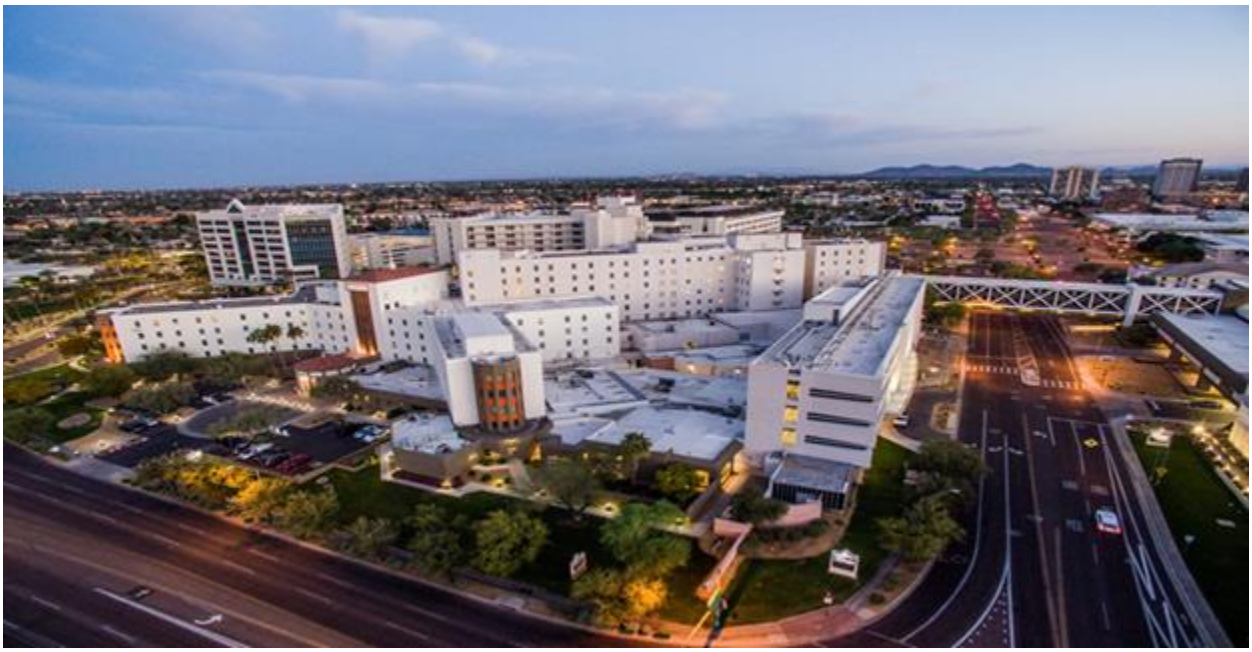
St. Joseph's Hospital and Medical Center
St. Joseph's Westgate Medical Center

Community Benefit 2022 Report and 2023 Plan

Adopted October 2022



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 Maria Spelleri, 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) share a commitment with others to improve the health of our community, and deliver programs and services to help achieve that goal. The Community Benefit 2022 Report and 2023 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 voluntarily 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 2022 (FY22), SJHMC and SJWMC provided $239,025,095 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $99,161,717 in unreimbursed costs of caring for patients covered by Medicare.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2022 Report and 2023 Plan at its October 26, 2022 meeting.

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

Gabrielle Finley-Hazle
President

Maria Spelleri
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	$239,025,095 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $99,161,717 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
	  ○ Maternal and Child Health
	  ○ Financial Security
	• Addiction/Substance Abuse
	• Affordable Housing / Homelessness
	• Cancer
	• Chronic Health Conditions
	  ○ Obesity
	  ○ Diabetes
	  ○ Cardiovascular Disease (CVDs)
	• Food Insecurity
	• Mental Health
	• Safety & Violence
	  ○ Unintentional Injuries

FY22 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. • 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.

FY23 Planned Programs and Services

- Access to Care - ACTIVATE, CATCH, Health Equity Initiative, Keogh Enrollment Specialist, Lyft Transportation Services, MOMobile, Patient Financial Assistance, Homeless Discharge Initiative, and Community-Based Patient Navigators.
- 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, Cocinando con Salud en Balance, Community Fitness Classes, Muhammed Ali Parkinson's Center Programs.

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 email to CommunityHealth-SJHMC@DignityHealth.org.

Our Hospital and the Community Served

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

SJHMC and SJWMC are members of Dignity Health, which is a part of CommonSpirit Health.

Located in the heart of Phoenix and founded in 1895 by the Sisters of Mercy, St. Joseph's Hospital and Medical Center is a 571-bed, not-for-profit hospital that provides a wide range of health, social and support services with special advocacy for the poor and underserved. As of 2020, SJHMC has 5,296 employees, 91 Employed Faculty Physicians, 1,114 Credentialed Community Physicians, 197 residents, and 334 Volunteers. SJHMC is a nationally recognized center for quality tertiary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Heart & Lung Institute®, Dignity Health Cancer Institute at St. Joseph's Hospital and Medical Center, and a Level 1 Trauma Center verified by the American College of Surgeons.

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

Our Mission

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

Our Vision

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

Financial Assistance for Medically Necessary Care

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

Description of the Community Served

The SJHMC and SJWMC community is defined as Maricopa County. The entire county was chosen as the community definition due to the broad range of SJHMC's and SJWMC's service areas. A summary description of the community is provided below. Additional details can be found in the CHNA report online.

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

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

Demographic information for the SJHMC primary service area.

Total Population	1,675,840
Race	
Asian/Pacific Islander	3.4%
Black/African American - Non-Hispanic	8.9%
Hispanic or Latino	51.4%
White Non-Hispanic	30.7%
All Others	5.7%
Total Hispanic & Race	
% Below Poverty	14.2%
Unemployment	5.3%
No High School Diploma	21.2%
Medicaid	27.0%

Uninsured	11.1%
Source: Claritas Pop-Facts® 2022; *SG2 Market Demographic Module*	

Demographic information for the SJWMC primary service area.

Total Population	1,182,960
Race	
Asian/Pacific Islander	3.5%
Black/African American - Non-Hispanic	7.9%
Hispanic or Latino	47.4%
White Non-Hispanic	35.8%
All Others	5.4%
Total Hispanic & Race	
% Below Poverty	11.2%
Unemployment	5.3%
No High School Diploma	18.2%
Medicaid	26.3%
Uninsured	10.9%
Source: Claritas Pop-Facts® 2022; *SG2 Market Demographic Module*	

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit report and plan and programs were identified in the most recent CHNA report, which was adopted in April 2022.

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous CHNA report.

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/content/dam/dignity-health/pdfs/chna/2022-chna/chna-sjhmc-22.pdf or upon request at the hospital's Community Health office.

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Access to Healthcare ● Maternal & Child Health ● Financial Security	**Access to healthcare** is defined as the timely use of health services to achieve the best possible health outcomes. Many people face barriers that prevent or limit access to needed health care services. ● **Maternal Health** refers to the health of women during pregnancy, childbirth, and postnatal period. There are opportunities at each stage that provide support ensuring women and their babies reach their full potential for health and well-being. ● **Financial Security** refers to having the coverage and/or other means necessary for health care expenses.	✓
Addiction / Substance Abuse	**Addiction** is a chronic disorder characterized by compulsive drug use despite adverse consequences. If left untreated, it can cause serious harmful effects and may lead to death. **Substance Abuse** is the repeated harmful use of any substance, including drugs and alcohol, which can lead to addiction.	
Affordable Housing / Homelessness	**Affordable Housing/Homelessness** is often identified as an important social determinant of health due to the range of ways in which a lack of housing, or poor quality housing, can negatively affect health and wellbeing.	
Cancer	**Cancer** is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.	✓

Chronic Health Conditions ● Obesity ● Diabetes ● Cardiovascular Disease (CVD)	**Chronic Health Conditions** are health conditions or diseases that are persistent or otherwise long-lasting in their effects. ● **Obesity** is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. Behaviors can include physical activity, inactivity, dietary, dietary patterns, medication use, and other exposures. ● **Diabetes** is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). The most common is type 2 diabetes. ● **Cardiovascular Diseases (CVDs)** are a class of diseases that affect the heart or blood vessels. The most important behavioral risk factors of heart disease and stroke are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.	✓
Food Insecurity	**Food Insecurity** refers to the state of being without reliable access to a sufficient quantity of affordable, nutritious food.	
Mental Health	**Mental Health** includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act.	
Safety & Violence ● Unintentional Injuries	**Safety and Violence** are a significant cause of death and burden of disease, and some people are more vulnerable than others depending on the conditions in which they are born, grow, work, live and age. ● **Unintentional Injuries** can be predictable and preventable. Leading causes of nonfatal injury include traffic-related injuries, falls, burns, poisonings, and drownings.	

Significant Needs the Hospital Does Not Intend to Address

The hospital has chosen not to address the following significant health needs due to limited capacity of hospital staff, limited capacity of available hospital services, and limited resources. While the hospital will not *directly* address the needs listed below, it will indirectly support work being done in the community to address these needs through strategic grant making and investments. The hospital will also secure and maintain key partnerships with community-based organizations that are addressing the needs listed below.

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

Using a Health Equity Lens

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

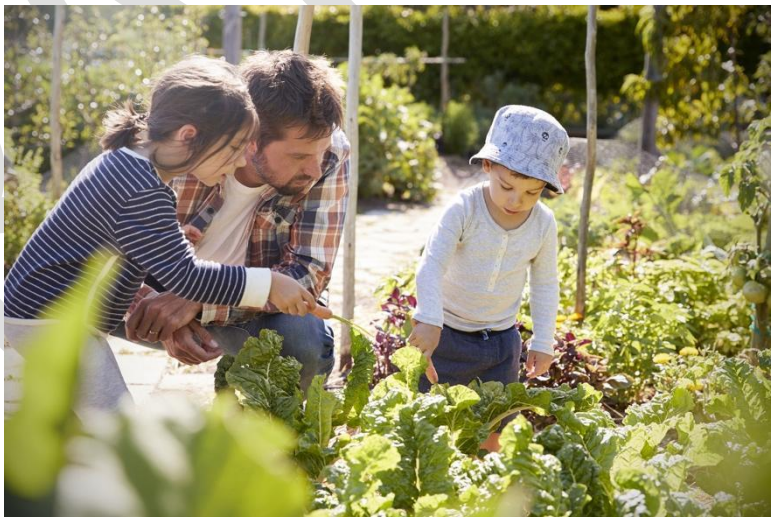
Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially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

2022 Report and 2023 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 FY22 and planned activities for FY23, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

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

Creating the Community Benefit Plan



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

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

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

The programs and initiatives described here were selected on the basis of priority as they relate to one or more of the following principles: focus on disproportionate unmet health-related needs; emphasize prevention including activities that address the social determinants of health; build community capacity; demonstrate collaboration; and contribute to a seamless continuum of care. The programs and strategies identified that address significant needs are achievable through the hospital's capacity to meet the need, available resources, existing hospital services, and collaborative partnerships.

Community Health 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.

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: Cancer

Strategy or Program	Summary Description	Active FY22	Planned FY23
Cancer Support Navigation & Screening	Collaboration with Cancer Support Community of Arizona and the American Cancer Society to provide onsite community education and navigation for cancer patients and their caregivers Cancer support navigators are bilingual and meet the cultural and linguistic needs of patients and community members	•	•
Lifestyle Management	Lifestyle management workshops, support groups, transportation support and other classes that support physical, mental, and spiritual wellbeing.		•
Medication Assistance	Cancer center will assist in completing applications for cancer medications for uninsured and underinsured.	•	•

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

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

Addressing Health Equity: At SJHMC, 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 cancer. These partnerships help to improve health care delivery, quality of healthcare, 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.

Health Need: Chronic Health Conditions

Strategy or Program	Summary Description	Active FY22	Planned FY23
Chronic Disease Self-Management	**DEEP (Diabetes Empowerment Education Program)** • Self-management workshops in English and Spanish • Collaboration with community partners providing education on chronic disease self-management to meet ongoing needs of individuals living with pre-diabetes and diabetes. **Healthier Living with Chronic Conditions** • Free Chronic Disease Education Program • Strategies and tools are provided to improve health and overall quality of life. • Offered in English and Spanish	•	•
Nutrition and Physical Activity Programs	• MOMobile education on nutrition for mother, baby and family • Advocate for SNAP benefits, access to healthy foods programs using SNAP benefits • Utilize Community Health Workers/Navigators to bridge access to social services and transportation to food distribution locations • Cocinando con Salud en Balance (Cooking Class) • Community Fitness Classes (i.e., Zumba, Yoga, and Tai Chi)	•	•
Chronic Disease Prevention and Assistance Programs	ACTIVATE • Care Management following hospital discharge • Home visiting program and increased monitoring for 30 days • Social needs being met by program • Education and prevention activities	•	•

Cardiovascular Patient Navigation	• Social determinants of health screening • Patient navigation		•

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

Collaborators: Collaboration with internal and external partners to address the chronic health conditions: obesity, diabetes, and **cardiovascular disease (CVDs)** strategy. Planned collaborators include SJHMC Cardiovascular Clinic, Chicanos por la Causa/Keogh, Foundation for Senior Living, and GetWell Network.

Addressing Health Equity: At SJHMC, 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 healthcare, 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.

Health Need: Access to Care

Strategy or Program	Summary Description	Active FY22	Planned FY23
Enrollment assistance, outreach activities, and financial assistance	• Chicanos Por La Causa/Keogh Health Connection, Foundation for Senior Living, Circle the City along with other community programs assist with insurance, program enrollment, hospital transition services and assistance. • Financial Assistance Committee	•	•
Community-based Patient Navigators	• Community Health Improvement Grants to establish medical homes, home visits, and social needs navigation. • Integration of care navigators within health care facilities to meet the needs of diverse patient populations (i.e., homeless, refugees, asylum	•	•

	seekers, aging, chronically ill, fragile infants and other areas as needed). • Bridging the gaps and linkage to community resources using internal hospital care navigators and external care navigators and community health workers.		
Community Health Workers	• Muhammed Ali Parkinson's Center Promotoras/Community Health Workers • Build a sustainable Community Health Worker program at St. Joseph's Hospital and Medical Center operated by the Community Benefit & Health Equity Department		•
Maternal and Fetal Health	• MOMobile (Maternal Outreach Mobile Unit) provide prenatal and postpartum care for low-income, uninsured pregnant women • Mobile clinic travels weekly to four different locations within Maricopa County • Nurse Family Partnership and home visiting programs for high risk families.	•	•
Get Well Network - Docent Navigators	• Virtual navigators who conduct social needs screening to address social determinants of health.		•
ACTIVATE & CATCH	• ACTIVATE - Case management of patients in acute care setting with limited or no insurance • CATCH - Case management of patients in ambulatory care setting with limited or no insurance • Kindness Closet - Provides access to free medical equipment • Patients are followed up to 90 days	•	•
Primary Care / Medical Home Partnerships	• Mission of Mercy - mobile primary care clinic • Mountain Park Health Center - access to affordable ambulatory care • Adelante Healthcare - access to affordable ambulatory care • CATCH (Internal Medicine Clinic) • Homeless patient navigator	•	•
Goal and Impact: The hospital's initiatives to address access to care are anticipated to result in: early identification and treatment of health issues; gains in public or private health care coverage; increased			

knowledge about how to access and navigate the healthcare system; and increase primary care "medical homes"; improve access to care and promote health equity for all across all prioritized significant health needs.
Collaborators: The hospital will partner with local community based organizations to deliver this access to care strategy. Current collaborators include Foundation for Senior Living, Chicanos por la Causa, MOMobile, Mission of Mercy, and Get Well Network.
Addressing Health Equity: At SJHMC, 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.

Community Health Improvement Grants Program

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

In FY22, the hospital awarded the grants below totaling $608,416. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Hushabye Nursery	Resilient Families, Thriving Communities	$89,035
BLOOM365	Y-VIPP: Youth Violence Intervention and Prevention Project	$90,000
Mission of Mercy	Improving the Health of Uninsured Patients with Diabetes	$80,000
Valley of the Sun YMCA	¡Viva! A Family Centered Obesity and Diabetes Prevention Program	$90,000
Cancer Support Community Arizona	Addressing the Impact of the Pandemic on Cancer Care & Screening	$99,381
Chicano's Por La Causa, Inc.	Sembrando Semillas/ Sowing Seeds	$80,000
Elaine	Overcoming Social Determinants of Health by Connecting Vulnerable Arizonans to Resources	$80,000

Program Highlights

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

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: ● Student Athletes ● The community ● The caregivers ● Health care providers Tools: ● Barrow Brainbook- An online course given to student-athletes prior to participation in interscholastic athletics ● Health profession presentations ● General public presentations BCN provides baseline and post-injury neurocognitive testing and concussion second opinions to our secondary school athletic trainers, especially in rural areas where they would not normally have access to adequate neurologists.
Population Served	Interscholastic athletes, their caregivers, secondary school athletic trainers, and the general public.
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.
FY 2022 Report	
Activities Summary	● Barrow Brainbook ● ImPACT Neurocognitive Testing ● Prevention Education ● Mobile Baseline Testing ● Concussion Second Opinions ● Professional Education through the annual August BCN event and May BCN event.
Performance / Impact	● Nearly 76,000 users of Barrow Brainbook ● Over 32,000 ImPACT administered

	• 26 concussion second opinions provided • Over 150 attendees to the BCN Professional Education events • Nearly 5,000 encounters for our activities
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 2023 Plan	
Program Goal / Anticipated Impact	• To provide concussion education to all Arizona secondary school athletes, promote Barrow Brainbook nationally. • To increase awareness and usage of our Barrow Spanish Brainbook • To continue to support Arizona secondary school athletic trainers through ImPACT concussion baseline testing and the concussion second opinion telemedicine • To spread awareness of the risk,
Planned Activities	In addition to last year, we are adding a presence at Super Bowl LVII.

Cancer Resource Navigator

Significant Health Needs Addressed	☑Access to Care ☑Mental/Behavioral Health ☑Chronic Diseases ☑Cancer ☐Safety & Violence ☐Homelessness & Housing Insecurity
Program Description	Cancer Resource Navigators (CRNs) provides evidence-based patient navigation, mental health, education, resources, and emotional support through Cancer Support Community Arizona (CSCAZ) psychosocial programs and triage to other community-based resources. The hospital connects the in- hospital navigator to clients who may benefit from the Program during clients' care in the hospital. It is through the hospital connection that CSCAZ CRNs support hospital patients by addressing social determinants of health, increasing access to care, combating well-documented cancer disparities, and improving the overall well-being of Phoenix-area cancer patients and their families.
Population Served	Cancer Resource Navigators serve vulnerable, Phoenix metropolitan area residents of any age impacted by cancer of any type and any stage. In 2021 and 2022, over 80% of those CSCAZ served were women and the elderly from underserved and minority populations.
Program Goal / Anticipated Impact	The goal of this program is to connect cancer patients of SJHMC with needed health and psychosocial services both in the hospital setting and

	outside the hospital post-discharge as well as for family members to improve their health outcomes and their confidence navigating multiple resources. Goal #1: The Cancer Support Community Arizona Navigator will serve an average of 15 unduplicated clients per month in FY2022. Goal #2: The Cancer Support Community Arizona Navigator will complete an average of 65 client encounters per month in FY2022.
FY 2022 Report	
Activities Summary	Cancer Resource Navigators collaborate with medical teams, screen for health insurance eligibility, and assist with enrollment, advocate for patients, facilitate distress screenings and provide individual follow-up to ensure mental and physical health needs are met. Navigators address social determinants of health and provide a warm hand-off to partnering service providers for needs outside of CSCAZ's scope. CRNs connect cancer patients and their families to no-cost, bilingual mental health and psychosocial support are provided to hospitalized and home-based cancer patients. This includes free, professional, one-on-one counseling as well as support groups, cancer education, nutrition/cooking workshops, mind/body wellness classes, and therapeutic arts. Programming is offered in-person as well as virtually to reduce barriers to participation.
Performance / Impact	**Goal #1: The Cancer Support Community Arizona Navigator will serve 15 unduplicated clients per month to total 180 in FY2022.** ● CSCAZ CRNs surpassed goal serving 291 unduplicated patients ● 870 hours invested at the hospital serving patients **Goal #2: The Cancer Support Community Arizona Navigator will complete 65 client encounters per month to total 780 in FY2022.** ● CSCAZ CRN exceeded goal and had 894 client/patient encounters Additional Impact: ● 291 patients and their families connected with CSCAZ support services and offered a distress screening tool. ● 380 resources provided at the point of care ● 91 resources provided post-discharge through follow up contact. ● 270 patients referred to external organizations and resources and 130 caregiver/families for a total of 300 people referred to other organizations.
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 2023 Plan	
Program Goal / Anticipated Impact	Goal# 1: Cancer Resource Navigators will serve a total of 350 low-income cancer patients as well as 100 of their family members/caregivers

	Goal # 2: Cancer Resource Navigator will increase the number of completed connections from 8 to 10 each month
Planned Activities	No planned changes in 2023

CATCH

Significant Health Needs Addressed	☑Access to Care ☐Mental/Behavioral Health ☑Chronic Diseases ☐Cancer ☐Safety & Violence ☑Homelessness & Housing Insecurity
Program Description	The CATCH Program is a social work program that collaborates with the Internal Medicine Clinic to provide on-going support and services to meet patients' health care needs. With a focus on social determinants of health, the CATCH program provides access to community support and resource utilization. The hospital and clinic's role is to refer patients to the CATCH program that would benefit from having a patient care advocate to assist with needs that otherwise present barriers to patients' ability to successfully access and receive treatment. The goal is to work in partnership to provide a holistic approach to the patient's care plan.
Population Served	The program serves an at-risk patient population that otherwise may be susceptible to hospitalization (acute level of care). The CATCH Program serves patients that are seen in the Internal Medicine Clinic with a wide range of socio-economic factors impacting their access and treatment of their health-related needs.
Program Goal / Anticipated Impact	The focus of the program is to ensure the patients receive treatment for their healthcare needs at a preventative level. The overall goal is to help patients to maintain or stabilize through the clinic's resources with the underlying objective being to reduce the risk of the patient needing to be hospitalized.
FY 2022 Report	
Activities Summary	Services provided include home visits with a Resident Doctor, telephone calls, medication assistance, resource identification and referrals, and coordination with clients' primary care physician.
Performance / Impact	187 patient lives were impacted through the support of the CATCH Program in FY22.

Hospital's Contribution / Program Expense	The program is grant funded. Approximately $64,000 supports the outcomes outlined FY23 program deliverables.
FY 2023 Plan	
Program Goal / Anticipated Impact	The CATCH Program is forecasted to serve 180 patients annually in FY23 needing assistance navigating the healthcare system as well as wrap around services and resources impacting their daily living needs

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.
Population Served	Low income, racial and ethnic minority populations.
Program Goal / Anticipated Impact	Expand the infrastructure to continue improving diabetes self-management and prevention by maintaining DEEP as a virtual and in-person educational program. 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 10 virtual and in-person workshops to effectively reduce the burden of diabetes on the community with a focus on reaching more diabetes at-risk ethnic groups including African American and Hispanic communities and increase education on prevention of chronic diseases.
FY 2022 Report	
Activities Summary	Hosted 2 virtual and 2 in-person English and Spanish workshops throughout the year, complemented with the implementation of a Healthier Living cooking series. Through the six week workshops, we had 51 DEEP completers.

Performance / Impact	6-week DEEP workshops resulted in improvements in outcomes among diabetic participants; participants demonstrated an increase of knowledge about diabetes prevention and control, dietary habits, blood glucose and blood glucose monitoring and control. An average of a 2 pounds weight loss throughout the six week workshop period occurred amongst participants.
Hospital's Contribution / Program Expense	Coordination, marketing and recruitment time, along with program supplies and materials provided by the Community Benefit and Health Equity Department
FY 2023 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 and in-person workshops to effectively reduce the burden of diabetes on the community with a focus on reaching more diabetes at-risk ethnic groups including African American and Hispanic communities.
Planned Activities	Host 10 virtual English/Spanish DEEP workshops throughout the year. Through these workshops, we will have 120 DEEP completers by the end of FY23

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 continuous prenatal and postpartum care for low-income, uninsured pregnant women in Maricopa County who would otherwise not be able to obtain prenatal care. The MOMobile has been serving our community since 1996.
Population Served	Uninsured, low-income pregnant women residing in Maricopa County and surrounding areas who would otherwise not be able to obtain prenatal care.
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.
FY 2022 Report	

Activities Summary	The MOMobile traveled to 4 different locations weekly within Maricopa County through community collaborations/partnerships. Our partnerships included: First Southern Baptist Church (Glendale), CARE Catholic Charity (Mesa), St John Vianney Church (Avondale), and Wesley Golden Gate Community Center (W. Phoenix). As well as First Teeth First of Maricopa County who provided oral exams for our patients and their children, education on mom's oral hygiene and babies/children, and oral hygiene supplies to these women and their families. We continued to see higher risk patients due to socioeconomic factors, underlying health issues in these patients, and limited access to medical care for these health issues (such as diabetes, hypertension).
Performance / Impact	During the time period 7/1/21-6/30/22, MOMobile had a total of 1257 in person patient visits to the MOMobile, and 100 healthy babies were delivered at St Joseph's Hospital. This is a slight increase from the previous year. The average birth weight of a MOMobile baby remains at a healthy weight of 7lb 4oz. And the average number of prenatal visits for each mom also remains at 10, slightly above the state's average of 8.
Hospital's Contribution / Program Expense	Supported by SJHMC, and the OB/GYN Department of DHMG, funded through SJH Foundation which covers all operating costs, including staffing. Office space for the staff is provided in the DHMG OB/Gyn office as well as supplies for the mobile clinic, parking for the MOMobile truck and trailer in a secured area is provided by SJHMC. The assistance for patients includes physicians for their delivery, ultrasounds, co-management of higher risk patients with maternal fetal medicine, pediatric cardiology and other specialists if indicated.
FY 2023 Plan	
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.
Planned Activities	Continue to provide prenatal and postpartum care for low -income, uninsured pregnant women in Maricopa County who would otherwise not be able to obtain prenatal care. Continue community collaborations to provide these services in areas where zip codes are indicating increased rates of premature birth, low birth weights, and higher infant mortality.

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 CommonSpirit 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. In 2021, the board approved a $2.525 million extension..	$ 2,525,000
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. The loan was extended for 7 years in 2022.	$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. This loan was paid in full in December 2021.	$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. This loan was paid in full in August 2021.	$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. The Stepping Stone Phase III loan for $1,000,000 was paid in full in November 2021.	$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 through 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 pre-development and construction expenses for a 40-lot affordable housing complex in Phoenix, Arizona.	$4,000,000

Economic Value of Community Benefit

9/29/2022					
500 St. Joseph's Hospital and Medical Center					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2021 through 6/30/2022					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits For Poor					
Financial Assistance	**17,078**	**36,832,439**	**0**	**36,832,439**	**2.5%**
Medicaid	**200,771**	**408,221,113**	**263,603,472**	**144,617,641**	**9.7%**
Community Services					
A - Community Health Improvement Services	4,163	1,852,686	340,363	1,512,323	0.1%
C - Subsidized Health Services	6,864	2,730,294	150,000	2,580,294	0.2%
E - Cash and In-Kind Contributions	17,035	957,951	21,760	936,191	0.1%
F - Community Building Activities	1,086	8,487	0	8,487	0.0%
G - Community Benefit Operations	1,603	1,338,205	0	1,338,205	0.1%
Totals for Community Services	**30,751**	**6,887,623**	**512,123**	**6,375,500**	**0.4%**
Totals for Poor	**248,600**	**451,941,175**	**264,115,595**	**187,825,580**	**12.7%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	120,388	115,698	17,226	98,472	0.0%
B - Health Professions Education	3,079	59,438,395	9,906,787	49,531,608	3.3%
D - Research	0	45,588,500	44,026,865	1,561,635	0.1%
F - Community Building Activities	24	7,800	0	7,800	0.0%
Totals for Community Services	**123,491**	**105,150,393**	**53,950,878**	**51,199,515**	**3.4%**
Totals for Broader Community	**123,491**	**105,150,393**	**53,950,878**	**51,199,515**	**3.4%**
Totals - Community Benefit	**372,091**	**557,091,568**	**318,066,473**	**239,025,095**	**16.1%**
Medicare	**98,443**	**254,561,677**	**155,399,960**	**99,161,717**	**6.7%**
Totals with Medicare	**470,534**	**811,653,245**	**473,466,433**	**338,186,812**	**22.8%**

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

2022 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 *(FY 22 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 *(FY22 Board Secretary) (FY23 Board Chair)* Executive V.P. & General Counsel, Chicanos Por La Causa, Inc.

2022 Community Benefit and Health Equity Committee

Agboola, Liz *(FY23 Co-Chair)* CEO of Moses Behavioral Care
Cardenas, Liliana Manager, Office of Community Empowerment, Maricopa County Department of Public Health
Crittenden, Sonora Director, Community Benefit and Health Equity Dignity Health, St. Joseph's Hospital and Medical Center
Daymude, Annie Community Impact Analyst, Maricopa County Department of Public Health
De Melo, Desiree Manager, Community Impact and Health Equity Dignity Health, St. Joseph's Hospital and Medical Center
Dhillon-Williams, Ruby Assistant Deputy Director of Housing and Development, Arizona Department of Housing
Gonzalez, Sarah *(FY23 Chair)* President of Gonzales Consulting, LLC
Graham, Julie Director, External Affairs, Dignity Health Arizona
Heredia, Carmen Chief Executive Officer, Valle del Sol (non-profit organization)
Hillman, Debbie Chief Administrative Officer, Mercy Care
Hoffman, Terri President and Chief Philanthropy Office, Dignity Health, St. Joseph's Hospital and Medical Center Foundation
Horn, Richard Retired Business Executive, Current Board Member, and Consultant
Jewett, Matt Director of Grants, Mountain Park Health Center
Jones, Ashley Program Manager, Community Benefit and Partnerships Dignity Health, St. Joseph's Hospital and Medical Center
Mascaro, CarrieLynn Vice President of Program Operations, Catholic Charities (non-profit organization)

McBride, Sr. Margaret Vice President of Mission Integration Dignity Health, St. Joseph's Hospital and Medical Center
Orsini, Craig Manager of Care Coordination Dignity Health, St. Joseph's Hospital and Medical Center
Riley, Julie Chief Administrative Officer and VP of Service Lines Dignity Health, St. Joseph's Hospital and Medical Center
Smith, Carrie Chief Operating Officer, Foundation for Senior Living (non-profit organization)
Spelleri, Maria *(FY22 Chair)* Executive Vice President & General Counsel, Chicanos Por La Causa/Keogh (non-profit organization)
Torrealva, Josy Lead Community Health Worker Dignity Health, St. Joseph's Hospital and Medical Center
Unrein, Serena Director, Arizona Partnership for Healthy Communities
VanMaanen, Pat Health Consultant, PV Health Solutions