St. Joseph's Hospital and Medical Center
St. Joseph's Westgate Medical Center

Community Benefit 2025 Report and 2026 Plan

Adopted October 2025

Dignity Health®
A member of CommonSpirit

A message from

Dr. Douglas Ross, Hospital President, and Tom Marreel, Chair of the Dignity Health Arizona Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social drivers of health.

St. Joseph's Hospital and Medical Center (SJHMC) and St. Joseph's Westgate Medical Center (SJWMC) share a commitment with others to improve the health of our community and promote health equity, and deliver programs and services to help achieve that goal. The Community Benefit 2024 Report and 2025 Plan describes much of this work. 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 2025 (FY25), SJHMC and SJWMC provided $220,764,944 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $69,969,750 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education.

The hospital's board reviewed, approved and adopted the Community Benefit 2025 Report and 2026 Plan at its October 22, 2025 meeting.

Thank you for taking the time to review this report and plan. We welcome any questions or comments, which can be submitted using the contact information in the At-a-Glance section of this report.

Dr. Douglas Ross
President

Tom Marreel
Chairperson, Board of Directors

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At-a-Glance Summary

Report Period Start Date: July 1, 2024 **Report Period End Date**: June 30, 2025

Community Served	SJHMC and SJWMC serve the geographic area of Maricopa County which encompasses 9,202 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations. With an estimated population of 4 million and growing, Maricopa County is home to well over half of Arizona's residents. The community served is ethnically and culturally diverse.
Economic Value of Community Benefit	$220,764,944 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $69,969,750 in unreimbursed costs of caring for patients covered by Medicare fee-for-service, not including Medicare reported as a part of Graduate Medical Education Community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.

Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:
	
	• Access to Care
	• Cancer
	• Social Determinants of Health
	• Violence and Injury Prevention
	
	• Mental Health
	• Chronic Health Conditions
	  o Cardiovascular Disease (CVD)
	  o Diabetes
	  o Chronic Kidney Disease (CKD)

FY25 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: • **Access to Care** – ACTIVATE (acute patient navigation post-discharge), Clients Aligned Thought Community Hub (CATCH), Keogh Enrollment Specialist, Hospital-based Community Navigators, Lyft Transportation Services, MOMobile, Community Health Workers, and Patient Financial Assistance.

	• **Cancer** – Cancer Medication Assistance Program, Cancer Resource Navigator, Lifestyle Management Workshops and Support Groups, and Women's Wellness Clinic. • **Chronic Conditions** – ACTIVATE, Chronic Kidney Disease Awareness, Diabetes Empowerment Education Program, Healthier Living, Muhammed Ali Parkinson's Center Programs, and Stroke Prevention Education. • **Social Determinants of Health** – Pathways to Healthier Living (Community Health Worker Program), Hospital to Shelter Bed Program, and Circle the City Health Resource Navigator. • **Violence and Injury Prevention** – THRIVE, Survive the Drive, Stop the Bleed, and Balance Masters.
FY26 Planned Programs and Services 	FY25 programs will continue, with the following changes. • A randomized controlled trial (RCT) has begun on the *Pathways to Healthier Living* program (CHW program) • Launch of the *Equity Heals: Addressing Chronic Kidney Disease* program • Including programs addressing mental health • Including programs addressing social determinants of health • Including programs addressing violence and injury prevention

Written comments on this report can be submitted to the St. Joseph's Hospital and Medical Center Community Health Office at 350 W. Thomas Road, Phoenix, AZ 85013 or by e-mail to communityhealth-sjhmc@commonspirit.org.

Our Hospital and the Community Served

About St. Joseph's Hospital and Medical Center and St. Joseph's Westgate Medical Center

SJHMC and SJWMC are Dignity Health hospitals. Dignity Health is a member of CommonSpirit Health.

Located in the heart of Phoenix, SJHMC is a 571-bed, not-for-profit hospital that provides a wide range of health, social and support services with special advocacy for the poor and underserved. Founded in 1895 by the Sisters of Mercy, SJHMC was the first hospital in the Phoenix Area. St. Joseph's is a nationally recognized center for quality quaternary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Norton Thoracic Institute, Center for Women's Health, the Dignity Health – Cancer Institute at St. Joseph's Hospital and Medical Center, and a Level I Trauma Center verified by the American College of Surgeons. The hospital is also a respected center for orthopedics, internal medicine, primary care and many other medical services. U.S. News & World Report routinely ranks SJHMC among the top hospitals in the United States for neurology and neurosurgery. As of 2024, SJHMC has 5,743 employees, 512 employed faculty physicians, 1,135 credentialed community physicians, and 175 volunteers.

SJWMC is one of eight Dignity Health acute care hospitals in the Arizona market. The hospital and its programs take new approaches to health care that utilize the most innovative uses of materials to promote patient safety, patient satisfaction and medical efficiency. Services include general surgery, orthopedics, urology, gastrointestinal care, bariatrics, and endoscopy. It is Arizona's first Center of Excellence for Colorectal Surgery. St. Joseph's Westgate, which is a not-for-profit hospital, continues the Sisters of Mercy's mission to provide care and compassion to the west valley. As of 2024, SJWMC has 250 employees, 14 employed faculty physicians, and 127 credentialed community physicians.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

SJHMC and SJWMC serve Maricopa County. A summary description of the community is below. Additional details can be found in the CHNA report online.

Both SJHMC and SJWMC are located in Maricopa County, the fourth most populous county in the U.S., with a population of over 4.4 million people. It is home to well over half of Arizona's residents. Covering 9,202 square miles, Maricopa County includes 27 cities and towns and is comprised of nearly five percent of Indigenous land from tribes such as the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation.

SJHMC and SJWMC serve patients across Maricopa County; hence, the community definition extends beyond their physical locations in the City of Phoenix and the City of Glendale. The table below describes the demographic and socioeconomic profile of residents in Maricopa County and Arizona, for comparison.

	Maricopa County	**Arizona**
Total Population Size	4,430,871	7,172,282
Population by Race / Ethnicity		
American Indian/Alaska Native (non-Hispanic)	1%	4%
Asian and Native Hawaiian/Pacific Islander (non-Hispanic)	4%	3%
Black/African American (non-Hispanic)	5%	4%
White (non-Hispanic)	53%	53%
Hispanic / Latino	32%	32%

	Maricopa County	Arizona
Population by Sex		
Male	50%	50%
Female	50%	50%
Population by Age Group		
0-14 years	19%	18%
15-24 years	14%	14%
25-44 years	28%	26%
45-64 years	24%	24%
65+ years	16%	18%
Languages, among those 5 year and older		
Non-English Languages Spoken at Home	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over		
Less than 9th grade	5%	5%
9th – 12th grade, no diploma	6%	6%
Employment Status		
Unemployed	5%	5%
Median Household Income		
Income	$80,675	$72,581
Poverty		
Below poverty level all ages	12%	13%
Below poverty level all ages under 18 years	16%	18%
Health Insurance Coverage		
Uninsured	11%	11%
Health Insurance Type		
Medicaid	18%	21%
Health Professional Shortage Area	Yes	Yes
Medically Underserved Area	Yes	Yes
Medically Underserved, Low Income, Minority Populations	Medically Underserved, Low Income	

Maricopa County and Arizona Demographic and Socioeconomic Profile - 2022 ACS Census, HRSA MUA Finder, PolicyMap

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its 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, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in April. 2025. The hospital makes the CHNA report widely available to the public online and a written copy is available upon request. To view the CHNA online: https://www.dignityhealth.org/arizona/locations/stjosephs/about-us/community-benefit/community-benefit-resources.

The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

This community benefit report also includes programs delivered during fiscal year 2025 that were responsive to needs prioritized in the hospital's previous CHNA report.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Care	**Access to Care** is defined as the timely use of health services to achieve the best possible health outcomes. Many people face barriers that prevent or limit access to needed healthcare services. Access to	☑

Significant Health Need	Description	Intend to Address?
	care includes availability, accessibility, affordability, acceptability, and appropriateness.	
Cancer	**Cancer** is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.	☑
Chronic Health Conditions ● Diabetes ● Cardiovascular Disease (CVD) ● Chronic Kidney Disease	**Chronic Health Conditions** are health conditions or diseases that are persistent or otherwise long-lasting in their effects. ● **Diabetes** is a chronic, metabolic disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine. ● **Cardiovascular Diseases (CVDs)** is defined as the primary diagnosis of acute rheumatic fever and the following diseases: chronic rheumatic heart, hypertensive, ischemic heart, pulmonary heart, pulmonary circulation, cerebrovascular, arteries, arterioles, capillaries, and other forms of heart disease. ● **Chronic Kidney Disease (CKD)** is a condition in which the kidneys gradually lose their ability to filter waste products and excess fluid from the blood. This can lead to kidney damage, buildup of harmful substances in the body, and other health problems.	☑
Maternal and Child Health ● Preterm Births	**Maternal and Child Health** focuses on the well-being of pregnant women, mothers, and children from birth through adolescence. It involves a comprehensive approach to care, including prenatal, childbirth, and postnatal services. ● **Preterm birth**, defined as a live birth before 37 completed weeks of gestation, is a critical component of maternal and child health. Preterm birth can lead to long-term health conditions	☐
Mental Health	**Mental Health** encompasses emotional, psychological, and social well-being. It influences thoughts, feelings, actions and plays a key role in coping with stress, interacting with others, and making decisions. Mental health is a vital component of overall well-being	☑

Significant Health Need	Description	Intend to Address?
Social Determinants of Health ● Housing & Homelessness ● Heat	**Social Determinants of Health** are the conditions where people are born, live, work, play, worship, and age that impact their health quality-of-life. ● **Housing & Homelessness** are often identified as important social determinants of health due to the range of ways in which a lack of housing, or poor quality housing, can negatively affect health and wellbeing. ● **Heat** stress, the leading cause of weather-related deaths, can exacerbate underlying illnesses such as cardiovascular disease, diabetes, mental health disorders, and asthma. Prolonged exposure to extreme temperatures can lead to serious health risks.	☑
Substance Use	**Substance Use** is a broad term that refers to the consumption of any psychoactive substance that can alter mood, consciousness, or behavior. It includes the use of alcohol, nicotine, illicit drugs, as well as the use of prescription medications for non-medical purposes.	☐
Violence and Injury Prevention ● Fall-related Injuries ● Assault-related Injuries	**Violence and Unintentional Injuries** are a significant cause of death and burden of disease, and some people are more vulnerable than others depending on the conditions in which they are born, grow, work, live and age. ● **Fall-related injury** is preventable and includes any physical harm that occurs as a direct result of a fall, ranging from minor issues like bruises or strains to severe injuries such as fractures, head trauma, or even death. ● **Assault-related Injury** is physical harm or bodily damage caused by an act of assault, which is an intentional act or threat by one person that causes another to reasonably fear imminent harmful or offensive contact	☑

Significant Needs the Hospital Does Not Intend to Address

The hospital has chosen not to address the following significant health needs due to limited capacity of hospital staff, limited capacity of available hospital services, and limited resources. While the hospital will not directly address the needs listed below, it will indirectly support work being done in the community to address these needs

through strategic grant making and investments. The hospital will also secure and maintain key partnerships with community-based organizations that are addressing the needs listed below.

- Maternal and Child Health
- Substance Use

2025 Report and 2026 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY25 and planned activities for FY26, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Community Benefit Plan

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, board, clinicians and staff, and in collaboration with community partners.

Hospital and health system participants included the CommonSpirit Health System Office, the SJHMC Community Health & Benefit Department, Executive Leadership Team, Mission Services, the Care Coordination Department, the SJHMC Quality Department, Dignity Health Medical Group (Internal Medicine), and the Community Benefit and Health Equity Committee.

Community input or contributions to this community benefit plan included conducting a Community Health Needs Assessment and Implementation Strategy with community input to guide planning and program implementation; measuring and tracking program indicators and their impact; input from the Community Benefit and Health Equity Committee (CBHEC), and other community stakeholders.

The programs and initiatives described here were selected on the basis of evaluating existing programs with evidence of success/impact, researching effective interventions, our ability to measure impact, and internal goals to address an urgent community need. The programs and strategies identified that address significant

needs are achievable through the hospital's capacity to meet the need, available resources, existing hospital services, and collaborative partnerships.

Community Health Core Strategies

The hospital intends that program activities to help address significant community health needs reflect a strategic use of resources. CommonSpirit Health has established three community health improvement core strategies to help ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Implement and sustain evidence-based health improvement program initiatives.
- Strengthen community capacity to achieve equitable health and well-being.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment. They are organized by health need and include statements of goals and anticipated impact, and any collaboration with other organizations in their delivery.

Health Need: Access to Care

Strategy or Program	Summary Description	Active FY25	Planned FY26
Patient Financial Assistance and Enrollment	Financial Assistance Program for uninsured and underinsured patients (free or reduced-cost care). Hospital programs that assist with transitions from the hospital to other care settings upon discharge with AllThrive 365 (formerly Foundation for Senior Living), Circle the City, and Cancer Support Community Arizona assist with insurance, program enrollment, and other assistance.	☑	☑
Enrollment Specialist located in Family Medicine Clinic	Partnership with Keogh Health Connection to have an enrollment specialist available in-person that offers free enrollment assistance for AHCCCS (Arizona's Medicaid), KidsCare, Marketplace Health Insurance (The Affordable Care Act), SNAP (food stamps), and TANF (emergency cash assistance).	☑	☑
Hospital-based Community Navigators	Integration of community navigators within hospitals to meet the needs of diverse patient populations (i.e., homeless, refugees, high social needs, aging, chronically ill, and other areas as needed). Navigators bridge the gaps during the transition home from the hospital and link patients to community resources	☑	☑
Community Health Workers / Promotores	• Pathways to Healthier Living Program - Community Health Workers (CHWs) identify high-need patients at the hospital and conduct a home-visiting program after discharge to address patient needs and connect them to community resources.	☑	☑

	• Muhammed Ali Parkinson's Center Promotores are volunteer patient liaisons trained to provide education and support in-home.		
MOMobile	MOMobile provides prenatal and postpartum care for low-income, uninsured pregnant women. The Mobile clinic travels weekly to four different locations within Maricopa County to provide free care.	☑	☑
ACTIVATE & CATCH	• ACTIVATE - Community case management of patients in acute care setting with limited or no insurance • CATCH - Community case management of patients in ambulatory care setting with limited or no insurance • Patients are followed up to 90 days. • Kindness Closet - Provides access to free medical equipment • Partnership with AllThrive 365 (Formerly FSL)	☑	☑
Primary Care / Medical Home Partnerships	• Mission of Mercy - mobile primary care clinic • St. Vincent de Paul - free clinic that serves as a temporary health care home. Provides specialty care and diabetes classes. • Circle the City - medical respite center for people experiencing homelessness	☑	☑
Goal and Impact: The hospital's initiatives to address access to care are anticipated to result in: early identification and treatment of health issues; gains in public or private health care coverage; increased knowledge about how to access and navigate community resources and the healthcare system; increased primary care "medical homes"; improved general access to care and promote health equity for all across all prioritized significant health needs.			
Collaborators: The hospital will partner with local community based organizations to deliver this access to care strategy. Current collaborators include AllThrive 365, Circle the City, Cancer Support Community Arizona, Keogh Health Connection (Chicanos por la Causa), MOMobile, Mission of Mercy, St. Vincent de Paul, and Arizona State University.			

Health Need: Cancer

Strategy or Program	Summary Description	Active FY25	Planned FY26
Cancer Support Navigation & Screening	Partnership with Cancer Support Community of Arizona to provide onsite community education and navigation for cancer patients and their caregivers. Cancer support navigators are bilingual and meet the cultural and linguistic needs of patients and community members	☑	☑
Lifestyle Management	Lifestyle management workshops, support groups, transportation services and other classes that support physical, mental, and spiritual wellbeing for cancer patients and their caregivers.	☑	☑
Medication Assistance	Dignity Health Cancer Institute (DHCI) assists in completing applications for cancer medications for uninsured and underinsured.	☑	☑
Participate in Cancer Prevention Activities and Develop Educational Resources	Partner with community organizations to promote and participate in cancer prevention programs and activities. Disseminate educational resources that promote prevention.	☐	☑

Goal and Impact: To increase access to care, social and medical supports, and to ensure patients are screened within the care guidelines. These projects also increase the patient's ability to continue to receive the care they need within their community. Improve access to care and promote health equity for all across all priorities significant health needs.

Collaborators: Collaborative partnerships with Cancer Support Community of Arizona and the American Cancer Society to enhance navigation and bridge the gaps in care, linking patients to appropriate resources that address their social and health needs.

Health Need: Chronic Health Conditions

Strategy or Program	Summary Description	Active FY25	Planned FY26
Diabetes Empowerment Education Program (DEEP)	Free diabetes self-management workshops offered in English and Spanish. Collaboration with community partners providing education on diabetes self-management to meet ongoing needs of individuals living with pre-diabetes and diabetes. 6-week workshop offered in community settings.	☑	☑
Healthier Living with Chronic Conditions	Free chronic disease self-management program offered in English and Spanish that provides strategies and tools to improve health and overall quality of life. 6-week workshop offered in community settings.	☑	☑
Healthier Living Programs	Free community wellness classes that promote better health and wellbeing. • Cocinando con Salud en Balance (Spanish healthy cooking series) • Zumba • Gentle Yoga	☑	☑
Chronic Kidney Disease – Community Outreach Initiative	This program aims to address health disparities, expand chronic disease awareness, and improve chronic kidney disease (CKD) diagnosis and outcomes. This is an expansion of the initiative started by CommonSpirit Health's Office of Diversity, Equity, Inclusion, and Belonging.	☐	☑

Goal and Impact: The hospital's initiative to address chronic conditions has anticipated results in: improved overall health through a reduction of co-morbidities, decrease in Emergency Department use, increase in primary care utilization, increase in knowledge and care for chronic conditions, reduction of mortalities, increase in education and disease prevention efforts. Reduction in length of hospital stays and readmissions. Improve access to care and promote health equity for all across all prioritized significant health needs.

Collaborators: Collaboration with external partners include Keogh Health Connection (Chicanos Por La Causa), AllThrive 365, Salud en Balance, Unlimited Potential, Aeroterra Senior Living, Marc Atkinson Resource Center, St. Paul's Church, Iglesia Unidos Por Una Vision, Marcos de Niza Learning Center, Fellowship Square, Wilson Community Center, Dysart Community Center, Wesley Community & Health Center, Glendale Elementary School, Isaac School District, Tanner Community Development, Arizona Faith Network, Arizona Kidney Foundation.

Health Need: Social Determinants of Health

Strategy or Program	Summary Description	Active FY25	Planned FY26
Pathways to Healthier Living *(Community Health Worker Program)*	Community Health Workers (CHWs) identify high-need patients at the hospital and conduct a home-visiting program after discharge to address patient needs and connect them to community resources. CHWs provide several resources, such as food boxes for clients facing food insecurity.	☑	☑
Hospital to Shelter Bed Program	Partnership with Central Arizona Shelter Services (CASS) to ensure there are shelter beds available for discharged patients experiencing homelessness. This ensures there is shelter and a bed available for vulnerable patients.	☑	☑
Health Resource Navigator	Partnership with Circle the City to embed a health resource navigator who specifically works with patients who are experiencing homelessness. The navigator supports care coordination in the discharge process for these patients and ensures they are connected to resources and shelter post discharge.	☑	☑
Participate in Heat-Relief Efforts	Build and strengthen partnerships that focus on heat relief. Participate as an active member in the Heat Relief Network, a network of partners providing water, cooling, and donation sites throughout the Valley with the goal of preventing heat-related illnesses and deaths among vulnerable populations	☐	☑

Goal and Impact: The hospital's initiatives to address social determinants of health (SDOH) are anticipated to improve health equity, enhance overall health outcomes, and lower healthcare costs by tackling the underlying conditions where people are born, live, and work. These initiatives focus on factors such as housing, food security, climate / environment (heat), education, and economic stability, which significantly influence health.

Collaborators: The hospital will collaborate with several organizations to address SDOHs including Circle the City, Central Arizona Shelter Services (CASS), Pathways Community Hub Institute, Nourish, Keogh Health Connection, and AllThrive 365.

Health Need: Mental Health

Strategy or Program	Summary Description	Active FY25	Planned FY26
Mental Health First Aid	Mental Health First Aid is a course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	☐	☑
Anti-Stigma "Responding to Addiction" Training	Addiction is one of the most stigmatized health conditions on earth. Stigma prevents people who are struggling from reaching out for help and isolates families affected by the disease who fear being judged by their communities. Responding to Addiction is designed to reduce addiction stigma, including stereotypes, prejudice, and discrimination, and increase knowledge about addiction, as well as helping behaviors.	☐	☑
Substance Use Navigator (SUN)	The Substance Use Navigator (SUN) is a healthcare professional who works in the hospital to help patients with substance use disorders (SUD) connect with treatment and recovery services.	☑	☑

Goal and Impact: The goal of implementing these programs is to enhance the hospital's capacity to recognize, understand, and compassionately respond to mental health crises and substance use disorders. This combined approach will directly reduce stigma, improve early intervention and appropriate referrals, and ultimately strengthen the continuum of care for vulnerable patients and community members.

Collaborators: To address this health priority, the hospital will collaborate with Mercy Care, National Council for Mental Wellbeing, Addiction Policy Forum, and the St. Joseph's Foundation.

Health Need: Violence & Injury Prevention

Strategy or Program	Summary Description	Active FY25	Planned FY26
THRIVE	A hospital-based violence intervention program (HVIP) that aims to reduce and prevent violence by supporting victims of community violence (e.g., shootings, stabbings, assaults) receiving hospital care. These patients constitute approximately 20% of annual trauma cases at SJHMC and are a top three mechanism of injury. Key HVIP components include trauma-informed care, peer support, case management, follow-up services, and violence prevention.	☑	☑
Survive the Drive	A free, two-hour program for young drivers and their parents. Developed by Trauma Injury Prevention Program Coordinators from Phoenix's five level-one trauma centers and supported by the Phoenix Fire Department, it educates on distracted and impaired driving dangers through hands-on activities and simulations, aiming to reduce crashes and improve road safety.	☑	☑
Stop the Bleed	Stop the Bleed is a national awareness campaign and a call to action. The program educates and empowers bystanders to help in a bleeding emergency by teaching them basic techniques of bleeding control.	☑	☑
Balance Masters	Balance Masters is a group class that addresses fear or risk of falling, through balance and strength exercises. The classes are free and open to community members who are 65 years or older.	☑	☑

Goal and Impact: The goal of implementing these programs is to build and maintain a comprehensive injury prevention system that addresses different types of traumas. The anticipated impact of addressing this health priority is to reduce preventable injury, re-injury, and death by cultivating safer community behaviors and equipping the public with critical life-saving skills.

Collaborators: To address this health priority, the hospital will collaborate with Phoenix Fire Department, Ability 360, Health Alliance for Violence Intervention (HAVI), Phoenix LISC, local high schools, local government agencies, community health centers, nursing students, and general community members who have a higher risk of injury.

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding restricted financial grants to non-profit organizations working to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY25, the hospital awarded the grants below totaling $1,033,000.00. Some projects also may be described elsewhere in this report. The figures below represent grant awards that the hospital made in conjunction with Arizona General Laveen.

Grant Recipient	Project Name	Health Needs Addressed	Amount
State of Black Arizona	The Black Maternal Infant Health in Arizona Coalition Collective	Maternal and Child Health	$50,000
Justa Center, Inc.	Justa Center Path to Housing Expansion	Housing / Homelessness	$99,190
Mission of Mercy Inc	Breast Cancer Education and Screenings for Uninsured Women	Cancer	$59,091
Cancer Matters Corporation	Cancer Matters - Mobile Cancer Screening	Cancer	$40,546
Creighton Community Foundation, Inc.	FrescaZona Medical Food Box Program: Building Healthy Communities	Social Determinants of Health	$100,000
Phoenix Indian Center	Preventing Substance Misuse in the Urban American Indian Community in Maricopa County	Behavioral Health (mental health, substance use)	$89,177
The Joy Bus	Cancer Care Continuum by The Joy Bus and Determined4Life	Cancer	$150,000
Hushabye Nursery	Healthy Mom's, Cohesive Families	Behavioral Health (mental health, substance use)	$48,000
Arizona Chapter of the American Academy of Pediatrics	Reach Out and Read Arizona	Behavioral Health (mental health, substance use)	$57,000

Grant Recipient	Project Name	Health Needs Addressed	Amount
Unlimited Potential	Supporting Latine Families with Chronic Diseases in South Phoenix	Chronic Disease	$70,000
Phoenix Chapter - The Links Incorporated	Social Determinants of Health	Social Determinants of Health	$50,000
Rehoboth Community Development Corporation	Rehoboth Community Development Corporation	Social Determinants of Health	$100,000
Bridges Reentry, Inc	Bridges Reentry, Inc	Social Determinants of Health	$119,996

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

ACTIVATE	
Significant Health Needs Addressed	• Access to Care • Chronic Health Conditions
Program Description	This collaborative program with AllThrive 365 is designed to help transition hospital patients from hospital to home. A Patient Care Advocate meets with the identified patients in the hospital or by phone and provides them with a Post-Hospital Care Plan. The plan includes a review of their medications, disease and health information, home needs, and assists with follow up medical appointments. The Patient Care Advocate provides the patient with follow up phone calls and additional home visits for a period of 30 to 90 days post discharge from the hospital.
Population Served	The program is specifically designed to help (1) patients transitioning from hospital to home, (2) patients who have joined the ACTIVATE program and receive comprehensive support, and (3) non- enrolled community members who benefit from services like DME and the Kindness Closet.

ACTIVATE	
Program Goal / Anticipated Impact	The ACTIVATE Program aims to transition patients successfully from the hospital to home, preventing readmissions and improving their overall health and stability. The anticipated impact and measurable achievements include: preventing hospital readmissions, providing patients stability and support in the home transition, addressing health-related social needs, and connecting patients to community resources and wrap-around services.
FY 2025 Report	
Activities Summary	The ACTIVATE program provided home safety assessments, post-discharge follow-up, education on diagnosis and medication, community resource referrals, prescription assistance, care coordination and case management, and assessment of health-related social needs.
Performance / Impact	In FY 25, 335 patients were enrolled in the program and received at-home follow-up. ● Of those 335 patients, ACTIVATE had a 93% success rate in preventing readmissions.
Hospital's Contribution / Program Expense	The hospital provides full operational support for the ACTIVATE staff located at the hospital as well as office space and a location for the kindness closet. Hospital staff connect the Patient Care Advocates to patients who may benefit from the program.
FY 2026 Plan	
Program Goal / Anticipated Impact	Based on the program's consistent success in preventing readmissions, in FY 26 the ACTIVATE team will maintain a 30-day readmission rate of 90% or higher for all enrolled patients, directly aligned with the program's primary goal of preventing hospital readmissions.
Planned Activities	In FY 26, the ACTIVATE program will continue with its current activities.

Cancer Resource Navigator	
Significant Health Needs Addressed	● Access to Care ● Cancer ● Mental/Behavioral Health

Cancer Resource Navigator	
Program Description	The Cancer Resource Navigator (CRN) provides emotional support, resources, and referrals to cancer patients, their family members, and caregivers. Services include one-on-one therapy, assistance with financial aid applications, and various support and educational programs. The program aims to alleviate the emotional and practical burdens faced by individuals during extended hospital stays and treatment. The hospital's role is to connect the CRN to patients and families who may benefit from the program during the patients' care in the hospital.
Population Served	At-risk and underserved Phoenix metropolitan area residents of any age impacted by cancer of any type and any stage.
Program Goal / Anticipated Impact	The goal of this program is to provide comprehensive emotional and psychosocial services to cancer patients and their families, alleviating burdens associated with extended hospital stays and treatment. The anticipated impact will be improved health outcomes and the confidence to navigate multiple resources.
FY 2025 Report	
Activities Summary	The CRN collaborated with medical teams, screened for health insurance eligibility, assisted with enrollment, advocated for patients, and provided individual follow-up to ensure mental and physical health needs are met. The CRN addressed social determinants of health and provided a warm hand-off to partnering service providers for needs outside of CSCAZ's scope.
Performance / Impact	In FY 25, the CRN served 161 patients, consistently providing comprehensive support to cancer patients and their families. Key achievements include offering emotional and financial assistance, such as connecting patients to transportation and financial aid resources, and distributing essential items such as wigs. The program also focused on early intervention by identifying patients awaiting diagnosis, supporting caregivers, and facilitating access to support groups.
Hospital's Contribution / Program Expense	The hospital provides the funding necessary for 50% of a full-time cancer navigator located at the hospital and provides them space to work on campus two days per week. The hospital connects the CRN to patients who may benefit from the program during patients' care in the hospital.
FY 2026 Plan	

Cancer Resource Navigator	
Program Goal / Anticipated Impact	In FY26, the CRN will enhance comprehensive support and expand financial assistance to achieve a 15% increase in financial aid applications completed and a 10% increase in patient and family emotional support interactions, ensuring continued positive outcomes for patients and their families.
Planned Activities	In FY26, the CRN will increase resource connections, referring patients to various resources, including transportation, and food delivery services where applicable.

Diabetes Empowerment Education Program (DEEP)	
Significant Health Needs Addressed	• Chronic Conditions • Mental / Behavioral Health
Program Description	DEEP is an evidence based curriculum designed to educate individuals living with pre-diabetes or diabetes. DEEP is free and open to the community. It focuses on providing individuals and their caretakers with a better understanding of diabetes and helps them gain practical skills to become better informed and more involved in their care. DEEP workshops are 6 weeks long and are held once a week for 2 hours and are usually held on hospital campuses, in community settings and via Zoom.
Population Served	Low income, racial and ethnic minority populations suffering from one or more chronic conditions including diabetes.
Program Goal / Anticipated Impact	Continue to expand program infrastructure to reach people by maintaining DEEP as an education platform. Continuing to operate under a Dignity Health license and creating our own program materials will allow the program to be more sustainable going forward, allowing us to continue offering more in-person workshops to effectively contribute to increased physical activity and self-management of chronic conditions, reducing the burden of diabetes on the community.
FY 2025 Report	
Activities Summary	Hosted 10 in-person English and Spanish workshops throughout the year, complemented with the implementation of a Healthier Living cooking series, Restorative Yoga classes and Zumba classes.
Performance / Impact	6-week DEEP workshops resulted in improvements in outcomes among diabetic participants; participants

Diabetes Empowerment Education Program (DEEP)	
	demonstrated an increase of knowledge about diabetes prevention and self-management, dietary habits, blood glucose and blood glucose monitoring and control. An average of a 2 pounds weight loss throughout the six week workshop period occurred amongst participants.
Hospital's Contribution / Program Expense	Coordination, marketing and recruitment time, along with program supplies and materials provided by the Community Benefit and Health Equity Department.
FY 2026 Plan	
Program Goal / Anticipated Impact	Host 5 English/Spanish DEEP workshops throughout the year. Through these workshops, we will have 100 DEEP completers by the end of FY26.
Planned Activities	In FY 26, the DEEP program will continue with its current activities.

Pathways to Healthier Living *(Community Health Worker Program)*	
Significant Health Needs Addressed	• Access to Care • Chronic Health Conditions • Food insecurity
Program Description	Pathways to Healthier Living utilizes the Pathways Community Hub Institute Model Certification, a proven community-based care coordination model connecting certified Community Health Workers (CHWs) with high risk patients identified through a SDOH screening. The Community Health Workers (CHWs) role at SJHMC is to work with high-risk patients and determine if they need navigation services post-discharge (i.e. food insecurity, utility assistance, transportation, etc.). Patients' needs are assessed and addressed using the PCHI home-visiting model.
Population Served	Low income and minority populations that have one or more health-related social needs, including but not limited to income, transportation, utility assistance, and food insecurity.
Program Goal / Anticipated Impact	The goal of this program is to reduce disparities by addressing social factors affecting well-being. This program aims to increase access to resources by connecting participants with services and individualized support and planning.

Pathways to Healthier Living *(Community Health Worker Program)*	
FY 2025 Report	
Activities Summary	The Pathways to Healthier Living team advocated for patients and provided individual follow-up and informal counseling to ensure social needs are addressed. CHWs served 87 participants in FY 2025 and initiated a research study in partnership with ASU in June 2025.
Performance / Impact	In FY25, the Pathways to Healthier Living Program enrolled 87 new participants and conducted 276 home visits throughout the year.
Hospital's Contribution / Program Expense	7 full time CHWs, a CHW apprentice, a CHW Lead, and Program Supervisor along with program supplies and materials provided by the Community Health and Benefit Department through a partnership with ASU.
FY 2026 Plan	
Program Goal / Anticipated Impact	In FY26, the goal of this program is to reduce disparities by addressing social factors affecting well-being. This program aims to increase access to resources by connecting 75 participants with services and individualized support and planning.
Planned Activities	In FY26, the program will continue with its current activities and begin the research portion of the project in conjunction with ASU.

Other Community Health and Community Building Programs

The hospital delivers community programs, services 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.

Medical Education and Research
Medical education at SJHMC includes education for medical students through a partnership with Creighton University School of Medicine as well as post-medical school training through residency and fellowship programs. As part of their medical training, students and residents provide services to communities that are poor and disenfranchised. For example, medical residents of Internal Medicine provide home visits through the CATCH program for patients who are uninsured and underinsured.

Community Investment Program
The CommonSpirit Community Investment Program is funded out of Common Spirit's funded depreciation. This program is one way in which Common Spirit

realizes its mission and enhances the advocacy, social justice and healthier communities' efforts of its hospitals and religious and community sponsors. Current investment projects for Arizona are as follows:

Brighter Way Institute (BWI) In June 2018 Dignity Health approved a 3-year $500,000 loan to BWI to help manage cash flow as it expands its dental health programs. BWI is a dental clinic serving low-income adults, high-risk children, and military veterans with basic preventive procedures, orthodontia, dentures and implants. BWI operates three clinics—Parsons Center for Pediatric Dentistry in south central Phoenix, the Brighter Way Dental Center on the Homeless Services Campus of Central Arizona Shelter Services in central Phoenix, and the Canyon State Academy Clinic in Queen Creek. The loan was extended for 7 years in 2022.	$500,000
Chicanos Por la Causa (CPLC) In November 2023 CommonSpirit approved a $10,000,000 unsecured loan to Chicanos por la Causa (CPLC) for fifteen years at an annual interest rate of 3.0%. CPLC is a community development corporation committed to building strong, healthy communities as a lead advocate, coalition builder, and direct service provider. Since its founding in 1969, CPLC has grown to address unmet needs through providing comprehensive services throughout Arizona, Nevada, California, New Mexico, and Texas and, offers services supporting housing, economic development; integrated health & human services, social services & education. Loan proceeds will be used initially to support a 53-unit affordable housing project in north Phoenix and will continue to support other affordable housing projects in need of predevelopment financing. The approval of this new loan will be contingent upon the full payoff and closing of the two CPLC loans totaling $4,000,000 outstanding, netting $6,000,000 in increased capital.	$10,000,000
Circle The City (CTC) In May 2024 CommonSpirit approved a $4,000,000 loan to Circle The City to build a 100-bed Medical Respite Center in Mesa. The facility will provide acute and post-acute for persons experiencing homelessness who are to ill or frail to recover from physical illness or injury on the streets but are not ill enough to be in a hospital.	$4,000,000
Hush-A-Bye Nursery ("HN") In November 2020 CommonSpirit approved a $500,000 loan to Hush-A-Bye Nursery to pay for tenant improvements for HN's new 12-bed facility in metro Phoenix, Arizona. HN was founded in 2018 and is one of only a handful of companies nationwide specializing in Neonatal Abstinence Syndrome.	$500,000

Housing Solutions of Northern Arizona In June 2020 CommonSpirit Health approved a 7-year $2,680,000 loan to HSNA to help lower finance costs of 12 scattered site affordable housing properties and refurbish and expand Sharon Manor, HSNA's domestic violence supportive housing property. Eight of the current 16-units at Sharon Manor will be upgraded to include interior bathrooms, new flooring, new fixtures, and two of the units will be upgraded to be ADA accessible. HSNA was founded as the Affordable Housing Coalition in 1990 through the grassroots efforts of local citizens concerned about the lack of affordable housing in the Flagstaff community.	$2,680,000
Native American Connections (NAC) In 2010, Dignity Health approved a 7-year $420,419 loan to NAC (originally with HomeBase Youth Services Inc.) for providing a transitional living facility for homeless youth ages 18-24 in Phoenix, Arizona. The loan was extended for 7 years in 2018 with a loan maturity date of September 2025.	$420,419
Tempe Community Action Agency In February 2023, CommonSpirit approved a 10-year secured loan for $5.0 million to Tempe Community Action Agency (TCAA), a Tempe, Arizona based nonprofit social services agency. TCAA is Tempe's largest social service agency in terms of number of people served and range of programs offered. Funds will be used to purchase land and construct a new facility that will become TCAA's permanent home, with adequate space to support current needs and allow for future growth as the surrounding population increases. The new facility will support multiple programs and resources addressing nutritional, health, employment, shelter, housing, and education.	$5,000,000
Trellis In January 2018 Dignity Health approved a 7-year $500,000 loan to this CDFI specializing in promoting home ownership to low- and moderate-income residents of Maricopa County through first and second mortgages and down payment assistance. Trellis also provides financial counseling and homeownership education.	$500,000

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. The economic value of community benefit for patient financial assistance (charity care), Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Medicare reported here excludes Medicare reported as a part of Graduate Medical Education.

Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

St. Joseph's Hospital Medical Center		
Complete Summary - Classified (Programs) - Including Non Community Benefit (Medicare)		
For period from 07/01/2024 through 06/30/2025		
	Persons	**Net Benefit**
Benefits for Poor		
Financial Assistance	15,798	$49,869,581
Medicaid	225,490	$123,708,680
Community Services		
A - Community Health Improvement Services	12,270	$2,237,313
C - Subsidized Health Services	1,301	$6,573,680
E - Cash and In-Kind Contributions	10,925	$985,361
G - Community Benefit Operations	501	$6,380,086
Totals for Community Services	**24,997**	**$16,176,440**
Totals for Benefits for Poor	**266,285**	**$189,754,701**
Benefits for Broader Community		
Community Services		
A - Community Health Improvement Services	123,415	$814,124
B - Health Professions Education	2,577	$27,902,406
D - Research	-	$1,862,787
E - Cash and In-Kind Contributions	85	$430,926
Totals for Community Services	**126,077**	**$31,010,243**
Totals for Broader Community	**126,077**	**$31,010,243**
Totals - Community Benefit	**392,362**	**$220,764,944**
Medicare	78,600	$69,969,750
Totals Including Medicare	**470,962**	**$290,734,694**

Hospital Board and Committee Rosters

2025 Hospital Board

AGBOOLA, Liz CEO of Moses Behavioral Care
BLISS, M.D., Lindley Chief of Medical Staff, Desert Hospitalists
BREMNER, M.D., Ross Executive Director of the Norton Thoracic Institute, Department Chairman for Thoracic Disease and Transplantation at Norton Thoracic Institute
BRICKER, Tim President and CEO, CommonSpirit Central Region
BURNS, M.D., Anne Physician, Chairman and Medical Director for Emergency Dept., Dignity Health
DURAN III, Chief Mike Fire Chief, Phoenix Fire Department
EGBO, M.D., Obinna Physician, Associate CMO, Quality & Patient Safety Chair, Dignity Health
GANATRA, M.D., Vipul Medical Staff Services, Dignity Health
GENTRY, Patti Partner/Designated Broker, Keyser
GONZALEZ, Sarah President of Gonzales Consulting, LLC
HARPER, M.D., Oliver Medical Staff Relations Chair
HOFFMAN, Joel, Board Development Committee Member
JONES, Sister Gabrielle Marie Sister of Mercy, retired hospital executive and nurse

PONCE, M.D., Francisco *(FY25 Board Chair)* Neurosurgeon and Associate Professor, Barrow Brain and Spine, Board Chair
ROSS, M.D., Doug St. Joseph's Hospital and Medical Center President
SPELLERI, Maria *(FY23 Board Chair)* Chair, Board Development Committee

2025 Community Benefit and Health Equity Committee

Agboola, Liz *(FY25 Co-Chair)* CEO of Trinity Integrated Care
Crittenden, Sonora Director, Community Health & Benefit St. Joseph's Hospital and Medical Center
Daymude, Annie Community Health Assessment and Impact Supervisor, Maricopa County Department of Public Health
Gonzalez, Sarah *(FY25 Chair)* President of Gonzales Consulting, LLC
Hillman, Debbie Chief Administrative Officer, Mercy Care
Hoffman, Terri President and Chief Philanthropy Office, St. Joseph's Hospital and Medical Center Foundation
Jackson, Anita Trauma Center Injury Prevention Coordinator, St. Joseph's Hospital and Medical Center
Jones, Ashley Program Manager Community Benefit and Partnerships, St. Joseph's Hospital and Medical Center
Longoria, David Program Officer, LISC Phoenix (non-profit organization)
Mascaro, CarrieLynn Vice President of Program Operations, Catholic Charities (non-profit organization)
McBride, Sr. Margaret Vice President of Mission Integration, St. Joseph's Hospital and Medical Center
Montgomery, Keon Assistant Deputy Director of Housing and Development, Arizona Department of Housing
Orsini, Craig Manager of Care Coordination, St. Joseph's Hospital and Medical Center
Torrealva, Josy Community Health Supervisor, St. Joseph's Hospital and Medical Center
VanMaanen, Pat Health Consultant, PV Health Solutions