

# St. Joseph's Westgate Medical Center

## 2022 Community Health Implementation Strategy






**Adopted October 2022**



# Table of Contents

<b>At-a-Glance Summary</b>	<b>3</b>
<b>Our Hospital and the Community Served</b>	<b>4</b>
About the Hospital	4
Our Mission	4
Financial Assistance for Medically Necessary Care	4
Description of the Community Served	5
<b>Community Assessment and Significant Needs</b>	<b>6</b>
Significant Health Needs	6
<b>2022 Implementation Strategy</b>	<b>9</b>
Creating the Implementation Strategy	9
Community Health Strategic Objectives	10
Strategies and Program Activities by Health Need	11
Strategies and Programs for Health Equity	16

## At-a-Glance Summary

<p><b>Community Served</b></p> 	<p>SJWMC serves 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 4.3 million and growing, Maricopa County is home to well over half of Arizona’s residents. The community served is ethnically and culturally diverse.</p>		
<p><b>Significant Community Health Needs Being Addressed</b></p> 	<p>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:</p> <table border="1" data-bbox="410 651 1427 846"> <tr> <td data-bbox="410 651 857 846"> <ul style="list-style-type: none"> <li>• Access to Healthcare                             <ul style="list-style-type: none"> <li>• Maternal &amp; Child Health</li> <li>• Financial Security</li> </ul> </li> </ul> </td> <td data-bbox="865 651 1427 846"> <ul style="list-style-type: none"> <li>• Chronic Health Conditions                             <ul style="list-style-type: none"> <li>• Obesity</li> <li>• Diabetes</li> <li>• Cardiovascular Disease</li> </ul> </li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>• Access to Healthcare                             <ul style="list-style-type: none"> <li>• Maternal &amp; Child Health</li> <li>• Financial Security</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Chronic Health Conditions                             <ul style="list-style-type: none"> <li>• Obesity</li> <li>• Diabetes</li> <li>• Cardiovascular Disease</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• Access to Healthcare                             <ul style="list-style-type: none"> <li>• Maternal &amp; Child Health</li> <li>• Financial Security</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Chronic Health Conditions                             <ul style="list-style-type: none"> <li>• Obesity</li> <li>• Diabetes</li> <li>• Cardiovascular Disease</li> </ul> </li> </ul>		
<p><b>Strategies and Programs to Address Needs</b></p> 	<p>The hospital intends to take several actions and to dedicate resources to these needs, including:</p> <ul style="list-style-type: none"> <li>• Access to Care - ACTIVATE, Health Equity Initiative, Lyft Transportation Services, MOMobile, Patient Financial Assistance, Homeless Discharge Initiative, and Community-Based Patient Navigators.</li> <li>• Chronic Disease - ACTIVATE, Diabetes Empowerment Education Program, Healthier Living, Cocinando con Salud en Balance, Community Fitness Classes.</li> </ul>		
<p><b>Anticipated Impact</b></p> 	<p>Dignity Health, St. Joseph’s Westgate Medical Center will launch its three-year Community Health Implementation Strategy to address the identified significant health needs: access to care, cancer, and chronic disease with an overarching health equity lens.</p> <p>Anticipated impact of the hospital’s initiative includes social needs screenings for early identification of patients with limited access to care; an increase in cancer screenings for early detection and health care intervention; improvements in health insurance coverage enrollment; increase in healthcare system and social needs navigation with utilization of Community Health Workers, Patient Navigators and Promotoras; increase in access to quality primary care and establishing “medical homes”; management of chronic conditions; increase disease prevention and health promotion education; reduction in emergency department utilization; reduce hospital readmission rates and length of stay; reduction in mortalities and morbidities and an improvement in overall health and well-being of our communities.</p>		
<p><b>Planned Collaboration</b></p> 	<p>The hospital will partner with local community-based organizations and internal departments to improve access to care, address chronic health conditions: obesity, diabetes, and cardiovascular disease (CVDs), enhance navigation, bridge gaps in care, linking patients to appropriate resources that address their social and health needs.</p> <p>Planned collaborations and partnerships include the Foundation for Senior Living, Chicanos por la Causa / Keogh, MOMobile, Mission of Mercy, Get Well Network, SJHMC</p>		

This document is publicly available online at the hospital's website. Written comments on this report can be submitted to the Community Benefit and Health Equity Department located at 350 W Thomas Road, Phoenix, AZ 85013 or by e-mail to [CommunityHealth-SJHMC@dignityhealth.org](mailto:CommunityHealth-SJHMC@dignityhealth.org).

## Our Hospital and the Community Served

### About the Hospital

St. Joseph's Westgate Medical Center (SJWMC) is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America.

Located in the heart of Glendale, St. Joseph's Westgate Medical Center is a not-for-profit, 23 bed inpatient hospital that opened on May 13, 2014. The medical 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 include 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

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its 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.

### 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

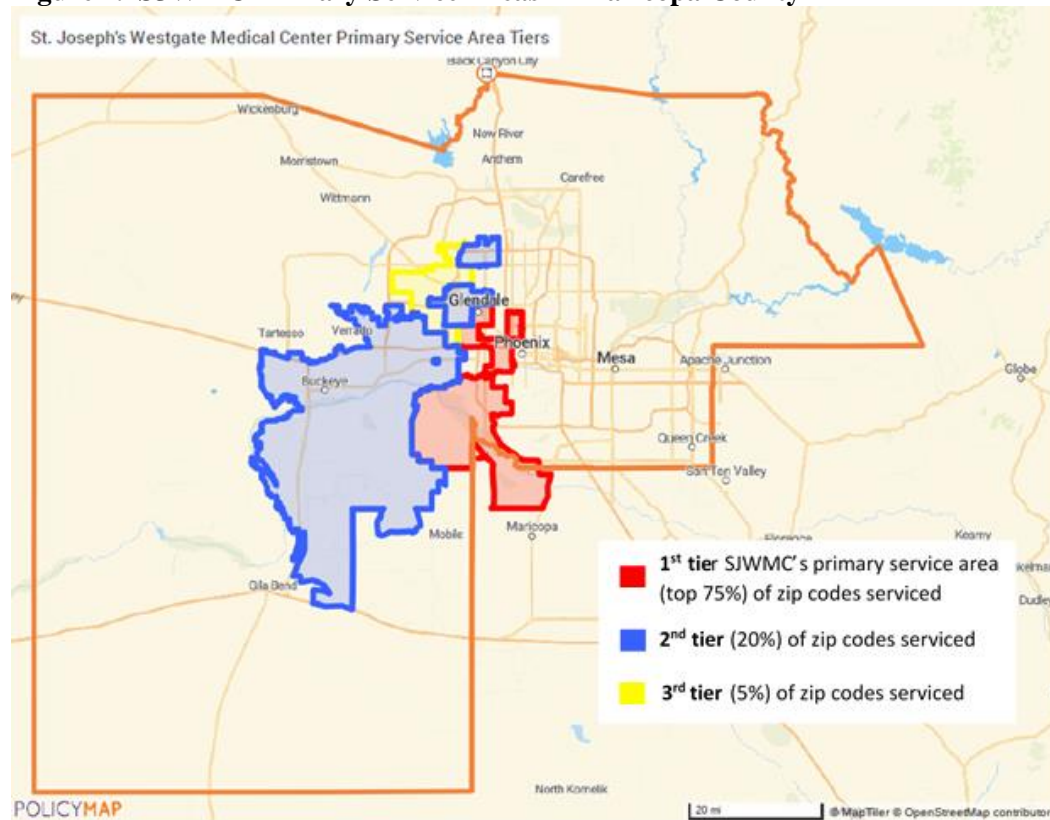
St. Joseph's Westgate Medical Center's community is defined as Maricopa County. The entire County was chosen as the community definition due to the broad range of SJWMC's service area. Figure 1 below displays the primary patient zip codes serviced by SJWMC, which span across Maricopa County. SJWMC's primary service area-specific information will also be provided when available.

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 Appendix D.



SJWMC serves patients across Maricopa County, hence the community definition extends beyond its physical location in the city of Glendale. The city of Glendale is primarily served by SJWMC for acute care and trauma services. Its population in 2019 was 247,813 with a median age of 34.2. The City of Glendale is made up of predominantly Caucasian/White (80.5%), followed by Latino/Hispanic (38.2%), Black/African American (8.5%), Asian (5.2%), American Indian/Alaska Native (2.4%), and Native Hawaiian and Other Pacific Islander (0.4%). In 2019, the median household income in Glendale was \$55,020 with a poverty rate of 18.2%. The educational attainment in Glendale in 2019 were as follows: less than high school graduate (16.6%), high school graduate (39.6%), some college/associate's degree (35.9%), and bachelor's degree or higher (7.9%).

**Figure 1. SJWMC Primary Service Areas in Maricopa County**



## Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy 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 on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

## 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?
<p>Access to Healthcare</p> <ul style="list-style-type: none"> <li>• Maternal &amp; Child Health</li> <li>• Financial Security</li> </ul>	<p><b>Access to healthcare</b> 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 health care services.</p> <ul style="list-style-type: none"> <li>• <b>Maternal Health</b> 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.</li> <li>• <b>Financial Security</b> refers to having the coverage and/or other means necessary for health care expenses.</li> </ul>	✓
<p>Addiction / Substance Abuse</p>	<p><b>Addiction</b> 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.</p> <p><b>Substance Abuse</b> is the repeated harmful use of any substance, including drugs and alcohol, which can lead to addiction.</p>	
<p>Affordable Housing / Homelessness</p>	<p><b>Affordable Housing/Homelessness</b> 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.</p>	
<p>Cancer</p>	<p><b>Cancer</b> 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.</p>	
<p>Chronic Health Conditions</p> <ul style="list-style-type: none"> <li>• Obesity</li> <li>• Diabetes</li> <li>• Cardiovascular Disease (CVD)</li> </ul>	<p><b>Chronic Health Conditions</b> are health conditions or diseases that are persistent or otherwise long-lasting in their effects.</p> <ul style="list-style-type: none"> <li>• <b>Obesity</b> 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.</li> <li>• <b>Diabetes</b> is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). The most common is type 2 diabetes.</li> <li>• <b>Cardiovascular Diseases (CVDs)</b> 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.</li> </ul>	✓
<p>Food Insecurity</p>	<p><b>Food Insecurity</b> refers to the state of being without reliable access to a sufficient quantity of affordable, nutritious food.</p>	

Significant Health Need	Description	Intend to Address?
Mental Health	<b>Mental Health</b> includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act.	
Safety & Violence <ul style="list-style-type: none"> <li>• Unintentional Injuries</li> </ul>	<b>Safety and Violence</b> 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. <ul style="list-style-type: none"> <li>• <b>Unintentional Injuries</b> can be predictable and preventable. Leading causes of nonfatal injury include traffic-related injuries, falls, burns, poisonings, and drownings.</li> </ul>	

**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
- Cancer
- Food Insecurity
- Mental Health
- Safety & Violence

**Using a Health Equity Lens**

At SJWMC, 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.



## 2022 Implementation Strategy

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others on to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

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 Implementation Strategy

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 include the CommonSpirit Health System Office, the SJHMC Community Benefit and Health Equity Department, Executive Leadership Team, Mission Services, the Care Coordination 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 implementation strategy included conducting a Community Health Needs Assessment 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) and the Health Equity Alliance (HEA) and other stakeholders in the development of the annual community benefit plan and triennial implementation strategy.

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 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.

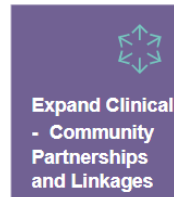
## Community Health Strategic Objectives

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 four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.



Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.



Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.





Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.



Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

## Strategies and Program Activities by Health Need


 <b>Health Need: Access to Healthcare</b>					
<b>Anticipated Impact (Goal)</b>	<p>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.</p>				
<b>Strategy or Program</b>	<b>Summary Description</b>	<b>Strategic Objectives</b>			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Enrollment assistance, outreach activities, health literacy and financial assistance	<ul style="list-style-type: none"> <li>Chicanos Por La Causa/Keogh Health Connection, Foundation for Senior Living, and other community programs assist with insurance, program enrollment, hospital transition services and assistance.</li> <li>Financial Assistance Committee</li> <li>Work with community partners to increase health literacy among community members</li> </ul>	●		●	
Community-based Patient Navigators	<ul style="list-style-type: none"> <li>Community Health Improvement Grants to establish medical homes, home visits, and social needs navigation.</li> <li>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, and other areas as needed).</li> <li>Bridging the gaps and linkage to community resources using internal hospital care navigators and external care navigators and community health workers.</li> </ul>	●	●	●	

 <b>Health Need: Access to Healthcare</b>					
Community Health Workers	<ul style="list-style-type: none"> <li>Build a sustainable Community Health Worker program operated by the SJHMC Community Benefit &amp; Health Equity Department</li> </ul>		•		•
ACTIVATE	<ul style="list-style-type: none"> <li>ACTIVATE - Case management of patients in acute care setting with limited or no insurance</li> <li>Kindness Closet - Provides access to free medical equipment</li> <li>Patients are followed up to 90 days</li> </ul>		•		•
Primary Care / Medical Home Partnerships	<ul style="list-style-type: none"> <li>Mission of Mercy - mobile primary care clinic</li> <li>Mountain Park Health Center - access to affordable ambulatory care</li> <li>Adelante Healthcare - access to affordable ambulatory care</li> <li>CATCH (Internal Medicine Clinic)</li> <li>Homeless patient navigator</li> </ul>		•	•	
<b>Planned Resources</b>	The hospital will provide care navigation, community health educators, community health improvement grants, outreach communications, and program management support for these initiatives.				
<b>Planned Collaborators</b>	The hospital will partner with local community based organizations to deliver this access to care strategy. Current collaborators include Foundation for Senior Living, Chicanos por la Causa, MOMobile, and Mission of Mercy.				
<b>Addressing Health Equity</b>	In 2019, 14.1% of adults under the age of 65 were uninsured; 10.62% of Maricopa County residents were considered uninsured and 10.4% of Arizona residents were uninsured. Health care expenses can be a major burden for vulnerable communities. At SJWMC, we are committed to addressing health inequities through a systems change approach that improves access to affordable quality health care, addresses health inequities, and eliminates health disparities. Improved access to care is met through an enhanced health and social needs screening, implementation of a closed loop referral system, and Community Health Worker Program, promoting health equity for all.				



**Health Need: Chronic Health Conditions**

<p><b>Anticipated Impact (Goal)</b></p>	<p>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.</p>				
<p><b>Strategy or Program</b></p>	<p><b>Summary Description</b></p>	<p><b>Strategic Objectives</b></p>			
		<p>Alignment &amp; Integration</p>	<p>Clinical – Community Linkages</p>	<p>Capacity for Equitable Communities</p>	<p>Innovation &amp; Impact</p>
<p>Chronic Disease Self-Management</p>	<ul style="list-style-type: none"> <li>● <b>DEEP (Diabetes Empowerment Education Program)</b> <ul style="list-style-type: none"> <li>○ Self-management workshops in English and Spanish</li> <li>○ Collaboration with community partners providing education on chronic disease self- management to meet ongoing needs of individuals living with pre-diabetes and diabetes.</li> </ul> </li> <li>● <b>Healthier Living with Chronic Conditions</b> <ul style="list-style-type: none"> <li>○ Free Chronic Disease Education Program</li> <li>○ Strategies and tools are provided to improve health and overall quality of life.</li> <li>○ Offered in English and Spanish</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>●</li> </ul>	<ul style="list-style-type: none"> <li>●</li> </ul>	
<p>Nutrition and Physical Activity Programs</p>	<ul style="list-style-type: none"> <li>● MOMobile education on nutrition for mother, baby and family</li> <li>● Advocate for SNAP benefits, access to healthy foods programs using SNAP benefits</li> <li>● Utilize Community Health Workers/Navigators to bridge access to social services and transportation to food distribution locations</li> <li>● Cocinando con Salud en Balance (Cooking Class)</li> </ul>	<ul style="list-style-type: none"> <li>●</li> </ul>			<ul style="list-style-type: none"> <li>●</li> </ul>

 <b>Health Need: Chronic Health Conditions</b>					
	<ul style="list-style-type: none"> <li>Community Fitness Classes (i.e., Zumba, Yoga, and Tai Chi)</li> </ul>				
Chronic Disease Prevention and Assistance Programs	<ul style="list-style-type: none"> <li>ACTIVATE               <ul style="list-style-type: none"> <li>Care Management following hospital discharge</li> <li>Home visiting program and increased monitoring for 30 days</li> <li>Social needs being met by program</li> <li>Education and prevention activities</li> </ul> </li> </ul>		•		•
<b>Planned Resources</b>	The hospital will facilitate community health educators, free chronic disease management classes, cooking classes, care navigation for SNAP benefits, and access to healthy food programs.				
<b>Planned Collaborators</b>	Collaboration with internal and external partners to address the chronic health conditions: obesity, diabetes, and cardiovascular disease (CVDs) strategy. Planned collaborators include SJWMC Cardiovascular Clinic, Chicanos por la Causa/Keogh, Foundation for Senior Living, and GetWell Network.				
<b>Addressing Health Equity</b>	<p>In 2019, Black/African Americans followed by American Indians had the highest inpatient hospitalization rates. <b>Cardiovascular disease</b> was ranked second for inpatient hospitalization visits, and third for emergency department visits in Maricopa County, with Black/African Americans had the highest rate for emergency department visits.</p> <ul style="list-style-type: none"> <li><b>Gender disparity:</b> males had a higher inpatient stay at 14%, death rate at 5% while females had a higher emergency department visit at 1%.</li> <li><b>Age disparity:</b> patients aged 75 years and older had the highest inpatient stay at 502%, emergency department visits at 322%, and a death rate of 910%.</li> <li><b>Racial disparity:</b> Black/African American patients had the highest inpatient stays at 44% and emergency department visits at 104%, while White/Caucasian patients had the highest death rate at 47%.</li> </ul> <p><b>Diabetes</b> affects an estimated 29.1 million people in the United States and is the 7<sup>th</sup> leading cause of death. In 2019, diabetes was ranked sixth for inpatient hospitalization visits, and seventh for emergency department visits in Maricopa County, with Black/African Americans and American Indians having the highest rates for</p>				



## Health Need: Chronic Health Conditions


emergency department visits.

- **Gender disparity:** males had a higher inpatient stay at 21%, females at 20%, and emergency department visits 1%.
- **Age disparity:** patients aged 75 and older had the highest inpatient stays at 91% and death rate at 508%, while patients aged 55 – 64 had the highest emergency department visits at 104%.
- **Racial disparity:** Black/African American patients had the highest inpatient stays at 107%, emergency department visits at 155%, and death rate at 113%.


**Obesity** is associated with the leading causes of death in the United States and worldwide, including diabetes, heart disease, stroke and some types of cancer. In 2019, 34.4% of Arizona residents were considered overweight (BMI 25.0 – 29.9) and 31.4% were considered obese (BMI 30.0 - 99.8). In Maricopa County, 34% of residents were considered overweight and 30.1% were considered obese in 2019.

At SJWMC, we are committed to addressing health inequities through internal and external partnerships, including local community-based organizations to provide continuity of care for patients living with chronic health conditions. These partnerships help to improve health care delivery, quality of health care, address health inequities, and eliminate health disparities. An enhanced health and social needs screening, implementation of a closed loop referral system, and Community Health Worker Program, significantly enables us to expand our reach to serve and support diverse populations, increase knowledge and education, navigation, disease prevention, improve health outcomes and promote health equity for all.

## Strategies and Programs for Health Equity

 <b>Health Equity</b>					
<b>Anticipated Impact (Goal)</b>	Initiate and support systems change (internally and externally) that proactively promote the elimination of health disparities and the achievement of health equity for all. To develop and implement programs and system change initiatives that address identified significant community health needs, health inequities, proactively promote the elimination of health disparities, and achieve health equity for all.				
<b>Strategy or Program</b>	<b>Summary Description</b>	<b>Strategic Objectives</b>			
		Alignment & Integration	Clinical - Community Linkage	Capacity for Equitable Community	Innovation & Impact
Health Equity Initiative	<ul style="list-style-type: none"> <li>● Hospital Board subcommittee focused on health equity</li> <li>● Health Equity Alliance will provide education and collaboration opportunities to community partners with the shared goal of improving health equity.</li> <li>● Internal review and transition of current demographic/ collection methods</li> <li>● Development of the health equity dashboard to support the tracking and measurement of health equity advancements and improved health outcomes</li> <li>● Internal Implicit bias, Anti-racism, and</li> <li>● cultural competency training</li> <li>● Implementation of a 5 year Health Equity Strategy for St. Joseph's Westgate Medical Center</li> </ul>	●			
CommunityCares (Connected Community Network)	<ul style="list-style-type: none"> <li>● Social needs screening and closed loop referral system for community-based resources</li> </ul>	●	●		●



 <b>Health Equity</b>					
Health Equity Alliance	<ul style="list-style-type: none"> <li>Health Equity Alliance will engage cross sector collaborations to address social determinants of health, reduce health disparities, and improve health equity for all</li> </ul>			•	
Community Health Worker Program	<ul style="list-style-type: none"> <li>Build and strengthen community capacity through development of the Pathways Community Hub model for the Community Health Worker program that includes social needs screening and navigation for 21 social needs pathways.</li> </ul>		•		•
<b>Planned Resources</b>	The hospital will provide the program management support for these initiatives.				
<b>Planned Collaborators</b>	The hospital will partner with local community-based organizations, CommunityCares - Arizona's Connection for Whole Person Care, Pathways Community Hub Institute, and the National Training Institute on Race & Equity / Morehouse College.				

