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

Community Benefit 2021 Report and 2022 Plan

Adopted September 2021

Dignity Health
St. Joseph's Hospital and Medical Center

Dignity Health
St. Joseph's Westgate Medical Center

A message from

Gabrielle Finley-Hazle, president and CEO of St. Joseph's Hospital and Medical Center (SJHMC) and St. Joseph's Westgate Medical Center (SJWMC), and Carmen Heredia, Chair of the Dignity Health St. Joseph's Hospital and Medical Center Community Board.

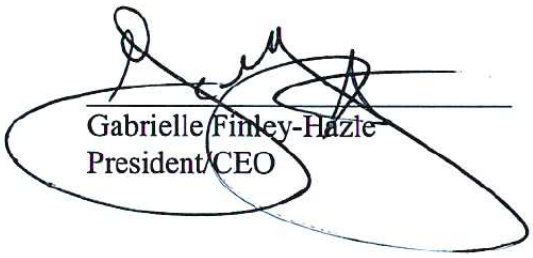
Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial 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 determinants of health.

St. Joseph's Hospital and Medical Center (SJHMC) and St. Joseph's Westgate Medical Center (SJWMC) shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2021 Report and 2022 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntary produce these reports and plans, as well. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

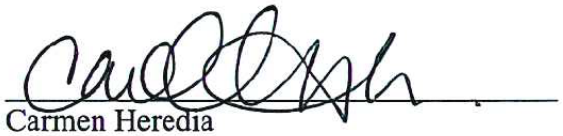
In fiscal year 2021 (FY21), SJHMC and SJWMC provided $165,595,258 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $156,281,002 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2021 Report and 2022 Plan at its September 22, 2021 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 to out to CommunityHealth-SJHMC@DignityHealth.org.



Gabrielle Finley-Hazle
President/CEO



Carmen Heredia
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

$165,595,258 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits

$156,281,002 in unreimbursed costs of caring for patients covered by Medicare

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
- Chronic Diseases
- Homelessness and Housing Insecurity
- Mental/Behavioral Health
- Safety & Violence

FY21 Programs and Services

The hospital delivered several programs and services to help address identified significant community health needs. These included:

- Access to Care – ACTIVATE, CATCH, Health Equity Initiative, Keogh Enrollment Specialist, Lyft Transportation Services, MOMobile, 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.
- Homelessness and Housing Insecurity: Homeless Patient Navigator, Homeless Discharge Initiative, and 2MATCH.
- Mental/Behavioral Health – Community Grants Program, Prenatal & Parenting Classes, and Smooth Way Home.
- Safety and Violence – Balance Masters, Barrow Concussion Network, Human Trafficking Initiative, Stop the Bleed, and 2MATCH.

FY22 Planned Programs and Services

- Access to Care – ACTIVATE, CATCH, Health Equity Initiative, Keogh Enrollment Specialist, Lyft Transportation Services, MOMobile, and Patient Financial Assistance.
- Cancer – Cancer Medication Assistance Program, Cancer Resource Navigator, Lifestyle Management Workshops and Support Groups, and Women's Wellness Clinic.
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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 595-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

SJHMC and SJWMC are dedicated to creating healthier communities by providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. Advocating for the poor and vulnerable is both our mission and our passion. The hospital has financial assistance available to help pay for medically necessary services provided to those patients who meet certain income requirements. The financial assistance policy, a plain language summary of the policy, and a financial assistance application are on the hospital's web site.

Description of the 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. A summary description of the community is below. Additional details can be found in the CHNA report online.

With an estimated population of 4 million and growing, Maricopa County is home to well over half of Arizona's residents. Maricopa County is ethnically and culturally diverse, home to more than 1.2 million Hispanics (30% of all residents), 216,000 African Americans, 157,000 Asian Americans, and 77,000 American Indians. According to the U.S. Census Bureau, 14% percent of the population does not have a high school diploma, 17% are living below the federal poverty level, and over 600,000 are uninsured.

Dignity Health defines the community served by a hospital as those individuals residing within its primary and secondary service areas. For this report the focus will be on the primary service area of SJHMC. The primary service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. Located in the heart of Phoenix, Arizona, SJHMC draws populations from Maricopa County, outside Maricopa County but within Arizona, and from outside the state. SJHMC's primary service area is within the urban inner city areas, and it also serves the suburban and rural communities for high-risk services. According to the Community Need Index (CNI), a proprietary tool developed by Dignity Health, the primary service area includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85003, 85004, 85006, 85007, 85008, 85009, 85015, 85017, 85019, 85031, 85033, 85040, and 85301.

Demographic information for the SJHMC primary service area.

Total Population	1,672,976
Race	
White - Non-Hispanic	30.9%
Black/African American - Non-Hispanic	8.1%
Hispanic or Latino	53.8%
Asian/Pacific Islander	3.2%
All Others	4.0%
Total Hispanic & Race	
% Below Poverty	15.8%
Unemployment	5.8%
No High School Diploma	21.4%
Medicaid (household)	12.3%

Uninsured (household)	6.4%
Source: Claritas Pop-Facts® 2021; *SG2 Market Demographic Module*	

Demographic information for the SJWMC primary service area.

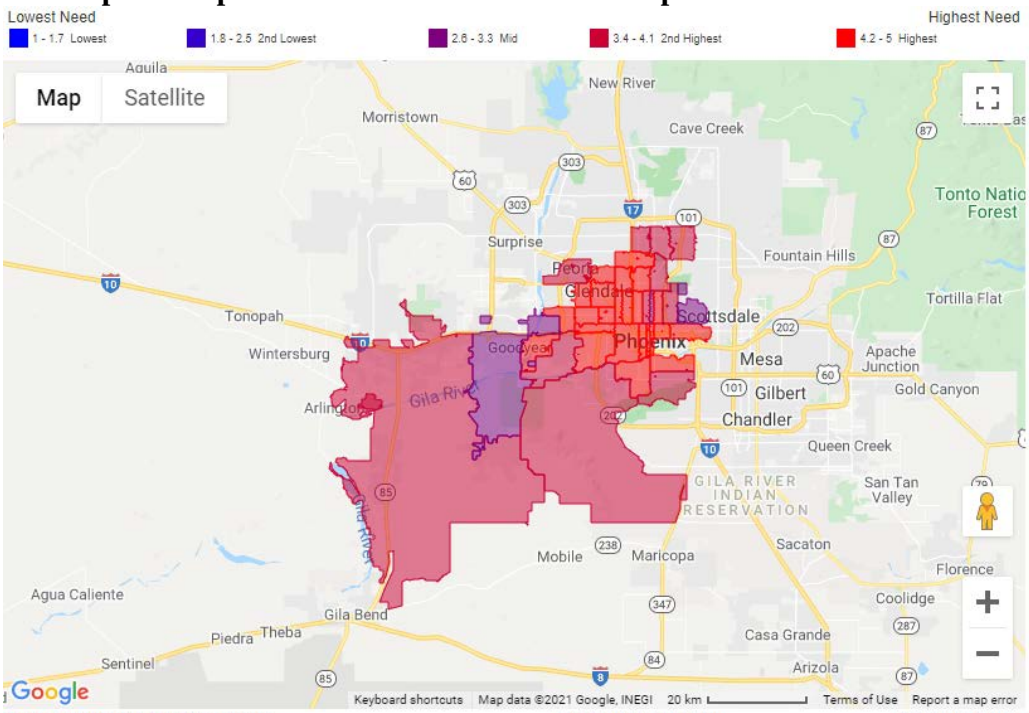
Total Population	1,182,957
Race	
White - Non-Hispanic	37.6%
Black/African American - Non-Hispanic	7.5%
Hispanic or Latino	47.2%
Asian/Pacific Islander	3.9%
All Others	3.8%
Total Hispanic & Race	
% Below Poverty	11.7%
Unemployment	5.5%
No High School Diploma	17.6%
Medicaid (household)	10.0%
Uninsured (household)	5.8%
Source: Claritas Pop-Facts® 2021; *SG2 Market Demographic Module*	

Community Need Index

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and IBM Watson Health. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage.

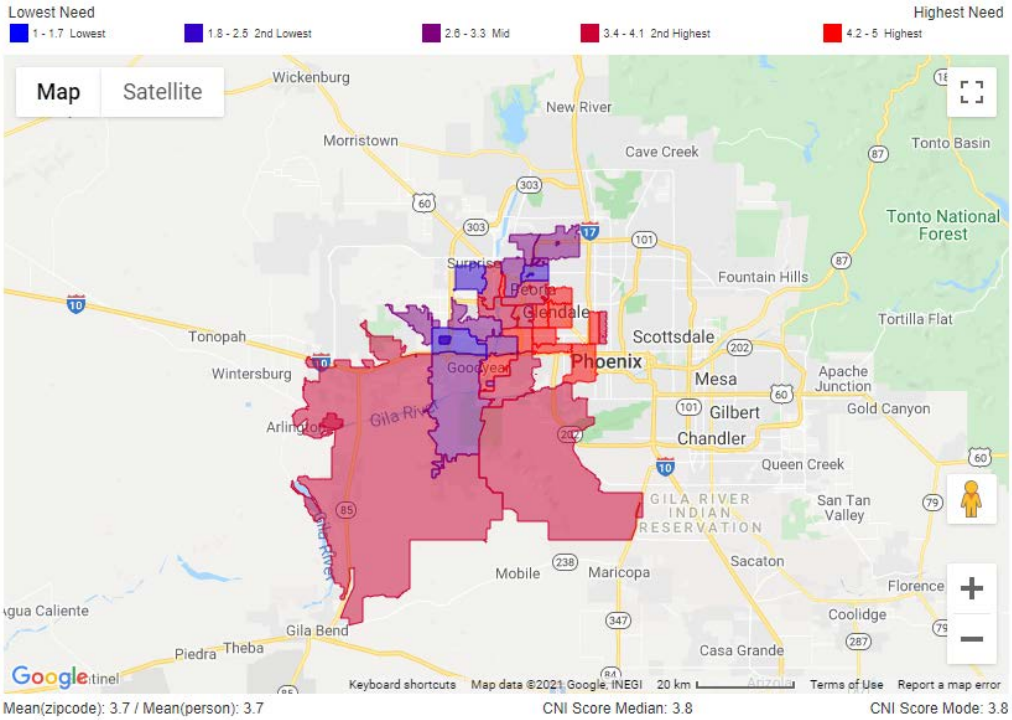
Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.

St. Joseph's Hospital and Medical Center CNI Map



Mean(zipcode): 4.3 / Mean(person): 4.2 CNI Score Median: 4.4 CNI Score Mode: 5

St. Joseph's Westgate Medical Center CNI Map



Mean(zipcode): 3.7 / Mean(person): 3.7 CNI Score Median: 3.8 CNI Score Mode: 3.8

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 January, 2019.

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 or upon request at the hospital's Community Health office.

Significant Health Needs

The most recent community health needs assessment identified the following significant community health needs:

1. **Access to Care** – Access to care is a critical component to the health and well-being of the community members in the primary service area. Often individuals without insurance, and even those who are underinsured, experience greater difficulty readily accessing health care services, particularly preventive and maintenance health care. This can be very costly, both to the individuals and the health care system.

2. **Mental/Behavioral Health** - Mental and behavioral health are terms often used interchangeably to refer to a spectrum of health conditions which are each distinct yet often co-occurring and overlapping. Behavioral health includes not only ways of promoting well-being by preventing or intervening in mental illness such as anxiety or depression, but also has an aim preventing or intervening in substance abuse and suicide. Emergency department visits related to mental and behavioral health have increased over the last 5 years in Maricopa County.

3. **Chronic Disease** – The specific chronic diseases that will be focused on include cardiovascular disease, diabetes, and overweight/obesity. Cardiovascular disease is the second leading cause of death in Maricopa County and diabetes is the sixth. Obesity is related to several adverse health conditions including heart disease, stroke, type 2 diabetes, and certain types of cancer.

4. **Cancer** - Cancer is a generic term for a large group of diseases characterized by the growth of abnormal cells beyond their usual boundaries that can then invade adjoining parts of the body and/or spread to other organs. While advancements continue to be made in the fight against cancer, it remains the leading cause of death in Maricopa County.

5. **Safety and Violence** – This health need includes trauma/injury prevention, falls, pedestrian injuries, and violence. In 2016, unintentional injuries were the fifth leading cause of deaths in Maricopa County and falls were ninth leading cause of death.

6. **Homelessness and Housing Insecurity** – A social determinant of health (SDOH) is a condition in the environment in which people are born, live, learn, work, play, and worship that affect a wide range of health, functioning, and qualify-of-life outcomes and risks. Homelessness and Housing Insecurity specifically are a major problem and health gap in Maricopa County.

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

2021 Report and 2022 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 FY21 and planned activities for FY22, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs' goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

The anticipated impacts of the hospital's activities on significant health needs are summarized below, and for select program initiatives are stated in Program Digests. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital works to evaluate impact and sets priorities for its community health programs in triennial Community Health Needs Assessments.

Creating the Community Benefit Plan

SJHMC and SJWMC are 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.

The Community Benefit and Health Equity Committee (CBHEC) is a subcommittee of the SJHMC Community Board, comprised of members who provide stewardship and direction for the hospital as a community resource. The Health Equity Alliance (HEA) is a large group of community organizations that the SJHMC community benefit staff bring together quarterly to work on the shared goal of improving the health and well-being of Maricopa County residents while reducing health disparities. Both of these groups were instrumental in developing the community benefit plan.

The process for prioritization of community needs included engagement with both internal Dignity Health stakeholders and community partners from the former Community Health Integration Network (CHIN) and the former Arizona Community of Care Network (ACCN). The first step of the process was a

comprehensive presentation of the CHNA findings and significant health needs. Stakeholders in attendance of 2019 Arizona Community of Care Network meetings participated in "needs strategy" activities where they identified strategies and opportunities to create healthier and sustainable communities. The ACCN identified areas and programs to collaborate with the hospital on over the following three years. CHIN members also participated in a strategy activity, where they reviewed community outcomes, discussed major inequities, and determined the best three-year strategies for each outcome.

Fiscal year 2021 marked the third year of the three-year strategies. Programs with evidence of success and positive community impact will either be continued or expanded upon in FY22. While some programs had to take a full stop in the beginning of the fiscal year due to a surge in COVID-19 cases, this gap was made up for with an increase of financial assistance for our vulnerable patients. Programs that have not shown success, or that have not been able to properly function in the midst of the pandemic will either be adapted or discontinued in FY22. The details of these decisions are further explained in the Report and Plan by Health Need section of this report.

Impact of the Coronavirus Pandemic

The coronavirus pandemic severely exacerbated existing community needs. The most urgent need exacerbated by the coronavirus pandemic is the issue of equitable healthcare, specifically related to racial inequity. Racial inequity is not a new or emerging need, but the severity of the issue has been emphasized by the pandemic. Achieving equity will require developing bold, targeted, race-conscious strategies that eliminate barriers to equitable healthcare. The FY22 plan will include an expansion to the FY21 health equity initiative focused on reducing disparities to advance equity in quality of care for all.

Shelter in place and social distancing orders presented an immediate need for those suffering from homelessness. The already-existing gap in shelter beds and long-term placements expanded as shelters were forced to reduce their intake of clients to maintain social distancing standards. In addition, the need to isolate and shelter in place after contracting coronavirus was impossible for patients suffering from homelessness. In order to address these needs, the Dignity Health Arizona hospitals (including SJHMC) partnered with the City of Phoenix, Maricopa County, Circle the City, Community Bridges, CASS, and various hotels to provide transportation and placement for homeless COVID-19 positive patients and "patients under investigation" being discharged from the hospital. When isolation units at the shelters were full, partnering hotels designated entire floors specifically for COVID-19 positive homeless patients to rest and recover in isolation.

The coronavirus pandemic also continued to bring significant challenges to community outreach and programming. Luckily, many programs were able to adapt to a new virtual environment to reach community members. Due to limitations on in-person events, several community outreach programs hosted by the Hospital had to be adapted. For example, the Diabetes Empowerment Education Program

(DEEP) converted its six in-person workshops to an entirely online platform in order to serve community members from the comfort and safety of their homes. The Balance Masters program also had to adapt its in-person exercise classes. Balance Masters now has an exercise routine published online that can be accessed by community members in their homes at any time.

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 Name	Summary Description	Active FY21	Planned FY22
Health Equity Initiative	• Hospital Board subcommittee focused on health equity • Health Equity Alliance will provide education to community partners • Internal review and transition of current demographic tracking/collection methods • Development of a 3-5 year Health Equity Strategy for SJHMC	☒	☒
Pathway Community HUB	• Begin to build the infrastructure of a Pathway Community HUB in Maricopa County • Evidence based approach that addresses risk factors in a coordinated way across partners and sectors while advancing equity and health outcomes. • Supports and sustains the CHW model	☐	☒
ACTIVATE Program	• Intense case management for patients with limited or low insurance • Provides access to free medical equipment • Patients followed for 30-90 days post discharge	☒	☒
CATCH (Internal Medicine Clinic)	• Clients Aligned Though Community and Hospital program coordinates social supports and clinical care services for high-risk patients • Intense case management for patients with multiple chronic illnesses and repeated hospitalizations	☒	☒

Community Navigator Program	• Navigators who are experts in their field are embedded in the hospital to assist with follow-up care for high-risk patients • Current navigator specialties: homeless, transportation, refugee, enrollment, cancer, and NICU • Muhammed Ali Parkinson's Center Promotores follow patients for 6 months	☒	☒
MOMobile	• Maternal Outreach Mobile Unit that travels to 4 different locations within Maricopa County weekly • Provides prenatal and postpartum care for low-income, uninsured pregnant women	☒	☒
Patient Financial Assistance	• Programs available to uninsured or underinsured patients who meet criteria and income requirements • Free or discounted care may be offered depending on eligibility for medically necessary hospital services	☒	☒
Lyft Transportation Services	• Free transportation home from the hospital upon discharge is made available for patients who have a financial need or who are homeless	☒	☒

Impact: The hospital's initiatives to address access to care are anticipated to result in: early identification and treatment of maternal health issues; gains in public or private health care coverage; increased knowledge about how to access and navigate the health care system; increased primary care "medical homes" among those reached by navigators and promotores; reduction in Emergency Department utilization; reduced readmission rates and length of stay in hospital; and increased access to health and human services.

Collaboration: The hospital will partner with Foundation for Senior Living, Chicano's Por La Causa, Circle the City, Catholic Charities Community Services, Southwest Human Development, and Cancer Support Community Arizona to deliver this access to care strategy.

Health Need: Cancer

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Cancer Patient Navigation	• Collaboration with Cancer Support Community to provide on-site community education and navigation for cancer patients and their caregivers. • Bilingual navigators help individuals who are poor, disenfranchised and underserved navigate their social and health needs related to cancer	☒	☒

Cancer Center Lifestyle Management Workshops and Support Groups	• Free, monthly workshops designed to promote optimal well-being for those currently or previously diagnosed with cancer • Free support groups for caregivers, patients diagnosed with cancer, and cancer survivors	☒	☐
Medication Assistance	• Cancer Center assists in completing applications for Cancer Medications for uninsured and underinsured • Typically results in free or reduced cost medication	☒	☒
Women's Wellness Clinic	• Provides free breast exams, mammograms, pap smears, pelvic exams, and rectal exams to low income and uninsured women • Focus on teaching women ways to reduce their cancer risks, including risks of skin cancer, cervical cancers, and colorectal cancers	☒	☒
Psychosocial Support for Underserved Cancer Patients and Their Families.	• Community grant for a program that improves health status and quality of life for underserved, primarily Spanish-speaking cancer patients and their families.	☒	☐

Impact: The hospital's initiatives to address cancer are anticipated to result in: increased access to appropriate care and social and medical supports; ensure patients are screened within cancer guidelines for early detection; education on methods of prevention; access to affordable medication for better health outcomes; and increased health outcomes among cancer patients.

Collaboration: The hospital will partner with Cancer Support Community Arizona, the Dignity Health Medical Group, and various pharmacies to deliver this cancer strategy.

Health Need: Chronic Disease

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
ACTIVATE Program	• Management of sepsis, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD) patients post hospital visits • Home visiting program and increased monitoring for 30 days Social needs being addressed as well	☒	☒

Diabetes Empowerment Education Program	• Diabetes self-management workshops in English and Spanish • Free to all community members	☒	☒
Healthier Living with Chronic Conditions	• Chronic disease self-management workshops in English and Spanish • Free to all community members	☒	☒
Muhammed Ali Parkinson's Center Programs	• Ali Care helps people with Parkinson's disease and little or no health care insurance receive health care • MAPC Promotores deliver an in-home educational program for Hispanic patients with language barriers	☒	☒
Stroke Prevention	• Health promotion and stroke prevention education for seniors and community members • Increases the number of individuals who recognize signs and symptoms of stroke	☒	☒
¡Viva!– A Family Centered Obesity and Diabetes Prevention Program	• Community grant for an evidence-based diabetes prevention program focused on improving health behaviors and health outcomes of high-risk children.	☒	☐
Improving the Health on Uninsured Patients with Diabetes	• Community grant for comprehensive diabetes care and education resources, to establish regular medical care, medication, access to fresh produce, and nutrition education.	☒	☐

Impact: The hospital's initiatives to address chronic conditions are anticipated to result in: increased education on how to self-manage chronic health conditions; ability to identify early signs of stoke; improved care plans and treatment options for septic patients; and improved well-being of patients with chronic conditions.

Collaboration: The hospital will partner with Area Agency on Aging, Esperanca, Chicano's Por La Causa, Maricopa County Dept. of Public Health, and Foundation for Senior Living to deliver this chronic disease strategy.

Health Need: Homelessness and Housing Insecurity

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Community Navigator Program	• Navigators who are experts in their field are embedded in the hospital to assist with follow-up care for high-risk patients	☒	☒

	• Current navigator specialties: homeless, transportation, refugee, enrollment, cancer, and NICU		
Homeless Discharge Initiative	• Care and discharge planning for patients suffering from homelessness • Increase collaborations for assisting homeless individuals with their transfer to community and provide food, clothing, transportation and other social needs when necessary	☒	☒
2MATCH (To Match and Align Through Community Hubs)	• Advocates survey Medicare and Medicaid beneficiaries (in the hospital, telephonically, and at community clinics) on their social needs and navigates their needs by connecting them to services • Patients are case managed for 12 months post discharge	☒	☒

Impact: The hospital's initiatives to address homelessness and housing insecurity are anticipated to result in: increased partnerships with community organizations who specialize in specific SDOHs, a more seamless transition from hospital to home/community; increased education to clinical staff on SDOH resources available; reduction in Emergency Department utilization and readmissions; increased overall health of high-risk patients.

Collaboration: The hospital will partner with Circle the City, Chicano's Por La Causa, Catholic Charities Community Services, Southwest Human Development, Cancer Support Community Arizona, Foundation for Senior Living and various community healthcare clinics to deliver this homelessness and housing insecurity strategy.

Health Need: Mental / Behavioral Health

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Smooth Way Home	• Embedded community program that supports fragile infants and their families as they transition from NICU to home • Qualifying NICU parents receive intense support that combats social isolation, feeding disorders, substance abuse disorders, and mental health problems including post –partum depression, PTSD, anxiety disorder, and Obsessive Compulsive Disorder	☒	☐

Strong Families, Strong Communities	• Community grant to help integrate maternal mental health support, substance use disorder, and parenting concurrently for families.	☒	☐
Refugee Health Partnership	• Community grant to identify and respond to barriers faced by vulnerable immigrant populations when accessing medical and mental/behavioral health care.	☒	☐
Parenting and Prenatal Classes	• Free or reduced price classes offered to pregnant women and new parents • Class subjects include postpartum depression and breastfeeding support	☒	☒

Impact: The hospital's initiatives to address mental/behavioral health are anticipated to result in: increased education on signs and symptoms of mental and behavioral health conditions, improved care plans and treatment options for pregnant and new parents; and building community capacity to provide a response to the growing need for mental/behavioral health resources.

Collaboration: The hospital will partner with Southwest Human Development, Raising Special Kids, Nourish, Community Medical Services, Hush-a-Bye Nursery, Women's Health, Catholic Charities Community Services, Inc., International Rescue Committee, Women's Health Innovations, and Barrow Neurological Institute to deliver this mental/behavioral health strategy.

Health Need: Safety and Violence

Strategy or Program Name	Summary Description	Active FY21	Planned FY22
Stop the Bleed	• National awareness campaign and a call to action that educates and empowers bystanders to help in a bleeding emergency by teaching basic techniques of bleeding control • Classes held in community settings and provides bleeding control kits to organizations	☒	☒
Balance Masters	• Group class that addresses fear or risk of falling among seniors through balance and strength exercises • Free for seniors 65+	☒	☒
Human Trafficking Initiative	• Education for clinic staff on how to identify and treat human trafficking victims • Educate and Promote the use of the PEARR tool (Trauma Informed Care) • Provides support to community and individuals requiring assistance	☒	☒

Barrow Concussion Network	• Provides concussion prevention education to the community, the caregivers, and healthcare providers through Barrow Brainbook, health profession presentations, and general public presentations.	☒	☒
Youth Violence Intervention and Prevention Project	• Community grant to address the individual, relationship, community, and societal risk factors associated with youth interpersonal violence perpetration.	☒	☐
2MATCH (To Match and Align Through Community Hubs)	• CMS AHC Model funded program that screens Medicare and Medicaid beneficiaries for social determinants of health including exposure to personal violence • High Risk beneficiaries that report that they have been exposed to violence or experience personal violence are provided navigation services to community service organizations for information and assistance. Navigation services are available for the beneficiary for one year.	☒	☒

Impact: The hospital's initiatives to address safety and violence are anticipated to result in: increased education to community on how to react to a bleeding emergency, how to improve balance, and identify signs and symptoms of concussion; ability of clinical staff to identify human trafficked victims and treat them appropriately; reduction in falls and fear of falling among seniors; and improved well-being of patients of high-risk patients.

Collaboration: The hospital will partner with Foundation for Senior Living, Catholic Charities Community Services, BLOOM 365, One n Ten, and Barrow Neurological Institute to deliver this safety and violence strategy.

Community 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.

In FY21, the hospital awarded the grants below totaling $585,708. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
BLOOM365	Y-VIPP: Youth Violence Intervention and Prevention Project	$97,038
Cancer Support Community Arizona	Psychosocial Support for Underserved Cancer Patients and Their Families	$70,000
Catholic Charities	Refugee Health Partnership	$54,800
Maggie's Place	Strong Families, Strong Communities	$94,790
Mission of Mercy	Improving the Health of Uninsured Patients with Diabetes	$97,040
Southwest Human Development	Smooth Way Home	$75,000
Valley of the Sun YMCA	¡Viva! A Family Centered Obesity and Diabetes Prevention Program	$97,040

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.

Barrow Concussion Network (BCN)

Significant Health Needs Addressed	☑ Access to Care ☑ Mental/Behavioral Health ☑ Chronic Diseases ❑ Cancer ☑ Safety & Violence ❑ Homelessness & Housing Insecurity
Program Description	BCN provides concussion prevention education to the community, the caregivers, and health care providers through Barrow Brainbook, health profession presentations, and general public presentations. Barrow Brainbook is an online course given to high school students prior to participation in interscholastic athletics. BCN provides baseline neurocognitive testing and concussion consultations to our high school athletic trainers, especially in rural areas where they would not normally have access to adequate neurologists

Community Benefit Category	A2-d Community-Based Clinical Services- Immunizations/Screenings A1-a Community Health Education- Lectures/Workshops B3- Other Health Professions Education A3-h Health Care Support Services- General/Other
FY 2021 Report	
Program Goal / Anticipated Impact	The goal of this program is to provide educational material to all populations (students, parents, healthcare providers, etc) on concussion prevention and how to recognize the signs and symptoms, as well as the appropriate follow-up care to take.
Measurable Objective(s) with Indicator(s)	• Increase the number of student-athletes reached for Barrow Brainbook • At least 200 Athletic Trainers for professional education • At least 150 attendees for general community education.
Intervention Actions for Achieving Goal	• For high school students we provide an interactive online learning module to complete prior to participation in sports • For health professionals we provide education and conferences for them to attend • For the general public information is provided through presentations
Collaboration	None at this time.
Performance / Impact	• We have greatly felt the impact of the pandemic, despite that the BCN was still very impactful this year. • Barrow Brainbook reached over 46,000 student-athletes just in FY21 alone. This resulted in an increase in concussion education and prevention. Barrow Brainbook educates athletes on the signs and symptoms of a concussion, what to do if they have symptoms or suspect their teammate of having signs and/or symptoms. • BCN provided continuing education units to 139 athletic trainers through 2 conferences and general education to 534 professionals. • BCN provided over 18,000 baseline concussion tests in FY21 • BCN directly served 1,221 through education presentations
Hospital's Contribution / Program Expense	Provides staffing assistance for Program Coordinator for Barrow Concussion Network, software development and maintenance, and provides licenses for baseline testing.
FY 2022 Plan	
Program Goal / Anticipated Impact	• To provide concussion education to all Arizona HS athletes, promote Barrow Brainbook nationally. • To have good usage of our brand new Barrow Spanish Brainbook

	• To continue to support Arizona HS athletic trainers through ImPACT concussion baseline testing and the concussion consultation telemedicine • To spread awareness of the risk, how to recognize, and how to prevent concussions to the community
Measurable Objective(s) with Indicator(s)	• Reach 50,000 student-athletes for Barrow Brainbook, to include the Spanish version • Provide CEU education to at least 100 athletic trainers • Increase in usage for our upgraded concussion consultation portal • Provide general concussion education to over 500 individuals
Intervention Actions for Achieving Goal	• For high school students we provide an interactive online learning module to complete prior to participation in sports • For health professionals we provide education and conferences for them to attend • For the general public information is provided through presentations
Planned Collaboration	None at this time

Cancer Resource Navigator

Significant Health Needs Addressed	☑ Access to Care ☑ Mental/Behavioral Health ☑ Chronic Diseases ☑ Cancer ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Program Description	Collaboration with Cancer Support Community Arizona to provide on-site and community education and navigation for cancer patients and their caregivers. Bilingual navigators help individuals who are poor, disenfranchised and underserved navigate their social and health needs related to cancer.
Community Benefit Category	A3-g. Health Care Support Services - Case management post-discharge
FY 2021 Report	
Program Goal / Anticipated Impact	The goal of this program is to connect cancer patients of SJHMC with needed health and social services post-discharge to improve their health outcomes and their confidence navigating multiple resources.
Measurable Objective(s) with Indicator(s)	Goal #1: The Cancer Support Community Navigator will increase the number of patients contacted from 15 to 25 each month in FY2021. Goal #2: The Cancer Support Community Navigator will increase the number of completed connections from 5 to 8 each month in FY2021.

Intervention Actions for Achieving Goal	Cancer Support Community Arizona Navigator will be located onsite at SJHMC for 3 days a week to better reach patients.
Collaboration	Collaboration with Cancer Support Community and the American Cancer Society.
Performance / Impact	The CSCAZ Navigator provided 317 patients with necessary resources and provided 726 patient visits in FY21.
Hospital's Contribution / Program Expense	The hospital provides the funding necessary for 50% of a full-time cancer navigator located at the hospital. The hospital connects the in-hospital navigator to clients who may benefit from the Program during clients' care in the hospital.
FY 2022 Plan	
Program Goal / Anticipated Impact	The goal of this program is to connect cancer patients of SJHMC with needed health and social services post-discharge to improve their health outcomes and their confidence navigating multiple resources.
Measurable Objective(s) with Indicator(s)	Goal #1: The Cancer Support Community Arizona Navigator will serve 15 unduplicated clients per month to total 180 in FY2022. Goal #2: The Cancer Support Community Arizona Navigator will complete 65 client encounters per month to total 780 in FY2022.
Intervention Actions for Achieving Goal	Cancer Support Community Arizona Navigator will be located onsite at SJHMC for 3 days a week for 5-6 hours per day to better reach patients.
Planned Collaboration	None

Diabetes Empowerment Education Program (DEEP)

Significant Health Needs Addressed	❑ Access to Care ❑ Mental/Behavioral Health ☑ Chronic Diseases ❑ Cancer ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
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 campus, in community settings and via Zoom.
Community Benefit Category	A1-a. Community Health Education – Lectures/Workshops

FY 2021 Report	
Program Goal / Anticipated Impact	Expand the infrastructure to continue reaching people by converting DEEP into a virtual education platform. Operating 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 workshops to effectively reduce the burden of diabetes on the community midst the current pandemic with a focus on reaching more diabetes at-risk ethnic groups including African American and Hispanic communities.
Measurable Objective(s) with Indicator(s)	Host 15 virtual English/Spanish DEEP workshops throughout the year. By hosting 15 virtual DEEP workshops, we will have 150 DEEP completers by the end of FY21
Intervention Actions for Achieving Goal	Increase community and hospital-based referrals. Increase community relationships where workshops can be held (i.e. churches, community centers) or where a community group can be formed for a virtual workshop. Increase virtual outreach (Eventbrite).
Collaboration	Chicanos Por La Causa (Keogh Health Connection), University of Illinois, Area Agency on Aging.
Performance / Impact	The DEEP Program was converted into a virtual platform via Zoom which resulted in the program successfully hosting and completing 8 virtual DEEP workshops, resulting in 90 completers. Through this platform, the program also reached participants from various other states and countries.
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 2022 Plan	
Program Goal / Anticipated Impact	Continue to expand the infrastructure to continue reaching 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 workshops to effectively reduce the burden of diabetes on the community midst the current pandemic with a focus on reaching more diabetes at-risk ethnic groups including African American and Hispanic communities.
Measurable Objective(s) with Indicator(s)	Host 15 virtual English/Spanish DEEP workshops throughout the year. Through these workshops, we will have 150 DEEP completers by the end of FY22
Intervention Actions for Achieving Goal	Increase community and hospital-based referrals. Increase community relationships where workshops can be held (i.e. churches, community centers) or where a community group can be formed for a virtual workshop. Increase virtual outreach (Eventbrite).

Planned Collaboration	Chicanos Por La Causa (Keogh Health Connection), University of Illinois, Area Agency on Aging.

Maternity Outreach Mobile (MOMobile)

Significant Health Needs Addressed	☑ Access to Care ❑ Mental/Behavioral Health ☑ Chronic Diseases ❑ Cancer ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Program Description	Provide prenatal and postpartum care for low -income, uninsured pregnant women in Maricopa County who would otherwise not be able to obtain prenatal care. Mobile clinic travels to 4 different locations within Maricopa County weekly. Supported by SJHMC, and the OB/GYN Department of DHMG, funded through SJH Foundation which covers all operating costs, including staffing
Community Benefit Category	A2-f. Community-based clinical services – Mobile Units
FY 2021 Report	
Program Goal / Anticipated Impact	Decrease preterm and low birth weight infants in Maricopa County, increase number of mothers receiving adequate prenatal care. Decrease both infant and maternal mortality.
Measurable Objective(s) with Indicator(s)	Measurements include number patient visits, number of prenatal visits per patient receiving their prenatal care through MOMobile, average birth weight of infants, and outcomes of births.
Intervention Actions for Achieving Goal	Provide services in areas where zip codes are indicating increased rates of premature birth, low birth weights, and higher infant mortality.
Collaboration	St John Vianney Church, First Southern Baptist Church, Wesley Center, and Catholic Charities. Patients also received collaborate services with First Teeth First, Mission of Mercy, St Vincent de Paul, Wesley Community Health Centers.
Performance / Impact	During the time period 7/1/20-6/30/21, MOMobile had a total of 1168 in person patient visits to the MOMobile, and 97 healthy babies were delivered at St Joseph's Hospital. The average birth weight of a MOMobile baby was 7lb 4oz. And the average number of prenatal visits for each mom was 10.
Hospital's Contribution / Program Expense	Provides staffing, assistance for patients including physicians for delivery, ultrasounds, co-management of higher risk patients, office space for staff, parking for mobile clinic, and supplies for clinic.

FY 2022 Plan	
Program Goal / Anticipated Impact	Provide prenatal and postpartum care for low -income, uninsured pregnant women in Maricopa County who would otherwise not be able to obtain prenatal care. Travel to 4 different locations within Maricopa County weekly to provide better health outcomes for uninsured or underinsured expectant mothers.
Measurable Objective(s) with Indicator(s)	Measurements will include tracking the number patient visits, number of prenatal visits per patient receiving their prenatal care through MOMobile, the average birth weight of infants, and the outcomes of all the births.
Intervention Actions for Achieving Goal	Provide services in areas where zip codes are indicating increased rates of premature birth, low birth weights, and higher infant mortality.
Planned Collaboration	Collaboration with St John Vianney Church, First Southern Baptist Church, Wesley Center, and Catholic Charities; who will allow the MOMobile to be operational weekly at their locations. Patients will also receive collaborative services with First Teeth First, Mission of Mercy, St Vincent de Paul, and Wesley Community Health Centers.

2MATCH	
Significant Health Needs Addressed	☑ Access to Care ☑ Mental/Behavioral Health ❑ Chronic Diseases ❑ Cancer ☑ Safety & Violence ☑ Homelessness & Housing Insecurity
Program Description	In 2017, Dignity Health, St. Joseph's Hospital and Medical Center received funding from the Center for Medicare and Medicaid Services (CMS) for five years to implement the Accountable Health Communities Model (AHC). Dignity Health named this program To Match, Align Through Community Hubs (2MATCH). 2MATCH addresses health related social needs of Medicare and Medicaid beneficiaries within St. Joseph's hospital and 12 internal and external clinical sites. The AHC model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual's ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.
Community Benefit Category	A3-g. Health Care Support Services – Case management post-discharge.

FY 2021 Report	
Program Goal / Anticipated Impact	2MATCH will conduct systematic health-related social determinant of health screenings of Medicaid and Medicare beneficiaries who received care in St. Joseph's Hospital and Medical center and the12 2MATCH Clinical Delivery Sites and provide navigation services to at least 1,463 high risk beneficiaries who reported that they have received care within an emergency room at least twice over the past year and have at least one or more social need, i.e. food insecurity, housing instability, transportation, utility assistance and exposure to violence. At least 1,463 high risk beneficiaries will be identified and provided navigation assistance to access community services by April 30, 2022.
Measurable Objective(s) with Indicator(s)	In Year 5, 1,463 high risk beneficiaries will receive navigation assistance to obtain the social need(s) that they identified when they participated in the 2MATCH survey. All screening data is captured within Healthify, a cloud based software system, and then uploaded to CMS for review.
Intervention Actions for Achieving Goal	2MATCH screening and navigation scopes of practice will be utilized to identify and navigate 1,463 beneficiaries who are in need of assistance obtaining social services.
Collaboration	2MATCH will continue to contract with Foundation for Senior Living, Native American Connections and Valleywise Health to screening eligible Medicare and Medicaid beneficiaries, identify high risk beneficiaries eligible for navigation services, and if applicable, provide navigation services. 2MATCH will continue to collaborate with Creighton University College of Nursing. Their nursing students assist in screening beneficiaries twice a year to identify high risk beneficiaries in need of assistance. 2 MATCH will establish a collaboration with Arizona State University College of Nursing and Health Innovation. Their nursing students will assist in screening beneficiaries once a week from September 2021 through December 2021 to identify high risk beneficiaries in need of assistance.
Performance / Impact	High risk beneficiaries who report that they are in need of social services (food insecurity, housing instability, transportation, utility assistance and exposure to violence) will be identified and navigated by 2MATCH Advocates and referred to community based organizations that can provide services.
Hospital's Contribution / Program Expense	2MATCH is entirely funded by CMS ($898,378/year for 5 years) to implement the AHC Model; the 2MATCH Program Manager and 2MATCH Project Director were hired with grant funds. 2MATCH utilized grant funds to contract with Chicanos Por La Causa, Inc. (Keogh Health Connection) to provide a Community Health Worker Supervisor and five to seven Community Health Workers to screen beneficiaries,

	identify high risk beneficiaries, and provide navigation assistance. 2MATCH also contracts with external Clinical Sites that include Native American Connections, Valleywise Family Clinic, Valleywise Pediatrics and Foundation for Senior Living.
FY 2022 Plan	
Program Goal / Anticipated Impact	2MATCH will provide at least three months of navigation services for eligible beneficiaries from February 1, 2022 to April 30, 2022 The 2MATCH will adjust navigation workflows accordingly to document and report progress with resolving identified needs by April 30, 2022. 2MATCH will make every effort to resolve beneficiary needs by the end of the model and plan to transition beneficiaries to other care managers according to the 2MATCH sustainability plan.
Measurable Objective(s) with Indicator(s)	All eligible beneficiaries will receive navigation services from February 1, 2022 to April 30, 2022.
Intervention Actions for Achieving Goal	Screening of Medicare and Medicaid beneficiaries in all 2MATCH Clinical sites ends on January 31, 2022. Navigation workflows will be adjusted accordingly. All 2MATCH Advocates will focus on navigation beginning February 1, 2020 through April 30, 2020. Referrals for social services are created and closed out by April 30, 2022. If needed, beneficiaries are transitioned to other care managers.
Planned Collaboration	2MATCH Program staff to meet with all 12 Clinical Delivery sites to plan and implement final programmatic strategies to conclude the AHC Model by April 30, 2022.

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:

Arizona Community Foundation (ACF) ACF has been a partner with Dignity Health since 2012. It is using its current 5-year $5,000,000 loan approved in 2016 to extend financing for the creation of health clinics, charter schools and affordable housing for low-income families and communities in Phoenix and the surrounding area.	$ 5,000,000
Ascend (Autism Spectrum Center for Educational and Neurological Development) In September 2020 CommonSpirit approved a $400,000 loan to Ascend to pay for construction expenses for a new 4,300 square foot facility to house both child and adult services. Ascend was originally formed in 2007 as an Arizona Department of Education Private Approved Day School. For the past 12 years, ASCEND has been providing quality educational services to K-12 students with autism and related disorders in Yavapai County, Arizona.	$400,000
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.	$500,000
Clothes Cabin In January 2019 Dignity Health approved a 7-year $500,000 loan to Clothes Cabin, who is a nonprofit organization providing clothing to those in need-specifically low-income children who need clothes for school, low-income men and women for work, and the homeless in Chandler, Arizona.	$500,000

Chicanos Por la Causa (CPLC) In January 2017 Dignity Health approved a 7-year $3,000,000 loan to CPLC, a multifaceted nonprofit organization offering a wide array of bilingual and bicultural services that include education, advocacy, small business lending, and affordable housing development. This loan complements CPLC's Neighborhood Stabilization Program grant specifically to help acquire, rehabilitate, and manage 95 units of affordable multi-family housing in Phoenix, Arizona with wraparound services. Another 7-year loan for $1,000,000 was approved in 2018 to provide bridge financing for the development of 187 units of affordable mixed-use and mixed-income housing as part of a comprehensive revitalization for the City of Mesa.	$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
Foundation for Senior Living (FSL) In June 2018 Dignity Health approved a 7-year $2,400,000 participation loan with the Arizona Community Foundation to FSL for the relocation of its adult day care center in Glendale to a new building closer to Peoria. This new center will allow FSL to serve twice as many seniors (up to 100 persons)—especially those with complex medical conditions that require medical, restorative, and therapeutic care.	$2,400,000
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 ("NAS").	$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 to NAC (originally with HomeBase Youth Services Inc.) for providing a transitional living facility for homeless youth ages 18-24 in Phoenix, Arizona. Another 7-year loan for $1,000,000 was approved in September 2019 to NAC to develop Stepping Stone Phase III, a 42 unit affordable housing development for homeless individuals.	$1,420,419

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 though first and second mortgages and down payment assistance. Trellis also provides financial counseling and homeownership education. In September 2020, a new $3,5000,000 loan was approved for 7-years pay for predevelopment and construction expanses for a 40-lot affordable housing complex in Phoenix, Arizona.	$4,000,000

Economic Value of Community Benefit

500 St. Joseph's Hospital and Medical Center					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2020 through 6/30/2021					
	Persons	**Expense**	**Revenue**	**Net Benefit**	**% of Expense**
Benefits for Poor					
Financial Assistance	**22,910**	**30,034,876**	**0**	**30,034,876**	**2.3%**
Medicaid	**179,185**	**376,928,264**	**285,274,890**	**91,653,374**	**6.9%**
Community Services					
A - Community Health Improvement Services	7,828	2,996,142	356,269	2,639,873	0.2%
C - Subsidized Health Services	1,289	2,952,690	150,000	2,802,690	0.2%
E - Cash and In-Kind Contributions	9,788	793,273	0	793,273	0.1%
F - Community Building Activities	274	11,456	0	11,456	0.0%
Totals for Community Services	415	933,363	0	933,363	0.1%
Totals for Community Services	**19,594**	**7,686,924**	**506,269**	**7,180,655**	**0.5%**
Totals for Poor	**221,689**	**414,650,064**	**285,781,159**	**128,868,905**	**9.7%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	82,104	257,709	66,878	190,831	0.0%
B - Health Professions Education	1,838	37,497,750	2,873,553	34,624,197	2.6%
D - Research	0	39,218,434	37,408,394	1,810,040	0.1%
F - Community Building Activities	294	101,285	0	101,285	0.0%
Totals for Community Services	**84,236**	**77,075,178**	**40,348,825**	**36,726,353**	**2.8%**
Totals for Broader Community	**84,236**	**77,075,178**	**40,348,825**	**36,726,353**	**2.8%**
Totals - Community Benefit	**305,925**	**491,725,242**	**326,129,984**	**165,595,258**	**12.4%**
Medicare	**120,917**	**482,571,594**	**326,290,592**	**156,281,002**	**11.7%**
Totals with Medicare	**426,842**	**974,296,836**	**652,420,576**	**321,876,260**	**24.2%**

The economic value of all community benefit is reported at cost. The economic value of community benefit for patient financial assistance (charity care), Medicaid and other means-tested programs 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.

Hospital Board and Committee Rosters

2021 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
BURNS, M.D., Anne Physician, Chairman and Medical Director for Emergency Dept., Empower Emergency Physicians
DAVIS, J.D., Helen (ex-officio representative from East Valley Hospitals Community Board) Managing Partner, The Cavanagh Law Firm
DOHONEY, Jr., Milton Assistant City Manager, City of Phoenix
FINLEY-HAZLE, Gabrielle President/CEO of St. Joseph's Hospital and Medical Center
GENTRY, Patti Partner/Designated Broker, Keyser
GONZALEZ, Sarah President of Gonzales Consulting, LLC
HEREDIA, Carmen *(Board Chair)* Chief Executive Officer, Valle del Sol (non-profit organization)
HOFFMAN, Joel
HORN, Rick Independent financial and retail advisor and corporate board member
HUNT, Linda (ex-officio member) Sr. Vice President of Operations of Dignity Health Arizona
JONES, Sister Gabrielle Marie Sister of Mercy, retired hospital executive and nurse
MORALES, Joanne Director of Refugee Programs, Catholic Charities Community Services
PALMER, Tom President of Claremont Capital Management
PONCE, M.D., Francisco Neurosurgeon and Associate Professor, Barrow Brain and Spine
SIMKIN, Gayle Retired Infection Preventionist
SPELLERI, Maria *(Board Secretary)* Executive V.P. & General Counsel, Chicanos Por La Causa, Inc.

2021 Community Benefit and Health Equity Committee

Community Members

Berger, Jami
Executive Director of Operations, Arizona Care Network
Cardenas, Lilliana
Community Empowerment Office Manager, Maricopa County Dept. of Public Health
Daymude, Annie
Community Impact Analyst, Maricopa County Dept. of Public Health
Dhillon-Williams, Ruby
Assistant Deputy Director of Housing Development, Arizona Department of Housing
Hillman, Deborah
Chief Administrative Officer, Mercy Care Plan
Horn, Richard
Independent Financial and Retail Advisor, St. Joseph's Hospital Community Board
Jewett, Matt
Grants Director, Mountain Park Health Center
Mascaro, CarrieLynn
Vice President of Program Operations, Catholic Charities
Spelleri, Maria - Chair
Executive V.P. & General Counsel, Chicanos Por La Causa, Inc.
Smith, Carrie
Chief Operating Officer, Foundation for Senior Living
Unrein, Serena
Director, Arizona Partnership for Healthy Communities
VanMaanen, Pat
Health Consultant, PV Health Solutions

Hospital Staff

Alonzo, Anna
Manager of 2MATCH Program, St. Joseph's Hospital Medical Center
Bethancourt, Bruce
Chief Medical Officer, St. Joseph's Hospital Medical Center
Graham, Julie
Director of External Affairs, Dignity Health Arizona
Hoffman, Terri
President, St. Joseph's Foundation
Manuel, Thelma
Patient Experience Advocate, Oasis Hospital

Orsini, Craig
Manager Care Coordination, St. Joseph's Hospital Medical Center

Raj, Jaya
Program Director and Vice Chair of Education, St Joseph's Hospital Medical Center, Creighton University School of Medicine
Riley, Julie
Chief Administrative Officer, St. Joseph's Hospital Medical Center

Department Staff

Crittenden, Sonora
Program Manager Community Benefit, St. Joseph's Hospital and Medical Center
De Melo, Desiree
Community Engagement and Health Equity Coordinator, St. Joseph's Hospital and Medical Center
Jones, Ashley
Community Benefit Specialist, St. Joseph's Hospital and Medical Center
McBride, Sr. Margaret
Vice President of Mission Integration, CommonSpirit Health
Torrealva, Josy
Community Health Integration Coordinator, St. Joseph's Hospital and Medical Center