain or spinal cord injury. This is done in a fun but meaningful way, which also involves teachers, parents and the community.

The curriculum for primary grades consists of 6 lessons which include:
1) General brain and spinal cord injury prevention
| Program Performance / Outcome | During Fiscal 2015 Staff spent 89.75 hours and drove 103 miles to 10 health fairs which were attended by 722 adults and 768 children who received information about Think First and preventing brain and spinal cord injuries. Staff also gave Think First lessons in 24 classrooms and 44 assemblies reaching 125 adults and 3049 children. Staff spent 145.5 hours and drove 1667 miles to bring these lessons to children in Chandler, Gilbert and the City of Maricopa. |
| Hospital’s Contribution / Program Expense | $15,297 – grant funding and Dignity Health support |

### FY 2016 Plan

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Present the Think First for Kids Program to at least two Title I schools and one after-school community center</td>
</tr>
<tr>
<td>2. Provide bike helmets for each student. We were not able to do this during 2014-2015 school year.</td>
</tr>
<tr>
<td>3. Continue collaboration with Maricopa School District in order to bring Think First for Kids Program to this new service area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable Objective(s) with Indicator(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Present 5 think First lessons to all third graders in public schools in the City of Maricopa, all of which are currently scheduled.</td>
</tr>
<tr>
<td>2. Continue to apply for grants to fund the program as evidenced by receiving either money or a rejection.</td>
</tr>
<tr>
<td>3. Pre and posttests were administered to 3rd grade students to assess knowledge transfer. Unfortunately not all schools in the City of Maricopa completed the pre-tests.</td>
</tr>
<tr>
<td>4. Post-evaluations will be given to all teachers once the classroom/assembly sessions are done in Maricopa.</td>
</tr>
<tr>
<td>5. Present Think First presentations to 2 schools in the Gilbert/Chandler school district if funding is secured.</td>
</tr>
<tr>
<td>6. Continue to collaborative Think First for Kids outreach events with SJHMC/BNI</td>
</tr>
<tr>
<td>7. If funding can be secured, provide lessons to children, 8-9 years at ICAN (Improving Chandler Area Neighborhoods)</td>
</tr>
</tbody>
</table>

### Baseline / Needs Summary

The Think First for Kids lessons are geared toward prevention in many areas.

**Please review what is listed under the previous heading of Baseline / Need Summary**

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide education to prevent brain and spinal cord injury at local health fairs and clinics.</td>
</tr>
<tr>
<td>2. Continue to provide Think First for Kids to the third graders in the public schools in the City of Maricopa public.</td>
</tr>
<tr>
<td>3. Continue to foster relationships with Gilbert Unified School District in order to be able to present in 1-2 schools.</td>
</tr>
<tr>
<td>4. Begin to foster relationships with Gilbert Unified School District in order to be able to present in 1-2 schools</td>
</tr>
<tr>
<td>5. Seek grant funding to sustain program</td>
</tr>
</tbody>
</table>
| Significant Health Needs Addressed | X  Chronic Disease Self-Management  
|                                  | X  Access to care  
|                                  | ❑  Obesity  
|                                  | ❑  Mental Health  
|                                  | ❑  Oral Health  |
| Program Emphasis | X  Disproportionate Unmet Health-Related Needs  
|                  | X  Primary Prevention  
|                  | ❑  Seamless Continuum of Care  
|                  | X  Build Community Capacity  
|                  | X  Collaborative Governance  |
| Program Description | Children's Vaccine Program: The award winning immunization program provides free immunizations (vaccines provided through the State Vaccines for Children Program) for children 18 years and younger who are uninsured, underinsured, on AHCCCS, or American Indian or Alaskan Native. Free clinics are held at Dignity Health and at sites throughout the East Valley service areas. Dignity Health provides staffing and supplies for the clinics.  
|                  | Adult Vaccine Program: Offers free adult immunizations (vaccines provided through the State Vaccines for Adults Program) for people 19 years and older who are uninsured, underinsured, on AHCCCS, or American Indian or Alaskan Native. A $15 administration fee is requested but is not mandatory. Free clinics are held at Dignity Health and at sites throughout the East Valley service areas. Dignity Health provides staffing and supplies for the clinics.  |
| Planned Collaboration | Chandler Unified School District, Chandler Care Center, Kyrene School District, Higley School District, Maricopa County WIC, VFC, VFA. Planned collaboration includes Queen Creek Fire Department and Town of Gilbert  |
| Community Benefit Category | A2b Community based clinics  |

### FY 2015 Report

| Program Goal / Anticipated Impact | 1. Administer vaccinations to children seeking immunization with emphasis on medically underserved communities and families.  
|                                  | 2. Provide access to 100% of our immunization clinics for agencies that assess eligibility of children for government subsidized healthcare programs.  
|                                  | 3. Provide education and awareness on the importance of immunizations.  
|                                  | 4. Data collection and entry of the data into the state immunization database.  
|                                  | 5. Ongoing evaluation of current contracts/partnerships.  
|                                  | 6. Enroll in the Vaccine For Adults (VFA) program to provide free vaccine to eligible adults.  
|                                  | 7. Provide adult vaccines at cost to the adult population at all contracted clinics.  
|                                  | 8. Offer seniors free flu vaccine and at cost shingles, t-dap and pneumonia.  
|                                  | 9. Modify adult immunization program discount as cost dictates, and increase client base through aggressive marketing and increase number of adult only clinics.  
|                                  | 10. Seek grant and donated funds to offset cost of program.  |
| Measurable Objective(s) with Indicator(s) | 1. Number of immunization clinics for children, adults, and seniors.  
|                                              | 2. Number of people served: children, adults, and seniors.  
|                                              | 3. Healthcare student discount program participants.  
|                                              | 4. VFA participants.  
|                                              | 5. Monitor and track revenue and pharmaceutical costs.  
|                                              | 6. Percentage of State data entered and up to date by June 30th 2015.  
|                                              | 7. Number and frequency of marketing contacts.  |
| Baseline / Needs Summary | According to the community needs assessment (2012-2015) some populations within the Dignity Health service areas in the East Valley have significant socio-economic barriers and are designated as Medically Underserved Populations (MUP). Many locations by zip code are also designated as Federal Medically Underserved Areas (FMUA). Children under the age of five living in poverty are 14.7% in the Dignity Health East Valley Service Area. Addressing the need for adult immunization availability, the CDC (2012) states, “Some
adults incorrectly assume that the vaccines they received as children will protect them for the rest of their lives. Generally this is true, except that:
- Some adults were never vaccinated as children
- Newer vaccines were not available when some adults were children
- Immunity can begin to fade over time
- As we age, we become more susceptible to serious disease caused by common infections (e.g., flu, pneumococcus)

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>Switched adult program to all VFA beginning in January of 2015</th>
</tr>
</thead>
</table>
| Program Performance / Outcome | 1. Provided 113 clinics for children and 102 clinics for adults  
2. Screened 2686 children for vaccine need, screened 1221 adults for vaccine need, administered 5427 vaccines to children, administered 1370 vaccines to adults, and administered 855 adult flu shots.  
3. Served 61 Healthcare students July through December 2014  
4. Served 233 VFA clients January through June 2015  
5. 100% of State data entered by June 30th 2015  
6. 42 physicians groups marketed to and all with one F/U encounter |
| Hospital’s Contribution / Program Expensed | $296,459 |

**FY 2016 Plan**

| Program Goal / Anticipated Impact | 1. Administer vaccinations to VFC eligible children seeking immunization with emphasis on medically underserved and disenfranchised communities and families.  
2. Administer vaccinations to VFCA eligible adults seeking immunization with emphasis on medically underserved and disenfranchised communities.  
3. Provide access to 100% of our immunization clinics for agencies that assess eligibility of children and families for government subsidized healthcare programs.  
4. Provide education and awareness on the importance of immunizations.  
5. Data collection and entry of the data into the state immunization database.  
6. Continue in the Vaccine For Adults (VFA) and the Vaccine for Children (VFC) program to provide free vaccine to eligible adults and children.  
7. Seek grant and donated funds to offset cost of program. |
| Measurable Objective(s) with Indicator(s) | 1. Number of immunization clinics for children and adults.  
2. Number of people served: children and adults.  
3. Monitor and track revenue and program costs.  
4. Percentage of State data entered and up to date by June 30th 2016.  
5. Number of grants written or awarded |
| Baseline / Needs Summary | According to the community needs assessment (2012-2015) some populations within the Dignity Health service areas in the East Valley have significant socio-economic barriers and are designated as Medically Underserved Populations (MUP). Many locations by zip code are also designated as Federal Medically Underserved Areas (FMUA). Children under the age of five living in poverty are 14.7% in the Dignity Health East Valley Service Area. The community partners that host the immunization clinics have done so for a number of years and the community members have an established relationship of trust with this Dignity Health provided service. The clinics are considered as safe havens for many of the clients.  
Addressing the need for adult immunization availability, the CDC (2012) states, “Some adults incorrectly assume that the vaccines they received as children will protect them for the rest of their lives. Generally this is true, except that:  
- Some adults were never vaccinated as children  
- Newer vaccines were not available when some adults were children  
- Immunity can begin to fade over time  
- As we age, we become more susceptible to serious disease caused by common infections (e.g., flu, pneumococcus)  
The ability to provide free VFA clinics increases the number of adults able to take advantage of the disease preventing benefits of immunization which in turn decreases the number of adults seeking urgent and emergent care in the community. |
| Intervention Actions | Maintain relationships with our current partners monitoring our ROI with their partnership. |
| for Achieving Goal | Continue to increase clients served at our current locations within budgeted means  
| | Continue to grow our multi-clinic offerings at Building Blocks clinic on Saturday and Tuesday evening.  
| | Continue to seek grant and other funds. |

### Building Blocks for Children Vision and Hearing Screening

#### Significant Health Needs Addressed
- Chronic Disease Self-Management
- Access to care
- Obesity
- Mental Health
- Oral Health

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

#### Program Description
Building Blocks For Children offers services to help medically prepare under-served children for school. The vision and hearing screening is a portable program targeting children 0-5 years in the East Valley community and serves children up to age 18 years. The clinics, located in areas of greatest need as identified in the 2012 Community Health Needs Screening for Chandler Regional Medical Center Service Areas, are accessible to those least likely to receive vision/hearing screening from mainstream health care. Dignity Health provides partial salary for the RN manager of the Community Wellness department and provides the employee benefits for the BBC program coordinator/screener. The salary of the coordinator is grant funded.

#### Planned Collaboration
Current collaborations include: City of Chandler, Chandler Care Center, Vision Quest 2020, HEARS for Children, Lions Vision Service Center, Ear Foundation of Arizona, Target Optic Service Center, The Birth Haven, Chandler Christian Community Center. Planned Collaboration: Gilbert Community Clinic

#### Community Benefit Category
A -2 Community Based Clinics

#### FY 2015 Report

| Program Goal / Anticipated Impact | To provide vision and hearing screening and education to the population of newborn -18 years in the Dignity Health service areas identifying those children requiring intervention and referral. |
| Measurable Objective(s) with Indicator(s) | 1. Number of clinics provided  
| | 2. Number of people served  
| | a. hearing screening  
| | b. vision screening  
| | c. H&V education  
| | 3. Number of grants  
| | a. submitted  
| | b. awarded  
| | 4. Number of partners  
| | 5. Number of referrals |

#### Baseline / Needs Summary
The community need assessment for the Service area continues to have high rates of poverty with limited access to healthcare, and a high MCH population. The current economic situation is impacting many insured, which are now under or uninsured, creating the need for more community based, affordable healthcare services. Families need assistance with building children’s readiness for school and providing vision screenings, vision education, hearing screenings, hearing education and referrals for follow-up care helps with this need. In addition, AZDHS and many pediatricians are sending their newborn patients to clinics for hearing screening as many families cannot afford the cost of this service when provided in the hospital at birth.

#### Intervention Actions for Achieving Goal
Weekly clinic at Chandler Christian Community Center, monthly clinic at Birth Haven, 7 preschool clinics. Attended community events to market the program.

#### Program Performance / Outcome
82 clinics were held  
76 were referred
636 were screened 944 were educated 8 partners 2 grants received 6 grants written

| Hospital's Contribution / Program Expense | $33,347 |

**FY 2016 Plan**

**Program Goal / Anticipated Impact**
To provide vision and hearing screening and education to the population of newborn -18 years in the Dignity Health service areas identifying those children requiring intervention and referral and ensuring that each child requiring intervention receives a referral in a timely manner.

**Measurable Objective(s) with Indicator(s)**
1. Number of clinics provided
2. Number of people served
   a. hearing screening
   b. vision screening
   c. H&V education
3. Number of grants
   a. submitted
   b. awarded
4. Number of partners
5. Number of referrals

**Baseline / Needs Summary**
The community need assessment states that the Service area continues to have high rates of poverty with limited access to healthcare, and a high MCH population. The current economic situation is impacting many insured, which are now under or uninsured, creating the need for more community based, affordable healthcare services. Families need assistance with building children’s readiness for school and providing vision screenings, vision education, hearing screenings, hearing education and referrals for follow-up care helps with this need. In addition, AZDHS and many pediatricians are sending their newborn patients to clinics for hearing screening as many families cannot afford the cost of this service when provided in the hospital at birth. Town of Gilbert is working with community partners to increase services and support to the citizens of Gilbert.

**Teen Pregnancy and Parenting Program**

**Significant Health Needs Addressed**
- Chronic Disease Self-Management
- Access to care
- Obesity
- Mental Health
- Oral Health

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

**Program Description**
1. Community- Teen Childbirth Preparation (CBP) - Childbirth classes are offered free to pregnant teens in the community. They are held every month (with the exception of July and December) at CRMC. The first 3 weeks concentrate on childbirth preparation and the 4th week focuses on preventing a second pregnancy through self-esteem exercises and discussion for the young women. The young dads are offered a Teen Boot Camp for New Dads (BCFND) facilitated by BCFND instructors who were also teen dads. Teens completing the entire series are awarded a child safety seat.
2. TEENS 4 Teens - provides teen moms and their babies’ empowerment through Teen Education, Encouragement, Networking and Support. The teen new moms group will concentrate on creating and assisting with positive & healthy life outcomes for this unique population. Pregnant teens are also welcome to attend.
3. High School Connect - on site childbirth education, healthy relationship skills, and financial literacy curricula are offered within several local high schools throughout the east valley.
<table>
<thead>
<tr>
<th>Planned Collaboration</th>
<th>Planned collaboration with local high school Compadre High School, Tempe Union School District. Also in process of running a pilot financial literacy curriculum within the Chandler Unified School District.</th>
</tr>
</thead>
</table>
| Community Benefit Category | A1a Community Health Education  
A1d Community Health Support group |

**FY 2015 Report**

| Program Goal / Anticipated Impact | 1. Secured funding from Phoenix Suns program expansion (healthy relationships curriculum within high school setting and continuation of child safety seat incentive.  
2. Continued offering TEENS 4 Teens on a weekly basis.  
3. Continue to offer Teen Childbirth Preparation a minimum of 6 times during the FY15.  
4. Consider program expansion for parenting teen dads.  
5. Expand program marketing/advertisement – currently working with marketing department. |
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Measureable Objectives(s) With Indicators(s) | 1. Research funding and submit a minimum of two grant applications prior to end of fiscal year.  
2. Discuss possibility of employee contributions to program with Foundation by FY15.  
3. Meet or exceed previous year attendance numbers for both Teen CBP and TEENS 4 Teens during the fiscal year.  
4. Implementation of Love is Not Abuse and Love Notes – healthy relationship curriculums at Compadre High School.  
5. Meet with various high schools in the service area and beyond to educate on Teen Pregnancy Programs offered by Dignity Health. |
| Baseline / Needs Summary | According to the community needs assessment, the Chandler and Mercy Gilbert service areas have one of the largest MCH populations in Maricopa County. There continues to be a high pregnancy rate in Chandler, and within smaller pockets of the service area. One third of the overall Arizona birth rate is attributed to teens 19 and under. Many pregnant teens are unemployed and dependents of their parents or live independently with little financial means. Some are uninsured, but most are eligible for state Medicaid (AHCCCS). Because of their limited financial means and resources available, they are clearly a disenfranchised population. This increases the need to provide education, access to care and community resources. Currently, there are very few resources in the state, county and city to address the needs of pregnant and parenting teens and their children. There are very limited resources or programs currently in our service area. |
| Intervention Actions for Achieving Goal | 1. Continued community outreach to high schools, OB offices, and social service agencies to market Teen Pregnancy and Parenting program.  
2. Create community partnerships/collaborations.  
3. Seek program grant and educational opportunities to expand and enhance program.  
4. Peer review of curriculum and implementation of Love Notes volume 2 within local high schools. |
| Program Performance / Outcome | Participants served during FY15  
Teen Childbirth Prep = 26  
TEENS 4 Teens = 143  
LINA/Love Notes High School = 98  
- Classes offered: 3  
- Support Groups offered:28  
- Classes offered: 12  
Secured to sources of funding |
| Hospital’s Contribution / Program Expense | $33,552 – Grant awards, Volunteer Services Fund, and system supported |

**FY 2016 Plan**

| Program Goal / Anticipated Impact | 1. Secure additional funding from grants for continued expansion (healthy relationships curriculum within high school setting and continuation of child safety seat incentive.  
2. Continued offering TEENS 4 Teens on a weekly basis.  
3. Continue to offer Teen Childbirth Preparation a minimum of quarterly throughout FY16  
4. Consider program expansion for parenting teen dads.  
5. Expand program marketing/advertisement – currently working with marketing department. Create a web page specific to the teen pregnancy and parenting program. |
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Measurable Objective(s) with Indicator(s) | 1. Research funding and submit a minimum of two grant applications prior to end of fiscal year  
2. Discuss possibility of employee contributions to program with Foundation. |

Chandler Regional Medical Center  
Community Benefit FY 2015 Report and FY 2016 Plan
3. Meet or exceed attendance numbers for both Teen CBP, TEENS 4 Teens, and high school component during the fiscal year.
4. Continue to offer Love Notes – healthy relationship curriculums at Compadre High School and work towards expanding to additional high schools.

**Baseline / Needs Summary**
According to the community needs assessment, the Chandler and Mercy Gilbert service areas have one of the largest MCH populations in Maricopa County. There continues to be a high pregnancy rate in Chandler, and within smaller pockets of the service area. One third of the overall Arizona birth rate is attributed to teens 19 and under. Many pregnant teens are unemployed and dependents of their parents or live independently with little financial means. Some are uninsured, but most are eligible for state Medicaid (AHCCCS). Because of their limited financial means and resources available, they are clearly a disenfranchised population. This increases the need to provide education, access to care and community resources. Currently, there are very few resources in the state, county and city to address the needs of pregnant and parenting teens and their children.

<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continued community outreach to high schools, OB offices, and social service agencies to</td>
</tr>
<tr>
<td>2. Create/continue to nurture community partnerships/collaborations.</td>
</tr>
<tr>
<td>3. Seek program grant and educational opportunities to expand and enhance program.</td>
</tr>
<tr>
<td>4. Peer review of curriculum, continue offering Love Notes volume 2, and implementation of financial literacy curriculum within local high schools.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Health Needs Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Chronic Disease Self-Management</td>
</tr>
<tr>
<td>X Access to care</td>
</tr>
<tr>
<td>X Obesity</td>
</tr>
<tr>
<td>X Mental Health</td>
</tr>
<tr>
<td>X Oral Health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Disproportionate Unmet Health-Related Needs</td>
</tr>
<tr>
<td>❑ Primary Prevention</td>
</tr>
<tr>
<td>X Seamless Continuum of Care</td>
</tr>
<tr>
<td>X Build Community Capacity</td>
</tr>
<tr>
<td>❑ Collaborative Governance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. The Self-Management Program is designed to enhance regular treatment and disease-specific education such as cardiac rehabilitation, or diabetes instruction. In addition, many people. The program is especially helpful for people who have more than one chronic condition, as it gives them the skills to coordinate all the things needed to manage their health, as well as to help them keep active in their lives. Dignity Health’s CDSMP is grant and foundation funded.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Living Well Institute</td>
</tr>
<tr>
<td>Dignity Health Parish Nurses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Benefit Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-1 Community Health Education</td>
</tr>
</tbody>
</table>

**FY 2015 Report**

<table>
<thead>
<tr>
<th>Program Goal / Anticipated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Send two to three Community Wellness Employees to classes to be a CDSMP Lay Leader.</td>
</tr>
<tr>
<td>2. Partnering with Arizona Living Well Institute and/or SJHMC facilitate a Chronic Disease Self-Management workshop two times in FY15.</td>
</tr>
<tr>
<td>3. Supply the dates, times and locations to the CHW-East Valley activity calendar (if available) or place on available Dignity Health web sites.</td>
</tr>
<tr>
<td>4. Collaborate with the Arizona Living Well Institute to ensure program fidelity and to have access to a support network.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measurable Objective(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How many Workshop Facilitators were trained?</td>
</tr>
</tbody>
</table>
### with Indicator(s)

2. Workshop facilitators will be committed to facilitating a minimum of one workshop per year upon completion of the facilitator training.
   - Number of facilitators leading one workshop
   - Number of facilitators leading more than one workshop

3. How many workshops were held?

4. Is there a community accessible calendar from Dignity Health-East Valley that lists all dates, times and locations for Living Well Workshops?

5. How many people who attended a Living Well Workshop were admitted to the hospital within 60 days of workshop completion?

6. How many admitted patients who attended a Living Well Workshop post discharge were readmitted within 30 days of workshop completion?

### Baseline / Needs Summary

The population of disabled elderly in the United States is growing rapidly. The number of Americans who will suffer functional disability due to arthritis, stroke, diabetes, coronary artery disease, cancer, or cognitive impairment is expected to increase at least 300 percent by 2049.1

Although people tend to develop chronic conditions as they age, growing old does not have to mean becoming disabled. Research sponsored by the Agency for Healthcare Research and Quality (AHRQ) led to the development of the Chronic Disease Self-Management Program (CDSMP), a patient self-management program that can help prevent or delay disability even in patients with arthritis, heart disease, or hypertension.2

These patients are taught how to better manage their symptoms, adhere to medication regimens, and maintain functional ability.2 Additional research funded by AHRQ has also shown that education and lifestyle changes can reduce disability, control costs, and have a positive influence on the quality of life of America’s elderly (http://www.ahrq.gov/research/elderdis.htm).

Federal law is dictating increased involvement from the hospital to prevent readmissions of people with chronic health care conditions.

- US Senate - H.R. 3590 Patient Protection and Affordable Care Act Sec. 2717. Ensuring quality of care. Requires the Secretary to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.

- House - H.R. 3962 The Affordable Health Care for America Act Sec. 1151. Reducing potentially preventable hospital readmissions. Beginning in fiscal year 2012, adjusts payments for 1886(d) hospitals, critical access hospitals and hospitals paid under 1814(b)(3) based on the dollar value of each hospital’s percentage of potentially preventable Medicare readmissions for 3 conditions. Directs the Secretary to expand the policy to additional conditions in future years and authorizes the Secretary to modify the adjustment based on a hospital’s performance in readmissions compared to a ranking of hospitals nationally.

### Intervention Actions for Achieving Goal

Partnered with organizations/agencies through the Arizona Living Well Institute to facilitate four CDSM workshops.

### Program Performance / Outcome

1. How many Workshop Facilitators were trained? - 0

2. Workshop facilitators will be committed to facilitating a minimum of one workshop per year upon completion of the facilitator training.
   - Number of facilitators leading one workshop
   - Number of facilitators leading more than one workshop

3. How many workshops were held? - 4

4. Is there a community accessible calendar from Dignity Health-East Valley that lists all dates, times and locations for Living Well Workshops? no

5. How many people who attended a Living Well Workshop were admitted to the hospital within 60 days of workshop completion? 4 were admitted within 90 days

6. How many admitted patients who attended a Living Well Workshop post discharge were readmitted within 30 days of workshop completion? See #5

### Hospital's Contribution / Program

Dignity Health provided $3,550.00 toward the four workshops with the majority being salary.

---

Chandler Regional Medical Center
Community Benefit FY 2015 Report and FY 2016 Plan

33
<table>
<thead>
<tr>
<th>Expense</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Goal / Anticipated Impact</strong></td>
<td>Community Wellness would use a contribution from Dignity Health East Valley Foundation to enhance the marketability and availability of our current CDSMP workshops. The seven-week long workshops, to be held twice per year, are currently facilitated by one employee of Dignity Health’s Community Wellness Department who is a certified CDSMP Lay Leader. Dignity Health East Valley Foundation would fund the new part time position of CDSMP outreach coordinator/certified workshop facilitator. The coordinator will be responsible for: a) arranging workshop dates and locations; b) procurement of participants through marketing efforts and partnerships with faith health nurses, community centers, physician’s offices and other community organizations serving the elderly or those with chronic conditions; c) co-facilitating workshops and d) participant follow-up data collection and entry required by the Stanford License as well as Dignity Health Corporate Office.</td>
</tr>
</tbody>
</table>
| **Measurable Objective(s) with Indicator(s)** | 1. Hire a CDSMP coordinator/facilitator position by Dec.31, 2015.  
2. Send coordinator and Community Wellness nurse to become certified as CDSMP Lay Leaders by March of 2016.  
3. Socialize new coordinator to Dignity Health, Community Integration and Community Wellness including our community partners during first six months post hire.  
4. Begin relationship building with parish nurses and other agencies/organizations who may partner with Dignity Health CDSMP coordinator to plan and present workshops by March 2016.  
5. Continue relationship with AZ Living Well Institute for opportunities to facilitate workshops for the newly certified Leaders.  
| **Baseline / Needs Summary** | Older adults are among the fastest growing age groups, and the first “baby boomers” (adults born between 1946 and 1964) turned 65 in 2011. More than 37 million people in this group (60 percent) will manage more than 1 chronic condition by 2030. Many experience hospitalizations, nursing home admissions, and low-quality care. They also may lose the ability to live independently at home. Chronic conditions are the leading cause of death among older adults. Chronic Disease Self-Management Education (CDSME) programs provide older adults and adults with disabilities with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS and depression. |
| **Intervention Actions for Achieving Goal** | Establish a CDSM program plan for the CRMC and MGMC service areas and begin implementation within budgetary constraints. |
| **Center for Diabetes Management** |  |
| **Significant Health Needs Addressed** | X Chronic Disease Self-Management-Center for Diabetes Management  
✓ Access to care  
✓ Obesity  
✓ Mental Health  
✓ Oral Health |
| **Program Emphasis** | ✓ Disproportionate Unmet Health-Related Needs  
✓ Primary Prevention  
✓ Seamless Continuum of Care  
✓ Build Community Capacity  
✓ Collaborative Governance |
| **Program Description** | Our comprehensive Center for Diabetes Management offers education for a wide variety of patient needs:  
• Diabetes self-management training for people with type 1 and type 2 diabetes  
• Gestational diabetes/diabetes and pregnancy classes  
• Blood glucose meter training  
• Insulin initiation and management  
• Pre-diabetes/metabolic syndrome  
• Continuous glucose monitoring |
<table>
<thead>
<tr>
<th>Planned Collaboration</th>
<th>Collaboration is planned with the Gilbert Wellness and Resource Center once it is built. We will continue to work with existing community partners and local municipalities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Benefit Category</td>
<td>A-1 Community Health Education</td>
</tr>
</tbody>
</table>

### FY 2015 Report

#### Program Goal / Anticipated Impact

- Increased patient volume.
- Formed appropriate community partnerships and collaborative efforts to meet our goals related to community outreach and serving the underserved populations.
- Continued collaboration with hospital departments, including nursing, social work, case management, wound care and the call center to improve referrals to the Center.
- Improved percentage of referral to scheduled patients.

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

- Conducted two in-service lunches at medical practices and attended two medical practice open houses to promote Center for Diabetes Management and our many services.
- Presented information about diabetes at three nursing education sessions.
- Percent of referrals that converted to scheduled patients increased by 31%.
- Participated in 17 community events.

#### Baseline / Needs Summary

Diabetes is currently one of the ten leading causes of death in Arizona. The number of adults in Arizona with type 2 diabetes has more than doubled in the last ten years. Close to 600,000 (9%) of adults in our state now have diabetes. Not only does diabetes cause detriment to the well-being of Arizona’s citizens, but it also puts a tremendous financial burden on the state. The total cost of diabetes in Arizona exceeds $3.46 billion per year.

#### Intervention Actions for Achieving Goal

- Continued to offer classes for patients with Type 1 and Type 2 diabetes in Ahwatukee and Gilbert.
- Continued to offer gestational diabetes classes.
- Presented information on gestational diabetes and diabetes in pregnancy for Labor and Delivery staff on three separate dates.
- Offered free community outreach support groups.
- Participated in JDRF special events, including the JDRF Walk.
- Participated in seventeen community events and health fairs, providing education and blood glucose screenings.
- Participated in the readmissions committee meetings and the Hypoglycemia No Harm campaign.
- CDM is featured on hospital media/entertainment programs.
- Physician visits conducted throughout the year to promote the Center.
- Needs of non-English speaking patients were met through bilingual educator and Cyracom Interpreter Services.

#### Program Performance / Outcome

- Participated in seventeen community events and health fairs.
- Offered 451 classes and conducted 1081 individual visits, for a total of 4137 patient visits.
- Offered 16 free outreach &support groups free to the community.

#### Hospital’s Contribution / Program Expense

Total expenses for FY15 was $503,468.

### FY 2016 Plan

#### Program Goal / Anticipated Impact

Actively market Center for Diabetes Management to promote our services to patients, hospital staff and health care providers to achieve an average of 360 patient visits per month.

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

Increase patient volume by 3%, with a subsequent increase in units of service.

#### Baseline / Needs Summary

The incidence of diabetes and pre-diabetes continues to rise. In the MGMC and CRMC service area, diabetes is the 7th leading cause of death. Only 7% of people with diabetes are attending comprehensive diabetes education programs.

#### Intervention Actions for Achieving Goal

- Actively market Center for Diabetes Management to providers in the Gilbert service area, and directly to patients via media coverage, website, and mailings.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Actively market Center for Diabetes Management to inpatient staff through rounding, special events during National Diabetes Month, and in-service education programs when needed.</td>
</tr>
<tr>
<td></td>
<td>• Participate in AZ Diabetes Coalition.</td>
</tr>
<tr>
<td></td>
<td>• Continue making second calls on referrals as staffing allows to improve referral to scheduled percentage.</td>
</tr>
</tbody>
</table>
## Economic Value of Community Benefit

**9/24/2015**  
510 Chandler Regional 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>% of Organization Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance</td>
<td>2,476</td>
<td>5,730,172</td>
<td>0</td>
<td>5,730,172</td>
<td>1.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Medicaid</td>
<td>42,850</td>
<td>74,300,669</td>
<td>45,051,289</td>
<td>29,249,380</td>
<td>7.1</td>
<td>6.5</td>
</tr>
</tbody>
</table>

| Community Services             |         |               |                    |             |                          |                          |
| A - Community Health Improvement Services | 9,258   | 609,348       | 226,492            | 382,856     | 0.1                       | 0.1                       |
| E - Financial and In-Kind Contributions | 9       | 4,344         | 0                  | 4,344       | 0.0                       | 0.0                       |

| Totals for Community Services | 9,267   | 613,692       | 226,492            | 387,200     | 0.1                       | 0.1                       |

| Totals for Living in Poverty   | 54,593  | 80,644,533    | 45,277,781         | 35,366,752  | 8.6                       | 7.9                       |

| Benefits for Broader Community |         |               |                    |             |                          |                          |

| Community Services             |         |               |                    |             |                          |                          |
| A - Community Health Improvement Services | 24,994  | 1,038,718     | 569,466            | 469,252     | 0.1                       | 0.1                       |
| B - Health Professions Education | 746     | 885,244       | 0                  | 885,244     | 0.2                       | 0.2                       |
| E - Financial and In-Kind Contributions | 193     | 235,031       | 0                  | 235,031     | 0.1                       | 0.1                       |

| F - Community Building Activities | 11      | 28,426        | 0                  | 28,426      | 0.0                       | 0.0                       |
| G - Community Benefit Operations | 0       | 104,058       | 0                  | 104,058     | 0.0                       | 0.0                       |

| Totals for Community Services | 25,944  | 2,291,477     | 569,466            | 1,722,011   | 0.4                       | 0.4                       |

| Totals for Broader Community | 25,944  | 2,291,477     | 569,466            | 1,722,011   | 0.4                       | 0.4                       |

| Totals - Community Benefit    | 80,537  | 82,936,010    | 45,847,247         | 37,088,763  | 9.0                       | 8.3                       |

| Unpaid Costs of Medicare     | 35,374  | 95,702,675    | 83,821,478         | 11,881,197  | 2.9                       | 2.7                       |

| Totals including Medicare    | 115,911 | 178,638,685   | 129,668,725        | 48,969,960  | 11.8                      | 11.0                      |

Accounting Method: Costs Accounting
## APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

### EAST VALLEY HOSPITALS COMMUNITY BOARD MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation/Title</th>
<th>Company</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terry Ambus, M.D.</td>
<td>Physician (anesthesiologist)</td>
<td>Chandler Regional Medical Center</td>
</tr>
<tr>
<td>Jason Bagley</td>
<td>Government Affairs Manager</td>
<td>Intel Corporation</td>
</tr>
<tr>
<td>Puneet Bhalla, M.D.</td>
<td>Physician (Oncology, Internal Medicine)</td>
<td></td>
</tr>
<tr>
<td>Tim Bricker (Ex officio)</td>
<td>Hospital President</td>
<td>Mercy Gilbert Medical Center and Chandler Regional Medical Center</td>
</tr>
<tr>
<td>Camille Casteel, Ed.D.</td>
<td>Superintendent of Schools</td>
<td>Chandler Unified School District</td>
</tr>
<tr>
<td>Jeff Clark</td>
<td>Fire Chief</td>
<td>City of Chandler Fire, Health &amp; Medical Department</td>
</tr>
<tr>
<td>Helen Davis, J.D.</td>
<td>Attorney (specializing in family law)</td>
<td>The Cavanagh Law Firm</td>
</tr>
<tr>
<td>Jim Hayden</td>
<td>CEO of firm specializing in board of directors</td>
<td>Board Developer, Inc.</td>
</tr>
<tr>
<td>John Hernandez</td>
<td>CEO of marketing communications agency</td>
<td>ON Advertising</td>
</tr>
<tr>
<td>Linda Hunt (Ex officio)</td>
<td>Service Area President/CEO</td>
<td>Dignity Health in Arizona</td>
</tr>
<tr>
<td>Rick Kettner</td>
<td>Senior Director of Engineering</td>
<td>Orbital Sciences Corp. (aerospace)</td>
</tr>
<tr>
<td>Sister Mary Kilgariff, R.S.M.</td>
<td>Liaison for Community Health &amp; Senior Programs</td>
<td>Dignity Health St. Mary’s Medical Center</td>
</tr>
<tr>
<td>Carl Landrum</td>
<td>Retired Aerospace Engineer</td>
<td></td>
</tr>
<tr>
<td>Linda Lujan, Ph.D.</td>
<td>New Ventures Officer</td>
<td>Maricopa County Community College District</td>
</tr>
<tr>
<td>Tom Marreel</td>
<td>CEO</td>
<td>Marreel Slater Insurance</td>
</tr>
<tr>
<td>Sister Bridget McCarthy, R.S.M.</td>
<td>Sister of Mercy; V.P. Mission Integration</td>
<td>Dignity Health</td>
</tr>
<tr>
<td>Paul McHale, M.D. (Board Vice Chair)</td>
<td>Physician (Emergency Medicine)</td>
<td>Chandler Regional Medical Center</td>
</tr>
<tr>
<td>Terry Miller, Ph.D. (Board Chair)</td>
<td>Business owner</td>
<td>Mill-Rite High Performance Polymers, Inc.</td>
</tr>
<tr>
<td>Marc Tobler, M.D. (Ex officio)</td>
<td>Physician (Radiologist), President of Medical Staff</td>
<td></td>
</tr>
<tr>
<td>Hector Peñuñuri</td>
<td>Senior Distribution Key Account Manager</td>
<td>Salt River Project</td>
</tr>
<tr>
<td>David Tierney (Ex officio)</td>
<td>Attorney (specializing in construction law)</td>
<td>Sacks, Tierney, P.A., Attorneys</td>
</tr>
<tr>
<td>Kathy Tilque</td>
<td>President/CEO</td>
<td>Gilbert Chamber of Commerce</td>
</tr>
<tr>
<td>Ivars Vancers (Board Secretary)</td>
<td>Owner of engineering consulting firm</td>
<td>Vancers Consulting Services</td>
</tr>
<tr>
<td>Veena Vats, M.D.</td>
<td>Physician (ear, nose, throat and facial surgery)</td>
<td>Trinity ENT and Facial Aesthetics</td>
</tr>
<tr>
<td>Joan Warner, M.D.</td>
<td>Physician (OB/GYN)</td>
<td>Desert Foothills OB/GYN</td>
</tr>
</tbody>
</table>
## EAST VALLEY HOSPITALS COMMUNITY BENEFIT COMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marty Breeden</td>
<td>VP, Mission Integration CRMC/MGMC</td>
</tr>
<tr>
<td>Tim Bricker</td>
<td>CEO President CRMC/MGMC</td>
</tr>
<tr>
<td>Milissa Chanice</td>
<td>Director Environment of Care CRMC/MGMC</td>
</tr>
<tr>
<td>Trinity Donovan</td>
<td>CEO Chandler Christian Community Center</td>
</tr>
<tr>
<td>Kathleen Dowler</td>
<td>Director of Community Integration CRMC/MGMC</td>
</tr>
<tr>
<td>John Ford</td>
<td>Fire/EMS Consultant Self Employed</td>
</tr>
<tr>
<td>Steve Gloyd</td>
<td>National Director of Business Development</td>
</tr>
<tr>
<td>Jim Hayden</td>
<td>Owner of consulting firm specializing in board development</td>
</tr>
<tr>
<td>Maria Hesse, Ed.D.</td>
<td>Vice Provost for Academic Partnerships</td>
</tr>
<tr>
<td>Joan Kruger</td>
<td>SVP Commercial Division</td>
</tr>
<tr>
<td>Carl Landrum</td>
<td>Retired</td>
</tr>
<tr>
<td>Dr. Paul McHale</td>
<td>MD Emergency Services</td>
</tr>
<tr>
<td>Adelaida Severson, Ph.D.</td>
<td>President/CEO</td>
</tr>
<tr>
<td>Ivars Vancers</td>
<td>Owner of engineering consulting firm</td>
</tr>
</tbody>
</table>
## Community Grants Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lori Bacsalmasi</td>
<td>Manager Community Education/Lactation</td>
</tr>
<tr>
<td>Jeanne Cahill</td>
<td>Manager Center for Diabetes Management</td>
</tr>
<tr>
<td>Milissa Chanice</td>
<td>Dignity Health – Director, Environmental Care</td>
</tr>
<tr>
<td>Staci Charles</td>
<td>Brain Lab – President &amp; CEO</td>
</tr>
<tr>
<td>Kathleen Dowler</td>
<td>Director Community Integration</td>
</tr>
<tr>
<td>Maria Hesse</td>
<td>Arizona State University, Vice Provost for Academic Partnerships</td>
</tr>
<tr>
<td>Sharae Kailan</td>
<td>Dignity Health Volunteer, Community Member</td>
</tr>
<tr>
<td>James Kern</td>
<td>Dignity Health Volunteer, Community Member</td>
</tr>
<tr>
<td>Mary Beth Lawler</td>
<td>I.T. Systems Analyst/Community Impact Service Manager</td>
</tr>
<tr>
<td>Ken Loop</td>
<td>Intel</td>
</tr>
<tr>
<td>Megan Miks</td>
<td>Manager Oral Health Program</td>
</tr>
<tr>
<td>Susan Ohton</td>
<td>Manager Community Wellness</td>
</tr>
<tr>
<td>Pamela Pearson</td>
<td>Dignity Health Volunteer, Community Member</td>
</tr>
<tr>
<td>John Sentz</td>
<td>Town of Gilbert, Community Member</td>
</tr>
<tr>
<td>Kathy Tilque</td>
<td>President/CEO Gilbert Chamber of Commerce</td>
</tr>
<tr>
<td>Ivars Vancers</td>
<td>Owner of engineering consulting firm</td>
</tr>
</tbody>
</table>
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.

Community Building Activities

CHANDLER COMMUNITY LEADERSHIP:
Dignity Health provides valuable leadership beyond the walls of the hospital by participating on community building boards that share our common goals and values. These include the Ahwatukee and Chandler Chambers of Commerce, Arizona Asthma Coalition, Arizona Bioindustry Association, Arizona-Mexico Commission, Arizona State University Health Advisory, Arizona Women’s Forum, Chandler Boys and Girls Club, Central Arizona College of Radiologic Technology, Chandler Education Foundation, Chandler Gilbert ARC, Chandler-Gilbert Community College, City of Chandler Economic Development Board, Desert Cancer Foundation, East Valley Hispanic Chamber of Commerce, ICAN, Intel, March of Dimes, Matthew’s Crossing Food Bank, Positive Pathways, Power of the Purse, State Trauma Advisory Board, and the YMCA of Chandler.

Ecology

Chandler Regional Medical Center exercises responsible stewardship of the environment and partners with others to advance ecological initiatives. Policies are developed and implemented to address waste minimization, energy and water conservation and reduction of greenhouse gas emissions. Environmental initiatives include various interested departments, set goals for improved environmental performance and monitor, report and hold employees accountable for progress toward those goals. Examples include:

Clinical Laboratory
- Plastic cuvettes used in coagulation analyzers to a company to be washed for our re-use. Diverts plastic waste from landfill.
- Local department-initiated recycle collection points for cardboard.
- The hospital-owned lab courier car is a Prius – a high mileage and high efficiency vehicle.

Security / Plant Operations
- Retrofitting parking lot lights with energy saving and longer life LED fixtures
- Installation of solar powered code blue stations in employee parking lots
- Responsible management of construction debris and metals recycling
- Landscaping choices include water minimization considerations
- Water treatment systems have been replaced with a soft water non-chemically treated solution. This replacement also reduces the generation of wastewater.

Clinical Informatics
- Implementation of electronic medical records and managed print equipment and services

Environmental Services
- Chandler Regional Medical Center has partnered with Chandler Gilbert ARC to further our ecology efforts. Employees of Chandler Gilbert ARC with intellectual and developmental disabilities provide many talents and do a great job in completing important recycling tasks. ARC employees are on site every day to collect recyclable materials from collection locations throughout the facility.