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

Community Benefit 2024 Report and 2025 Plan

Adopted October 2024

Dignity Health
St. Joseph's Hospital and Medical Center

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St. Joseph's Westgate Medical Center

A message from

Mary Alice Ragsdale, Interim President, and Dr. Francisco Ponce, Chair of the Dignity Health St. Joseph's Hospital and Medical Center (SJHMC) and St. Joseph's Westgate Medical Center (SJWMC) 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.

SJHMC and 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 2024 (FY24), SJHMC and SJWMC provided $237,709,730 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $50,158,679 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2024 Report and 2025 Plan at its October 23, 2024 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to CommunityHealth-SJHMC@DignityHealth.org.

Mary Alice Ragsdale
Interim President

Dr. Francisco Ponce
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	SJHMC and SJWMC serve the geographic area of Maricopa County which encompasses 9,224 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	$237,709,730 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $50,158,679 in unreimbursed costs of caring for patients covered by Medicare fee-for-service

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
	  ○ Maternal and Child Health
	  ○ Financial Security
	• Cancer
	• Chronic Health Conditions
	  ○ Obesity
	  ○ Diabetes
	  ○ Cardiovascular Disease (CVD)

FY24 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), Health Equity Initiative, 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 Disease – ACTIVATE, Diabetes Empowerment Education Program, Healthier Living, Muhammed Ali Parkinson's Center Programs, and Stroke Prevention Education.
FY25 Planned Programs and Services	FY24 programs will continue, with the following changes. • The Community Health Worker Program *(Pathways to Healthier Living)* is expanding to serve patients hospital wide as the team grows under a joint grant with Arizona State University.

This document is publicly available online at https://www.dignityhealth.org/arizona/locations/stjosephs/about-us/community-benefit/community-benefit-resources.

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@DignityHealth.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 members of Dignity Health, which is a part of CommonSpirit Health.

Located in the heart of Phoenix and founded in 1895 by the Sisters of Mercy, St. Joseph's Hospital and Medical Center 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. As of 2020, SJHMC has 5,296 employees, 91 Employed Faculty Physicians, 1,114 Credentialed Community Physicians, 197 residents, and 334 Volunteers. SJHMC is a nationally recognized center for quality tertiary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Heart & Lung Institute®, Dignity Health Cancer Institute at St. Joseph's Hospital and Medical Center, and a Level 1 Trauma Center verified by the American College of Surgeons.

St. Joseph's Westgate Medical Center is a not-for-profit, 23 bed inpatient hospital that opened on May 13, 2014. The medical campus and hospital feature new approaches to healthcare. The campus utilizes the most innovative uses of materials to promote patient safety, patient satisfaction and medical efficiency. SJWMC provides four operating rooms, two procedure rooms, 23 inpatient beds, which includes 5 critical care beds. Services included general surgery, orthopedics, urology, gastrointestinal and endoscopy. SJWMC continues the Sisters of Mercy's mission, providing care and compassion to the West Valley.

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

Maricopa County is the fourth most populous county in the United States. Based on 2019 American Community Survey (ACS five-year estimates, Maricopa County has an estimated population of over 4.3 million and growing, home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations. A list of all Maricopa County zip codes is located in the SJHMC Community Health Needs Assessment.

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 City of Phoenix is primarily served by SJHMC for acute care and trauma services. Phoenix is the 5th largest city in the United States by population, making it the most populous state capital. Its population in 2019 was 1,633,017 with a median age of 33.8. The City of Phoenix is made up of predominantly Caucasian/White individuals (76.1%), followed by Latino/Hispanic (42.6%), Black/African American (8.6%), Asian (5.0%), American Indian/Alaska Native (3.0%), and Native Hawaiian and Other Pacific Islander (0.5%). In 2019, the median household income in Phoenix was $57,459 with a poverty rate of 18.0%. The educational attainment statistics in Phoenix in 2019 were as follows: less than high school graduates (18.0%), high school graduates (36.0%), some college/associate's degree (37.6%), and bachelor's degree or higher (8.4%).

Demographic information for the SJHMC primary service area.

Total Population	1,675,840
Race	
Asian/Pacific Islander	3.4%
Black/African American - Non-Hispanic	8.9%
Hispanic or Latino	51.4%

White Non-Hispanic	30.7%
All Others	5.7%
Total Hispanic & Race	
% Below Poverty	14.2%
Unemployment	5.3%
No High School Diploma	21.2%
Medicaid	27.0%
Uninsured	11.1%
Source: Claritas Pop-Facts® 2022; *SG2 Market Demographic Module*	

Demographic information for the SJWMC primary service area.

Total Population	1,6182,960
Race	
Asian/Pacific Islander	3.5%
Black/African American - Non-Hispanic	7.9%
Hispanic or Latino	47.4%
White Non-Hispanic	35.8%
All Others	5.4%
Total Hispanic & Race	
% Below Poverty	11.2%
Unemployment	5.3%
No High School Diploma	18.2%
Medicaid	26.3%
Uninsured	10.9%
Source: Claritas Pop-Facts® 2022; *SG2 Market Demographic Module*	

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 2022.

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.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at https://www.dignityhealth.org/arizona/locations/stjosephs/about-us/community-benefit/community-benefit-resources and upon request from the hospital's Community Health office.

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 Healthcare ● Maternal & Child Health ● Financial Security	**Access to healthcare** 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. ● **Maternal Health** refers to the health of women during pregnancy, childbirth, and postnatal period. There are opportunities at each stage that provide support ensuring women and their babies reach their full potential for health and well-being. ● **Financial Security** refers to having the coverage and/or other means necessary for health care expenses.	✔

Addiction / Substance Abuse	**Addiction** is a chronic disorder characterized by compulsive drug use despite adverse consequences. If left untreated, it can cause serious harmful effects and may lead to death. **Substance Abuse** is the repeated harmful use of any substance, including drugs and alcohol, which can lead to addiction.	
Affordable Housing / Homelessness	**Affordable Housing/Homelessness** is often identified as an important social determinant of health due to the range of ways in which a lack of housing, or poor quality housing, can negatively affect health and wellbeing.	
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 ● Obesity ● Diabetes ● Cardiovascular Disease (CVD)	**Chronic Health Conditions** are health conditions or diseases that are persistent or otherwise long-lasting in their effects. ● **Obesity** is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. Behaviors can include physical activity, inactivity, dietary, dietary patterns, medication use, and other exposures. ● **Diabetes** is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). The most common is type 2 diabetes. ● **Cardiovascular Diseases (CVDs)** are a class of diseases that affect the heart or blood vessels. The most important behavioral risk factors of heart disease and stroke are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.	✔
Food Insecurity	**Food Insecurity** refers to the state of being without reliable access to a sufficient quantity of affordable, nutritious food.	
Mental Health	**Mental Health** includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act.	
Safety & Violence ● Unintentional Injuries	**Safety and Violence** 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. ● **Unintentional Injuries** can be predictable and preventable. Leading causes of nonfatal injury include traffic-related injuries, falls, burns, poisonings, and drownings.	

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.

- Addiction / Substance Abuse
- Affordable Housing / Homelessness
- Food Insecurity
- Mental Health
- Safety & Violence

Using a Health Equity Lens

At SJHMC, we are dedicated to improving access to care and promoting health equity for all across all prioritized significant health needs.

Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

2024 Report and 2025 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 FY24 and planned activities for FY25, 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 Benefit and Health Equity Department, Executive Leadership Team, Mission Services, the Care Coordination Department, the SJHMC Quality Department, Dignity Health Medical Group (Internal Medicine and Women's Clinic), 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 using five core principles to guide planning and program implementation; measuring and tracking program indicators and their impact; input from the Community Benefit and Health Equity Committee (CBHEC), the Health Equity Alliance (HEA), and other community stakeholders.

The programs and initiatives described here were selected on the basis of priority as they relate to one or more of the following principles: focus on disproportionate unmet health-related needs; emphasize prevention including activities that address the social determinants of health; build community capacity; demonstrate collaboration; and contribute to a seamless continuum of care. 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

Driven by a commitment to equity and social justice, we envision a future where health and well-being are attainable by all regardless of background or circumstance.

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to 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.
- Strengthen community capacity to achieve equitable health and well-being.
- Implement and sustain evidence-based health improvement program initiatives.

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 strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Access to Care

Strategy or Program	Summary Description	Active FY24	Planned FY25
Enrollment assistance, outreach activities, and financial assistance	• Chicanos Por La Causa/Keogh Health Connection, Foundation for Senior Living, Circle the City along with other community programs assist with insurance, program enrollment, hospital transition services and assistance. • Financial Assistance Committee	☒	☒

Hospital-based Community Navigators	• Integration of care navigators within health care facilities to meet the needs of diverse patient populations (i.e., homeless, refugees, asylum seekers, aging, chronically ill, fragile infants and other areas as needed). • Bridging the gaps and linkage to community resources using internal hospital care navigators and external care navigators and community health workers.	☒	☒
Community Health Workers	• Expand the Community Health Worker program at St. Joseph's Hospital and Medical Center operated by the Community Benefit & Health Equity Department • Muhammed Ali Parkinson's Center Promotoras/Community Health Worker	☒	☒
Maternal and Fetal Health	• MOMobile (Maternal Outreach Mobile Unit) provide prenatal and postpartum care for low-income, uninsured pregnant women • Mobile clinic travels weekly to four different locations within Maricopa County • Nurse Family Partnership and home visiting programs for high risk families.	☒	☒
ACTIVATE & CATCH	• ACTIVATE - Case management of patients in acute care setting with limited or no insurance • CATCH - Case management of patients in ambulatory care setting with limited or no insurance • Kindness Closet - Provides access to free medical equipment • Patients are followed up to 90 days	☒	☒
Primary Care / Medical Home Partnerships	• Mission of Mercy - mobile primary care clinic • Adelante Healthcare - access to affordable ambulatory care • CATCH (Internal Medicine Clinic) • Homeless patient navigator	☒	☒

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 the healthcare system; and increase primary care "medical homes"; improve 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 Foundation for Senior Living, Circle the City, Chicanos por la Causa, MOMobile, Mission of Mercy, and Arizona State University.

Health Need: Cancer

Strategy or Program	Summary Description	Active FY24	Planned FY25
Cancer Support Navigation & Screening	• Collaboration with Cancer Support Community of Arizona and the American Cancer Society 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 support and other classes that support physical, mental, and spiritual wellbeing.	☒	☒
Medication Assistance	• Cancer center will assist in completing applications for cancer medications for uninsured and underinsured.	☒	☒

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 FY24	Planned FY25
Chronic Disease Self-Management	**DEEP (Diabetes Empowerment Education Program)** • Self-management workshops in English and Spanish • Collaboration with community partners providing education on chronic disease self- management to meet ongoing needs of individuals living with pre-diabetes and diabetes. **Healthier Living with Chronic Conditions** • Free Chronic Disease Education Program • Strategies and tools are provided to improve health and overall quality of life. • Offered in English and Spanish	☒	☒

Nutrition and Physical Activity Programs	• MOMobile education on nutrition for mother, baby and family • Advocate for SNAP benefits, access to healthy foods programs using SNAP benefits • Utilize Community Health Workers/Navigators to bridge access to social services and transportation to food distribution locations • Cocinando con Salud en Balance (Cooking Class) • Community Fitness Classes (i.e., Zumba, Yoga, and Tai Chi)	☒	☒
ACTIVATE	• Care Management following hospital discharge • Home visiting program and increased monitoring for 30 days • Social needs being met by program • Education and prevention activities	☒	☒
Cardiovascular Patient Navigation	• Social determinants of health screening • Patient navigation	☒	☐
Chronic Kidney Disease – Community Outreach Initiative	• Community-facing awareness, education and screening campaign in the Phoenix area to increase the number of Black community members who have received CKD education and screenings. • Expanding in 2025 due to community grant	☒	☒

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 internal and external partners to address the chronic health conditions: obesity, diabetes, and cardiovascular disease (CVDs) strategy. Planned collaborators include SJHMC Cardiovascular Clinic, Chicanos Por La Causa / Keogh, Foundation for Senior Living, and the Arizona Kidney Foundation.

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together 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 FY24, the hospital awarded the grants below totaling $566,575. The figures below represent grant awards that the hospital made in conjunction with Arizona General Laveen Hospital. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
State of Black Arizona	The Black Maternal Infant Health in Arizona Awareness Campaign	Access to Healthcare	$40,000
Salud En Balance	Colectivo Comunitario por la Salud: Millones de Corazones	- Access to Healthcare -Chronic Disease	$92,215
Maggie's Place	Healthy Mom, Healthy Families	-Access to Healthcare -Housing/Homelessness	$78,000
Cancer Support Community Arizona	Combatting Cancer Disparities to Promote Health Equity in Underserved Communities in the SJHMC's Service Area	Cancer	$45,000
Cancer Matters Corporation	Cancer Matter-Do you know your PSA?	Cancer	$30,000
Asian Pacific Community in Action	Improving Access to Primary Care for Migrants, Immigrants and Displaced People in the Phoenix Urban Area	-Access to Healthcare -Chronic Disease	$75,000
Links Incorporated, Phoenix Chapter	Links Incorporated, Phoenix Chapter	Access to Healthcare	$45,000
Chicanos Por La Causa, Inc.	Sembrando Semillas / Sowing Seeds	-Addiction/Substance Abuse -Mental Health	$70,000
Hushabye Nursery	Healthy Mom's, Cohesive Families	-Addiction/Substance Abuse -Mental Health	$91,360

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 Conditions
Program Description	The ACTIVATE Program is designed to help transition 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, and home needs, and assists with follow-up medical appointments
Population Served	The program serves an at-risk patient population that otherwise may be susceptible to re-hospitalization, specifically reducing readmissions and Emergency Department visits. The ACTIVATE Program serves patients with a wide range of socio-economic factors impacting their access to and treatment of their health-related needs.
Program Goal / Anticipated Impact	The goal of the ACTIVATE program is to make patients' transition from the hospital to home as smooth as possible, prevent the need for the patient to be readmitted to the hospital, focus on Social Determinants of Health impacting the patient's health condition, and connect the patient to community resources and wrap-around services.
FY 2024 Report	
Activities Summary	The ACTIVATE program provides home safety assessments, education on diagnosis and medication, linkage to community resources, and assessment of health-related social needs.
Performance / Impact	In FY24, 1480 patients were referred to the ACTIVATE Program. 601 patients were enrolled in the program and received at-home follow-up. • Of those 601 patients, ACTIVATE has had a 96% 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 clients who may benefit from the Program during clients' care in the hospital.
FY 2025 Plan	

Program Goal / Anticipated Impact	In FY25, ACTIVATE will begin working off a new patient priority list that was developed by the SJHMC Quality Team. This should allow the program to be more efficient in identifying patients who can utilize their services.
Planned Activities	Begin use of new patient triage list and begin demographic reporting of patients served.

Cancer Resource Navigator

Significant Health Needs Addressed	● Access to Care ● Cancer ● Mental/Behavioral Health
Program Description	Cancer Resource Navigators (CRNs) provide evidence-based patient navigation, mental health, education, resources, and emotional support through Cancer Support Community Arizona (CSCAZ) psychosocial programs and triage to other community-based resources. The hospital's role is to connect the in-hospital navigator to patients and families who may benefit from the program during clients' 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 connect cancer patients of SJHMC with needed health and psychosocial services both in the hospital setting and outside the hospital post-discharge as well as for family members to improve their health outcomes and their confidence in navigating multiple resources.
FY 2024 Report	
Activities Summary	Cancer Resource Navigators collaborate with medical teams, screen for health insurance eligibility, assist with enrollment, advocate for patients, facilitate distress screenings, and provide individual follow-up to ensure mental and physical health needs are met. Navigators address social determinants of health and provide a warm hand-off to partnering service providers for needs outside of CSCAZ's scope.
Performance / Impact	Goal 1: The Cancer Support Community Arizona Navigator will serve 20 unduplicated clients per month to total 240 in FY2024. ● CSCAZ served a total of 290 unduplicated patients in FY24 Goal 2: The Cancer Support Community Arizona Navigator will complete 60 client encounters per month to total 720 in FY2024. ● CSCAZ completed 830 total client encounters in FY24

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 in-hospital navigator to clients who may benefit from the program during clients' care in the hospital
FY 2025 Plan	
Program Goal / Anticipated Impact	Goal 1: Cancer Resource Navigators will serve a total of 350 low-income cancer patients as well as 100 of their family members/caregivers. Goal 2: Cancer Resource Navigator will increase the number of completed connections from 8 to 10 each month.
Planned Activities	Begin demographic reporting of patients served.

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 open to the community and 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.
Program Goal / Anticipated Impact	Continue to expand program infrastructure to reach people by maintaining DEEP as a virtual 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 virtual and in-person workshops to effectively reduce the burden of diabetes on the community with a focus on reaching more diabetes at-risk ethnic groups including African American and Hispanic communities.
FY 2024 Report	
Activities Summary	Hosted 5 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 demonstrated an increase of knowledge about diabetes prevention and control, 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 2025 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 FY25.
Planned Activities	No planned program changes from FY24.

Other Programs and Non-Quantifiable Benefits

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 healthcare services to communities that are poor and disenfranchised. For example, medical residents of Internal Medicine provide health services at St. Vincent's de Paul Medical Clinic in the Pediatric Continuity Clinic 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 project 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
COPA Health In March 2021 CommonSpirit approved a $4,950,000 loan to COPA Health to expand its health clinic in north Phoenix. COPA Health was formed by a merger between Marc Community Resources and Partners in Recovery in 2018, and is the largest provider of services to the Severely Mentally Ill population in the greater Phoenix, Arizona market.	$ 4,950,000
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. 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.

500 St. Joseph's Hospital Medical Center					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)					
For period from 07/01/2023 through 06/30/2024					
	Persons	**Total Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Living In Poverty					
Financial Assistance	16,918	$42,663,791	$0	$42,663,791	2.8%
Medicaid	202,239	$489,886,447	$337,852,257	$152,034,190	10.0%
Community Services					
A - Community Health Improvement Services	11,297	$2,341,096	$387,492	$1,953,604	0.1%
C - Subsidized Health Services	7,057	$6,279,052	$145,440	$6,133,612	0.4%
E - Cash and In-Kind Contributions	31,637	$471,949	$0	$471,949	0.0%
G - Community Benefit Operations	25	$69,050	$0	$69,050	0.0%
Totals for Community Services	50,016	$9,161,147	$532,932	$8,628,215	0.6%
Totals for Living In Poverty	**269,173**	**$541,711,385**	**$338,385,189**	**$203,326,196**	**13.3%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	122,924	$182,223	$0	$182,223	0.0%
B - Health Professions Education	3,774	$56,259,742	$23,137,868	$33,121,874	2.2%
D - Research		$51,533,477	$50,875,147	$658,330	0.0%
E - Cash and In-Kind Contributions	148	$421,107	$0	$421,107	0.0%
Totals for Community Services	126,846	$108,396,549	$74,013,015	$34,383,534	2.3%
Totals for Broader Community	**126,846**	**$108,396,549**	**$74,013,015**	**$34,383,534**	**2.3%**
Totals - Community Benefit	**396,019**	**$650,107,934**	**$412,398,204**	**$237,709,730**	**15.6%**
Medicare	64,065	$274,139,362	$223,980,683	$50,158,679	3.3%
Totals Including Medicare	460,084	$924,247,296	$636,378,887	$287,868,409	18.9%

Hospital Board and Committee Rosters

2024 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., Empower Emergency Physicians
DURAN III, Chief Mike Fire Chief, Phoenix Fire Department
EGBO, M.D., Obinna Physician, Associate CMO, Quality & Patient Safety Chair, 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 *(FY24 Board Chair)* Neurosurgeon and Associate Professor, Barrow Brain and Spine, Board Chair
RAGSDALE, Mary Interim President/CEO of St. Joseph's Hospital and Medical Center

SPELLERI, Maria *(FY23 Board Chair)* Chair, Board Development Committee

2024 Community Benefit and Health Equity Committee

Agboola, Liz *(FY24 Co-Chair)* CEO of Trinity Integrated Care
Cardenas, Liliana Manager, Office of Community Empowerment, Maricopa County Department of Public Health
Crittenden, Sonora Director, Community Benefit and Health Equity Dignity Health, St. Joseph's Hospital and Medical Center
Daymude, Annie Community Impact Analyst, Maricopa County Department of Public Health
Dhillon-Williams, Ruby Assistant Deputy Director of Housing and Development, Arizona Department of Housing
Gonzalez, Sarah *(FY24 Chair)* President of Gonzales Consulting, LLC
Hillman, Debbie Chief Administrative Officer, Mercy Care
Hoffman, Terri President and Chief Philanthropy Office, Dignity Health, St. Joseph's Hospital and Medical Center Foundation
Jackson, Anita Trauma Center Injury Prevention Coordinator, St. Joseph's Hospital and Medical Center
Jewett, Matt Director of Health Policy, Children's Action Alliance
Jones, Ashley Program Manager, Community Benefit and Partnerships Dignity Health, 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 Dignity Health, St. Joseph's Hospital and Medical Center
Montgomery, Keon Deputy Director, Az Department of Housing
Orsini, Craig Manager of Care Coordination Dignity Health, St. Joseph's Hospital and Medical Center
Torrealva, Josy Lead Community Health Worker Dignity Health, St. Joseph's Hospital and Medical Center
VanMaanen, Pat Health Consultant, PV Health Solutions