Dignity Health.
St. Joseph's Westgate
Medical Center

St. Joseph's Westgate Medical Center

Community Health Implementation Strategy 2019– 2021

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At-a-Glance Summary

Community Served	Maricopa County and the defined service area are considered the community for St. Joseph's Hospital and Medical Center (SJHMC) and St. Joseph's Westgate Medical Center (SJWMC). Community is further defined through geographic primary and secondary borders as well as the demographic data from those patients who enter our doors. St. Joseph's Hospital draws approximately 85.7 % of its patients from Maricopa County, 10.75% from outside Maricopa County but within Arizona, and 3.52% from outside the state. Sixty-one percent of the population of the state of Arizona resides within Maricopa County. The primary service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. The primary service area for SJHMC includes the high-risk zip codes making up the top 75% of the total patient cases.
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). Those needs are: • Access to Care • Mental/Behavioral Health/Substance Abuse • Overweight/Obesity – Diet Related Illnesses • Cancer • Trauma/Injury Prevention • Social Determinants of Health
Planned Actions for 2019-2021	Dignity Health St. Joseph's Hospital and Medical Center and St. Joseph's Westgate and will launch its three-year Community Health Implementation Strategy entitled "Live Healthy and Well" (LiveHW). The LiveHW Initiative will provide the platform for the seven dimensions of wellness to be integrated throughout the health and community systems. These dimensions include social, emotional, spiritual, environmental, occupational, intellectual and physical wellness. Each of these seven dimensions act and interact in a way that contributes to our own quality of life. The increased recognition of the social needs of the community and how they intersect with the health needs will be a key focal point of the three-year initiative along with a focus on health equity for those individuals who are marginalized by race, culture, gender, age, and other social and physical barriers.

This document is publicly available at:
https://www.dignityhealth.org/arizona/locations/westgate/about-us/community-benefit This information is shared broadly with the community through e-mail distribution program. The information is shared on Facebook, Twitter, Linked In, e-mail list serves, community meetings and presentation. Written comments on this report can be submitted to the St. Joseph's Westgate

Medical Center (SJWMC) and St. Joseph's Westgate Community Health Office at 350 West Thomas Road, Phoenix, Arizona 85013 or by e-mail at CommunityHealth-SJWMC@DignityHealth.org.

MISSION, VISION AND VALUES

St. Joseph's Westgate Medical Center is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

Dignity - Respecting the inherent value and worth of each person.

Collaboration - Working together with people who support common values and vision to achieve shared goals.

Justice - Advocating for social change and acting in ways that promote respect for all persons.

Stewardship - Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence - Exceeding expectations through teamwork and innovation.

OUR HOSPITAL AND THE COMMUNITY SERVED

About St. Joseph's Westgate Medical Center

Located in the heart of Phoenix, founded in 1895 by the Sisters of Mercy, Dignity Health St. Joseph's Westgate Medical Center is a 586-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 2017, SJWMC has 4,565 staff, 200 Research Employees, 183 Employed Faculty Physicians, 1,109 Credentialed Community Physicians, 260 Residents in 20 specialties, and 813 Volunteers. SJWMC 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®, University of Arizona Cancer Center at St. Joseph's, and a Level 1 Trauma Center verified by the American College of Surgeons.

Description of the Community Served

St. Joseph's Westgate Medical Center (SJWMC) serves the geographic area for the hospital is Maricopa County, the common community for all partners participating in the Synapse collaborative. Maricopa County is the fourth most populous county in the United States. With an estimated population of 4 million and growing, Maricopa County is 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. 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[i].

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 SJWMC. 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, SJWMC draws populations from Maricopa County, outside Maricopa County but within Arizona, and from outside the state. SJWMC'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.[ii]

A summary description of the community is below, and additional details can be found in the CHNA report online.

Primary Care Area (PCA) Statistical Profiles are revised annually and provide detailed information on the demographics, health resources, hospital utilization, and health status indicators in defined geographic areas throughout Arizona. According to the Arizona Department of Health Services (ADHS), the Avondale, Buckeye, Camelback East, Central City Village, Chandler Central, Estrella Village, Glendale Central and North, Laveen, Maryvale Village, Peoria North, Surprise and Tempe North PCAs have been federally designated as a Medically Underserved Areas[iii]. More than half of the population of SJWMC's primary service area is adults between 20-64 years of age. Nearly 17.2% of residents do not have a high school diploma, and approximately 16.3% are without health insurance. These data show that the population as a whole is majority White, and with a median income below Maricopa County and the state of Arizona. Table 1 provides the specific age, sex, and race/ethnicity distribution and data on key socio-economic drivers of health status of the population in SJWMC's primary service area compared to Maricopa County and the state of Arizona.

Table 1. Demographic information for the St. Joseph Westgate Medical Center primary service area.

	SJWMC PSA	**Maricopa County**	**Arizona**
Population: estimated 2015	807,915	4,088,549	6,728,577
Gender			
• **Male**	49.0%	49.5%	49.7%
• **Female**	51.0%	50.5%	50.3%
Age			
• **0 to 9 years**	16.3%	13.8%	13.3%
• **10 to 19 years**	15.9%	13.8%	13.6%
• **20 to 34 years**	21.6%	21.2%	20.5%
• **35 to 64 years**	35.0%	37.3%	36.7%
• **65 to 84 years**	9.8%	8.0%	9.2%
• **85 years and over**	1.3%	5.9%	6.7%
Race			
• **White**	39.9%	56.9%	77.8%
• **Asian/Pacific Islander**	2.8%	4.0%	3.2%
• **Black or African American**	7.4%	5.0%	4.3%
• **American Indian/Alaska Native**	1.4%	1.5%	4.4%
• **Other**	2.3%	2.3%	7.0%
Ethnicity			
• **Hispanic**	46.3%	30.3%	30.5%
Median Income	$50,431	$53,694	$51,340
Uninsured	16.5%	13.9%	13.6%
Unemployment	4.8%	4.4%	5.4%
No HS Diploma	19.6%	14.0%	13.8%
***% of Population 5+ non-English speaking**	12.4%	9.3%	9.1%

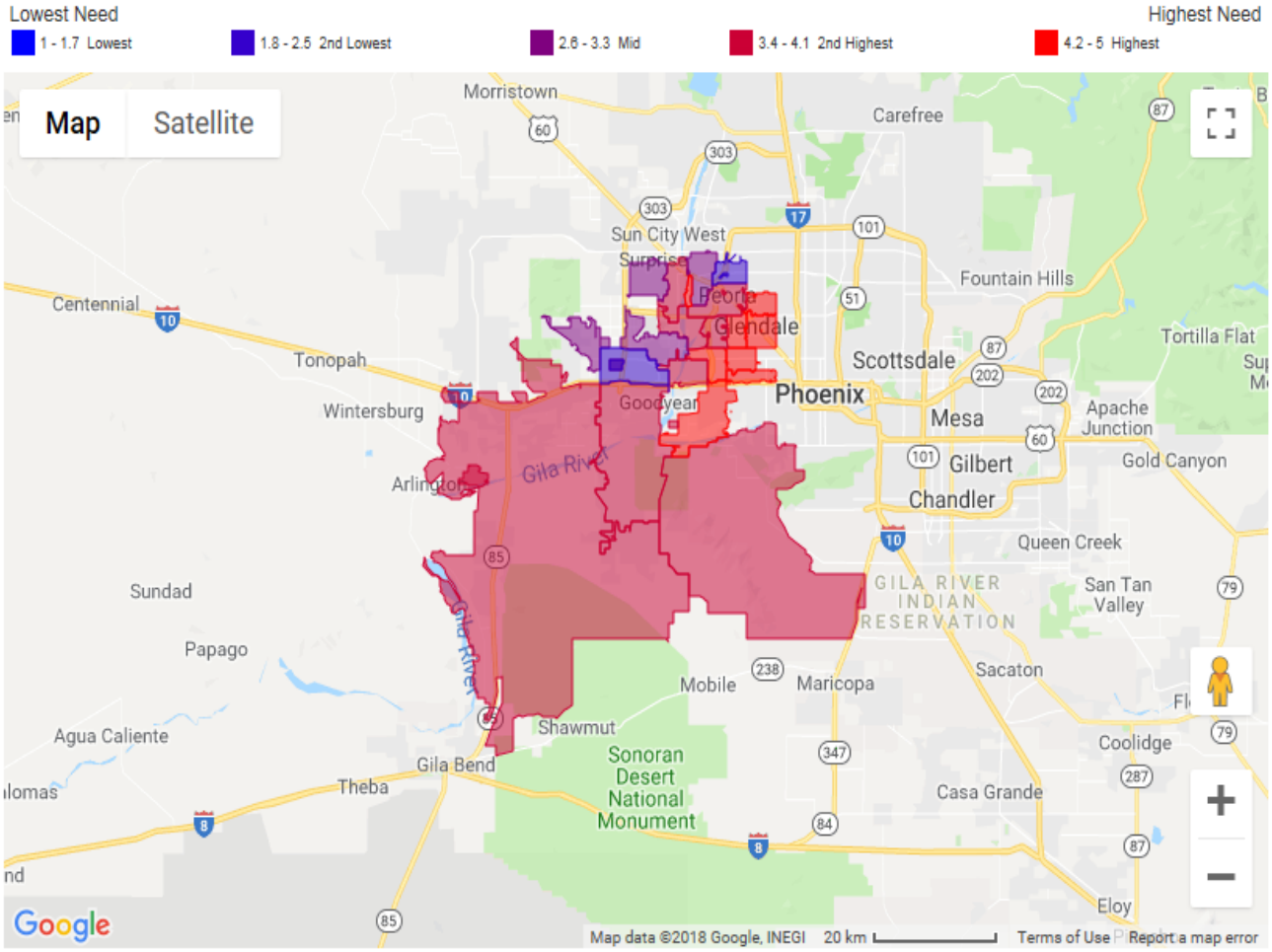
***Renters**	40.1%	39.6%	37.5%
CNI Median Score	3.6	39.6%	37.5%
Medically Underserved Area	Yes	-	-

*Source: U.S. Census American Community Survey, 5 year estimates 2013-2017

One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. 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.

Dignity Health has developed the nation's first standardized Community Need Index (CNI) in partnership with Truven Health Analytics. The CNI identifies the severity of health disparity for every zip code in the United States based on specific barriers to healthcare access. The CNI considers multiple factors that are known to limit health care access such as income, language, educational, insurance and housing barriers. The ability to pinpoint neighborhoods with significant barriers to health care access is an important new advancement for public health advocates and care providers. According to the CNI illustrated below, the primary service area has a mean CNI score of 4 and includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risks include 85003, 85004, 85006, 85007, 85007, 85009, 85014, 85015, 85017, 85019, 85021, 85023, 85029, 85031, 85033, 85035, 85037, 85040, 85041, 85042, 85043, 85051, 85122, 85201, 85204, 85210, 85281, 85301, 85302, 85303, 85323, 85353, and 85364[iv].

Primary Service Map – Community Needs Index



Mean(zipcode): 3.7 / Mean(person): 3.8 CNI Score Median: 3.6 CNI Score Mode: 3.4,3.6,4.2

Zip Code	CNI Score	Population	City	County	State
85033	5	56391	Phoenix	Maricopa	Arizona
85035	5	49036	Phoenix	Maricopa	Arizona
85037	4.2	49579	Phoenix	Maricopa	Arizona
85301	5	64419	Glendale	Maricopa	Arizona
85302	4.2	38875	Glendale	Maricopa	Arizona
85303	4.6	35890	Glendale	Maricopa	Arizona
85305	3.4	12319	Glendale	Maricopa	Arizona
85307	3.6	12277	Glendale	Maricopa	Arizona
85326	4	66221	Buckeye	Maricopa	Arizona
85335	3.6	38657	El Mirage	Maricopa	Arizona
85338	3.4	54696	Goodyear	Maricopa	Arizona
85339	3.6	46318	Laveen	Maricopa	Arizona
85340	2.8	33787	Litchfield Park	Maricopa	Arizona
85345	3.8	63930	Peoria	Maricopa	Arizona
85351	2.6	29594	Sun City	Maricopa	Arizona
85353	4.2	40153	Tolleson	Maricopa	Arizona

IMPLEMENTATION STRATEGY DEVELOPMENT PROCESS

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Community Health Integration Network (CHIN) and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment

The significant needs that form the basis of the hospital's community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted on January 23, 2019.

The hospital conducts a CHNA at least every three years to inform its community heath strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The following statements summarize each of the areas of priority for SJHMC, and are based on data and information gathered through the CHNA.

Access to Care

Community members and key informants overwhelmingly felt that access to care is an important issue for the community. When community survey respondents were asked, what was the most important "Health Problem" impacting their community, access to care was the number one concern. Within SJHMC's primary service area, 20.1% of the population is unemployed and uninsured with 20.7% employed making under $25,000[v]. Additionally, there are disparities experienced across members of certain racial/ethnic backgrounds, with Hispanics and American Indians being least likely to have insurance[vi].

Maternal Health is an important part of mothers, infants, and child's overall health and wellbeing. It determines the health of the next generation and can help predict health challenges for families, communities, and the medical care system. Moreover, healthy birth outcomes and early detection and treatment of health conditions among infants can prevent death[vii]. Maricopa County's infant mortality rates from 2012-2016 range from 5.3 to 6.3 infant deaths per 1,000 births. The SJHMC Primary Service Area infant mortality rate is higher than Maricopa County[viii].

Mental/Behavioral Health

Mental and behavioral health are terms often used interchangeably to refer to a spectrum of health conditions that can be distinct or often co-occurring. Mental/Behavioral health includes ways of promoting well-being by preventing or intervening in mental illnesses such as anxiety or depression, and also aims to prevent or intervene in substance abuse and suicide. Mental/behavioral health was ranked as one of the most important health problems impacting the community by key informants; this was echoed by focus groups participants.

Substance abuse was one of the top concerns for both focus group participants and key informants. Key informants listed alcohol and drug abuse as two of the riskiest health behaviors community members are engaging in. In 2017, the United States Health and Human Services Department declared a public health emergency and announced a plan to combat the opioid crisis. In 2016, 790 Arizonians died from opioid overdoses and trends show an increase of a startling 74% over the past four years.[ix]

Suicide was the eighth leading cause of death for Maricopa County residents and SJHMC's primary service area in 2016. Suicide rates across Maricopa County have slightly increased from 2012-2016, with male rates 3 times higher than female suicide rates. In Maricopa County, rates of suicide are highest among age groups 45-54 and 75+, which could indicate a potential health disparity in identification, referral or treatment of suicidal ideation.

Alzheimer's disease is a type of dementia that causes problems with memory, thinking, and behavior.[x] In Arizona, 2,943 deaths occurred in 2015 due to Alzheimer's disease and it is the fifth leading cause of death, which is a 182% increase since 2000[xi]. In Maricopa County and SJHMC's primary service area, Alzheimer's disease is the fourth leading cause of death.[xii]

Neurotic Diagnoses:	personality disorders, depressive disorders, anxiety disorders, OCD, phobias, eating disorders, stress and adjustment disorders and sleep disorders
Organic Psychotic Diagnoses:	dementias, alcohol induced mental disorders, drug-induced mental disorders, transient mental disorders, and persistent mental disorders
Other Psychoses Diagnoses:	schizophrenic disorders, episodic mood disorders, other nonorganic psychoses, pervasive developmental disorders

Suicide:	Intentional self-harm (gun discharge, jumping from a high place, crashing, etc.), poisoning by medicaments and biological substances, toxic effects of non-medicinal substances, asphyxiation
Alcohol Related Diagnoses:	alcohol abuse or dependence, toxic effects from alcohol, alcoholic myopathy, and alcohol-induced chronic pancreatitis
Drug Overdose Diagnoses:	drug abuse or dependence, overdose on all drugs (including opioids), and injuries related to be under the influence of a drug

Chronic Disease

Cardiovascular Disease

Cardiovascular disease is the second leading cause of death for Maricopa County and SJHMC's primary service area. The primary risk factors include diabetes, overweight/obesity, poor diet, physical inactivity and excessive alcohol use. Many of these are the same risky behaviors key informants reported being concerned about for the primary service area.

Overall, the number of deaths related to cardiovascular disease in the SJHMC PSA as well as Maricopa County overall are increasing. According to the hospital discharge data and death data for Maricopa County, adults age 75 and older have the highest rates of cardiovascular disease-related inpatient discharges, emergency department visits and mortality.

Diabetes

More than one million U.S. adults are now living with diabetes or pre-diabetes, according to a report released by the Centers for Disease Control and Prevention[xiii]. Diabetes is the sixth leading cause of death in SJHMC's primary service area indicating a sustained health need. The rate of deaths related to diabetes in Maricopa County has fluctuated across the years 2012 to 2016 with a low of 23.2 per 100,000 and a high of 26.4 per 100,000. Overall, there has been a slight increase in deaths due to Diabetes in both Maricopa County and the SJHMC primary service area. These mortality rates are very close to those of Maricopa County as a whole. According to the behavioral risk factor surveillance survey, the number of people reporting they have been told they have diabetes is also increasing. The ED rates per 100,000 for Diabetes in the SJHMC primary service area has been increasing overall since 2012 but the IP rates have held fairly steady.

Overweight/Obesity

Arizona has the 30th highest adult obesity rate in the nation, and the 32rd highest obesity rate for youth ages 10-17[xiv]. In Maricopa County, males have higher rates of being overweight, and Hispanics have higher rates of obesity when compared to non-Hispanic whites[xv]. Key informants felt that being

overweight, poor eating habits and lack of exercise were among the top five risky health behaviors community members were engaging in.

Cancer

While advancements continue to be made in the fight against cancer, it remains the leading cause of death in Maricopa County and the SJHMC's primary service area and was identified as one of the top five areas of concerns from key informants. Colorectal cancer death rates in Maricopa County and SJHMC primary service area has fluctuated over the last five years[xvi]. In SJHMC primary service area, colorectal rates are just below Maricopa County rate[xvii].

Safety & Violence

Trauma/Injury Prevention

In the United States, deaths from unintentional injuries is the seventh leading cause of death among older adults, and falls account for the largest percentage of those deaths. In 2016 unintentional injuries was the fifth leading cause of deaths in Maricopa County and SJHMC's primary service area and falls were ninth leading cause of death. Unintentional injuries are preventable and largely due to lifestyle choices. Nationally, nearly one-third of these deaths are due to car crashes and nearly another one-third is due to accidental poisonings[xviii]. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females.

From the years 2012-2016, the inpatient discharge and emergency department rates per 100,000 for motor vehicle accidents in the SJHMC PSA were consistently lower than the rates for Maricopa County as a whole. The death rates per 100,000 for the SJHMC primary service area were not higher than Maricopa County's rates either. In 2016, the death rate for the SJHMC PSA was 12.6 deaths per 100,000 which are almost to the goal of Healthy people 2020 with a goal of 12.4 deaths per 100,000 individuals. The races with the highest ED visits due to a motor vehicle accident were American Indian and African American. Even looking at the ED rates by race, Maricopa County's rates were still higher for those same populations.

Falls

Falls are a great concern, particularly among the aging population. Looking at both the inpatient hospitalization rates and emergency department rates for the SJHMC PSA, it can be seen that the rates follow almost the same exact trend as Maricopa County overall, but the rates are consistently lower than Maricopa County's.

Pedestrian Injuries

A pedestrian related injury is any injury to a pedestrian due to a motor vehicle accident. The SJHMC's primary service area has higher emergency department visit rates per 100,000 compared to Maricopa County's rates. It is also noteworthy that the inpatient hospitalization rates are lower than the emergency department visit rates.

Violence

In Maricopa County, males enter the emergency room due to violence at a much higher rate than females. It was also found that deaths due to interpersonal violence are more likely in the SJHMC primary service area than in Maricopa County overall.

Housing and Homelessness

A household is considered cost burdened if they are paying 30% or more (for homeowners) and 50% or more (for renters) of their gross income towards housing, which includes rent or mortgage, utilities, etc. If a household is cost burdened then it can make it more difficult to afford the other necessities such as transportation, health care, food, child care, clothing, etc. To better understand the population considered cost burdened by home ownership or renting, a map was created. The map indicated:

- At least an estimated 20% of all people are considered living in poverty
- At least an estimated 25% of all homeowners are considered cost burdened
- At least an estimated 46% of all renters are considered cost burdened

Social Determinants of Health

According to Health People 2020, a social determinants of health is a condition in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health and qualify-of-life outcomes and risks. For the SJHMC primary service area, transportation, access to food, and housing were mapped to better understand those social determinants of health for this primary service area.

Several social determinants are identified in the CHNA, which include, but are not limited to, housing and homelessness; access to food-low-income and low-access to grocery stores; and transportation.

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.

Creating the Implementation Strategy

Rooted in Dignity Health's mission, vision and values, St. Joseph's Hospital and Medical Center (SJHMC) is dedicated to improving community health and delivering community benefit with the engagement of its management team, Community Board and Community Health Integration Network (CHIN). The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital's community health director and other staff.

As a matter of Dignity Health policy, the hospital's community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these 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.

Process and Criteria for Prioritization

The process for prioritization included engagement with both internal Dignity Health stakeholders and community partners from CHIN and the ACCN. The first step of the process was a comprehensive presentation that included an overview of the CHNA findings and key emerging health needs. Stakeholders in attendance of the March 2019 Arizona Community of Care Network meeting participated in a "needs strategy activity" where they were able to identify strategies and opportunities for integration with the hospital. The ACCN identified areas and programs that they can collaborate with the hospital and community to create healthier and sustainable communities. CHIN members in attendance of the April 2019 meeting also participated in a strategy activity, where they reviewed community outcomes, discussed major inequities, and determined the best strategies for each outcome.

2019-2021 IMPLEMENTATION STRATEGY

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.

Strategy and Program Plan Summary

The following is a summary of the key programs and initiatives that have been a major focus of SJHMC's over the last year to address the identified and prioritized needs of the community. The key programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Health Integration Network (CHIN), Executive Leadership, the Community Board and Dignity Health receive reports regarding the success of the key initiatives as well as community benefit reports. We implemented the Coordinated Community Network Initiative (CCNI) to provide an opportunity for Care Coordinators to refer patients to hospital programs as well as community programs that assist individuals with chronic health conditions, housing, access to health services, transportation and much more. This tool provides the opportunity to evaluate the accessibility of resources and to determine what programs are still needed. We also use Healthify[xix] to survey and navigate resources for Medicare and Medicaid beneficiaries through the CMS Accountable Health Community, 2MATCH (To Match and Align Through Community Hubs) Project. [xx]

We have categorized the needs to reflect the "Dignity Health Community Health Strategy Blueprint 2019-2023" to increase the care continuum, promote innovation and transformational approaches to improve health outcomes, and to address the social determinants of health (SDOH) within our community and the health system. Existing programs with evidence of success and impact are identified within these key strategy areas to meet the community needs identified in the CHNA. Through our work and collaboration with Maricopa County and the State of Arizona's Department of Health and Human Services, we participate in the Health Improvement Partnership of Maricopa County (HIPMC) and Synapse to improve the outcomes for programs that are research and evidence-based, provide outcomes, and sustainable interventions. CHIS objectives are collected on an ongoing basis by the Maricopa County Department of Public Health (MCDPH) from organizations participating in HIPMC. We work closely with the partners within HIPMC and also contribute through the hospital's programs to improve the community. We also collaborate with our community partners in the Arizona Communities of Care Network where we use collective impact and asset-based strategies for program development and improvement.

Program outcomes are measured using SMART goals to address the immediate needs and provide a framework to address the preventive factors or social determinants of health. We do this in collaboration with our partnering service lines within the hospital, community partners, the County and State of Arizona. We will continue to engage and utilize the Collective Impact Model and

enhance the collaborations within the Arizona Communities of Care Network and further promote the work within HIPMC, Arizona Partnership for Healthy Communities, the Preventive Health Collaborative of Maricopa County, and Synapse.

Health Need: Access to Care	
Strategy or Activity	**Summary Description**
Education, Enrollment and Outreach Activities	• Collaboration with Keogh Health Connections, FSL, Circle the City and other Community programs to assist with insurance and program enrollments • Educate community and patients on end-of-life decisions
Care navigation for vulnerable populations and needy populations	• Community grant to Care Connection Resources, to establish primary care medical homes, home visits, social need navigation. Integrate 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. • Increase the integration of community resources using care navigators both in and outside the hospital.
Community Health Workers	**Muhammed Ali Parkinson's Center Promotores** • Trained volunteers deliver in-home educational program to Hispanic families, entirely in Spanish • Conduct 13 weekly visits and provide educational material for the families • Families are followed for 6 months.
Maternal/Fetal Care	**MOMobile (Maternal Outreach Mobile Unit)** • Provide prenatal and postpartum care for low -income, uninsured pregnant women • Mobile clinic travels to 4 different locations within Maricopa County weekly • **Nurse Family Partnership** and home visiting programs for high risk families.
Care Coordination Home Visiting	**ACTIVATE, ACTIVATE Prime/CATCH** • Case manage patients with limited or no insurance • Provide access to free medical equipment • Patients are followed for 30 - 90 days
Anticipated Impact: The hospital's initiatives to address access to care has anticipated to result in: early identification of patients with limited access to care; gains in public or private health care coverage; increased knowledge about how to access and navigate the health care system; increased enrollment in medical insurance, social service, social needs, and increased primary care "medical homes" among those reached by navigators and promotoras. Reduction in	

Emergency Department utilization, reduced readmission rates, length of stay in hospitals, and increased access to health and human services for primary prevention and health protection.

Health Need: Mental/Behavioral Health	
Strategy or Activity	**Summary Description**
Mental Health Awareness	**Mental Health First Aid** • 8-hour course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. • Builds mental health literacy, helping the public identifies, understand, and respond to signs of mental illness.
Community Grants	**Dignity Health Community Grants** • Communities of Care have proposed projects that deal directly with mental and behavioral health issues in our community
Substance Abuse Initiative	**Substance Abuse Initiatives with Community Medical Services** • Program to assist opioid and drug abuse patients with treatment beginning at the bedside and transitioning to treatment in community. • Collaborative and partnership program working with Community Medical Services, Hush-a-bye Nursery and others to provide care transitions for addicted individuals.
Maternal Mental Health	• Screenings of mothers and fathers for mood disorders and treatment options • Increase supports for parents both in home and in the community through collaborations and partnerships with organizations such as the Women's Health Innovations. • Educate on Adverse Childhood Experiences and Trauma Informed Care when possible
Alzheimer and Dementia Education	• Education program to be developed to educate on signs and symptoms of Alzheimer's and Dementia disease • Community collaborations to increase awareness and integrations • End of Life Education
Anticipated Impact: Improved mental and behavioral health of the community and patients utilizing hospital services, reduction in readmission rates, Emergency Department visits, length of stay, engagement with primary care and mental behavioral health provider, increased education on signs and symptoms of mental and behavioral health conditions – drug, substance, alcohol and memory disorders as well as knowing how to receive care and prevent disease.	

Health Need: Chronic Disease	
Strategy or Activity	**Summary Description**
Diabetes Prevention and Management	**DEEP (Diabetes Education and Empowerment Program**) self-management workshops in English and Spanish • Collaboration with community partners providing assistance to meet ongoing needs of Diabetics
Disease Self-Management	**Healthies Living with Chronic Conditions** • Series of free classes that teach participants how to self-manage their chronic conditions • Strategies and tools are provided to improve health and overall quality of life • Offered in English and Spanish
Stroke Prevention	• Health promotion and stroke prevention education for seniors, community and employees that identify cardiovascular risk factors • Increases the number of individuals who recognize signs and symptoms of stroke
Nutrition and Physical Activity Programs	• **MOMobile** education on nutrition for mother, baby and family • Collaboration with City parks in the Initiative to increase activity and nutrition • Promote healthy food trucks and farmers markets in the area with patients and community • Advocate for SNAP benefits, access to healthy food programs using SNAP benefits • Utilize Community Health Workers/Navigators to assist with obtaining social services and transportation to food locations
Chronic Disease Prevention and Assistance Program	**ACTIVATE Sepsis Prevention and Assistance Program** • Management of sepsis post hospital visits • Home visiting program and increased monitoring for 30 days • Social needs being met by program • Education and Prevention activities
Anticipated Impact: The hospital's initiative to address chronic conditions has anticipated results in: increasing the number of individuals being referred to appropriate professionals to receive medical care and education needs, improving the community's knowledge of how to manage chronic conditions, improving access to information on prevention, and increasing the community's capacity to improve their overall health. Improved overall health, reduction of morbid co-morbidities, reduction of use of Emergency Department, increase in primary care utilization, increased knowledge and care for chronic condition, reduction of deaths, increased education and disease prevention. Reduction in length of hospital stays and readmissions with an increase of utilization of primary health services.	

Health Need: Safety and Violence	
Strategy or Activity	**Summary Description**
Stop the Bleed	• Bleeding control classes held in community settings • National campaign to build resilience by better preparing the public to save lives by raising awareness of basic actions to stop life threatening bleeding. • Equips organizations with bleeding control kits
Injury Prevention	• **Pedestrian Safety** – community education • Improvement of walking areas for pedestrians and collaboration with local governments to improve walkways • Community Safety Education on use of motorized scooters • Collaboration between SJHMC Trauma Dept. and Barrow Community Outreach Dept. to develop outreach plan to increase awareness and education on motorized scooter safety.
Fall Prevention	**ACTIVATE/ACTIVATE Prime** to do home safety evaluation • Promote and collaborate with organizations who conduct home safety evaluation • Collaborations with Community organizations to provide support for fall prevention efforts. Referrals to organization such as FSL and other groups to do the home improvements **"Balance Matters"** - Balance and strengthening program to reduce falls. • Trauma and Emergency Department: The Trauma Prevention Staff provides a Home Safety curriculum that teaches parents and guardians how to have a more child safe environment, and prevent unintentional injuries. Presentations can be scheduled by appointment for agencies and organizations.
Human Trafficking	**Human Trafficking Task Force** • Education on Human Trafficking to community, clinical and staff to identify and assist individuals who are experiencing human trafficking. • Provides supports to community and individuals require assistance • Expands collaborations and partnerships to education, address and assist in prevention of human trafficking • Educate and Promote the use of the PEARR tool (Trauma Informed Care) • Work with organizations to educate and inform youth on human trafficking and abuse • Educate on Adverse Childhood Experiences.

Traumatic Brain Injury Prevention	**Barrow Brainbook** • Developed to provide a comprehensive concussion education to Arizona High School Athletes. • The interactive module offers students a fun-to-navigate series of educational activities, features videos from local high-profile athletes and utilizes a Q&A format to walk student-athletes through symptoms and signs of a concussion, encourages them to report all suspected concussion (in themselves or a teammate), and explains to them what to do if they have a concussion. **Barrow Brain Ball** • First video game that educates young children about concussion. The game offers special features that teach kids how to play smart and safely avoid collisions on the football field. • The free app is designed for children between the ages of 8 and 12 and is available for download on Google Play and Apple's App Store. Promotion of the benefits of this game to prevent concussions.
Anticipated Impact: The hospital's initiative to address trauma and injury have anticipated results in: increasing the community's knowledge of trauma/ injury risks, empowering the community to avoid these risks, and providing access to items that increase safety and reduce the likelihood of enduring a traumatic injury.	

Health Need: Homelessness & Housing Insecurity	
Strategy or Activity	**Summary Description**
Medical Respite and transitional placement	• **Circle the City** provides respite to homeless individuals discharging from the hospital and medical services – continue to increase opportunities to increase bed capacity and referrals • Health and Human Service Campus transition plan, campus alignments and system improvements through a coordinated transition planning system using NaviHealth and Healthify as a tool to send referrals and track patient and community referrals
Health and Housing	**HOMeVP Committee – "Continuum of Care Partnerships** • Collaborate with health providers, insurance organizations, city, county, state agencies, and other social service organization to educate, inform, prevent and advocate for better housing policies, increased affordable housing, increased advocacy for renters/homeowners rights, reduction in evictions and foreclosures • Prevention efforts to end homelessness

	• Collaborate and partner organizations that can increase assistance for supportive health and social services for homeless and nearly homeless individuals
Homeless Initiative	**Homeless Initiative (SB1152)** • Implement SB 1152 and Homeless Initiative • Increase collaborations for assisting homeless individuals with their transfer to community by providing food, clothing, transportation and other social needs when possible.
Social Determinants of Health	• **2MATCH (To Match Align and Match Through Community Hubs)** surveys Medicare and Medicaid beneficiaries on their social needs and navigates their needs connecting them to needed services • Support and integrate tenants of 2MATCH as best practice in other programs
Anticipated Impact: Reduce homelessness, increase housing, and improve social services that support the needs of the community. Reduce readmissions, injuries, improved health, advocate for improved policies and support increases in workforce navigation for overall improvement.	

Health Need: Cancer	
Strategy or Activity	**Summary Description**
Women's Wellness	• **Women's Wellness Clinic** provides free breast exams, mammograms, pap smears, pelvic exams, and rectal exams to low income and uninsured women. They focus on teaching women ways to reduce their cancer risks, including risks of skin cancer, cervical cancers, and colorectal cancers.
Breast and Ovarian Cancer	**AZ Department of Health – Breast and Ovarian Cancer Screening Program** • Collaboration with the AzDHS – Breast and Ovarian Cancer Screening Program to work closely with Federally Qualified Health Center's (FQHC's) physicians to be educated in appropriate screening guidelines for breast and ovarian cancer screening by Cancer Center Medical Directors. They will provide advice and guidance for the most up-to-date guidelines for screening and evaluation.
Cancer Support Navigation	• Collaboration with Cancer Support Community and the American Cancer Society to provide on-site and community education and navigation for cancer patients and their caregivers. Help individuals who are poor, disenfranchised and underserved navigate their social and health needs. Cancer Support Navigators and Interpreters are multi-lingual and meet the patients cultural and linguistic needs, especially for Spanish speaking patients and community members
Cancer Support Services	**Collaborative Summit Regional Hospital – Showlow, AZ**

	• Collaborative engagement between the Cancer Center Radiation Oncologist and Summit Regional Hospital to provide on-site radiation services that were not available in this area for those living in Northern Arizona
Medication Assistance	• Cancer Center assists in completing applications for Cancer Medications for uninsured and underinsured
Anticipated Impact: To increase access to care, increase social and medical supports and to ensure patients are screened within the cancer guidelines. These projects also increase patients and communities ability to continue to receive the care they need within their communities and culture.	

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 in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY19, the hospital awarded 8 grants totaling $548,753. Below is a complete listing of FY19 grant projects; some projects may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Catholic Charities Community Services, Inc.	Refugee Health Partnership	$74,800
Maggie's Place	Strengthening Homeless Pregnant and Parenting Women	$67,200
BakPAK	Arizona's First Health Navigation & Transportation System for the Homeless	$50,000
Purple Ribbon Council to Cut Out Domestic Abuse (DBA BLOOM365)	Youth Violence Intervention & Prevention Project (Y-VIPP)	$75,000
Circle The City	Coordinated Hospital Discharge and Diversion Program	$75,000
Valle del Sol	Healthy Kiddos, Healthy Communities	$79,753
Family Involvement Center (FIC)	Strong Families Healthy Communities	$84,500
Ability 360	The Ability Program	$42,500

Anticipated Impact

The anticipated impact of the hospital's activities on significant health needs are summarized above, and for select programs in the Program Digests section of this report. 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 is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, evaluates impact, and sets priorities for its community health program in triennial Community Health Needs Assessments.

Planned Collaboration

The Community Health Integration Network (CHIN), the Board Committee for St. Joseph's Hospital and Medical Center, is comprised of hospital experts, board members, community members, city, county, scholars, physicians, care coordinators, funders and others. CHIN comes together to work closely with the hospital by assisting in determining the needs, evaluating, and sustaining ongoing work within the hospital and community. This group provides supports and connections to current programs to meet the ongoing needs identified in the CHNA. Since 2012, SJHMC has engaged with the community, nonprofit organizations, businesses, and governmental agencies in the Arizona Communities of Care Network (ACCN). The ACCN is a demonstration of utilizing the Collective Impact Model and putting it into action. The key intent is to foster collaborations borne of shared responsibility among various organizations and agencies to transform health in our community by meeting the needs of the disenfranchised and underserved.

Through our work and collaboration with Maricopa County and the State of Arizona's Department of Health and Human Services, we participate in HIPMC and Synapse to improve the outcomes for programs that are research and evidence-based, provide outcomes, and sustainable interventions. CHIS objectives are collected on an ongoing basis by the Maricopa County Department of Public Health (MCDPH) from organizations participating in HIPMC. We work closely with the partners within HIPMC and also contribute through the hospital's programs to improve the community.

We also collaborate with our community partners in the Arizona Communities of Care Network where we use collective impact and asset-based strategies for program development and improvement.

St. Joseph's Hospital and Medical Center (SJHMC) engages in many community-building activities to improve the community's health and safety by addressing the root causes of health problems such as poverty, homelessness and environmental hazards. The Arizona Communities of Care Network provides the structure and engagement needed to bring the community together to work on complex issues facing our community. HOMeVP (Health and Housing of Medically Vulnerable

People) works to reduce and eliminate health and housing disparities and collaborates with more than 30 agencies, state and county. We work closely with Project Cure to provide unused medical supplies and equipment to improve the health of third world countries. The following are organizations we work with to strengthen the community's capacity to promote the health and well-being of its residents by offering the expertise and resources of health care organizations.

List of Current Community Organizations

1 and 10	Hospice of the Valley
Ability 360	Human Services Campus
Alzheimer's Association Desert Southwest Chapter	International Rescue Committee (IRC)
American Cancer Society	Jewish Family and Children's Services
American Heart Association	Juvenile Diabetes Research Foundation (JDRF)
American Lung Association in Arizona	Keogh Health Connections
American Stroke Association	Kids Sports Stars
Anti-Defamation League	Lodestar Day Resource Center
Arizona Asthma Coalition	Maggie's Place
Arizona Agency on Aging	Make-a-Wish Foundation
Arizona Behavioral Health Association (ABC Housing)	March of Dimes
Arizona Cardinals Charities	Maricopa Association of Governments
Arizona Chamber of Commerce	Maricopa County Healthcare for the Homeless
Arizona Chapter of the National Multiple Sclerosis Society	Maricopa County Public Health and Human Services
Arizona Children's Association	Mercy Housing Southwest
Arizona Community Foundation	Mid-Western University
Arizona Dental Association	Mission of Mercy
Arizona Department of Education	Mountain Park Health Center
Arizona Department of Health Services	Muscular Dystrophy Association
Arizona Department of Oral Health	NAMI of Southern Arizona
Arizona Diamondbacks Charities	National Kidney Foundation of Arizona
Arizona Early Intervention Program	National Safety Council, Arizona Chapter
Arizona Firearm Safety Coalition	Native American Connections
Arizona First Things First	Native American Community Health Center, Inc.
Arizona Kidney Foundation	Neighborhood Christian Center
Arizona State University	Not My Kid
Asian Pacific Community in Action	Parkinson's Association
Assisted Living Arizona Senior Housing Institute	Parson's Family Health Center
Autism Speaks	Phoenix Day Center/Health Links
B.R.A.I.N.S Clinic	Phoenix Fire Department

BHHS Legacy Foundation Black Nurses Association Bloom 360 Boys and Girls Club of Phoenix Brighter Way Foundation Catholic Charities Services Cancer Support Community Center for African American Health Arizona Central Arizona Shelter Services (CASS) Chicanos Por la Causa Children's Action Alliance Children's Museum of Phoenix Circle of the City – Homeless Respite City of Glendale City of Phoenix Cooperation for Supportive Housing (CSH) Community Bridges Inc. Delta Dental of Arizona Foundation Duet: Partners in Health & Aging Elaine Esperanca Family Involvement Center Feeding Matters Fight Night Foundation Florence Crittenton Services of Arizona, Inc. FSL- Foundation for Senior Living Fresh Start Women's Foundation and Center Girls Ranch Golden Gate Community Center Glendale Fire and Police Department HARP Foundation Health Services Advisory Group (HSAG) Healthy Communities Healthy Lifestars Homeward Bound	Phoenix Indian Health Center Phoenix Police Department Phoenix Rescue Mission Phoenix Sympathy Project C.U.R.E Raising Special Kids Re-Invent Phoenix Rural Metro Ryan's House Save the Family Society of St. Vincent de Paul Sojourner Center Southwest Autism Research and Resource Center (SARRC) Southwest Center for HIV/ Southwest Human Development Students Supporting Brain Tumor Research The American Indian Prevention Coalition Touchstone Behavioral Health Center Tumbleweed Center for Youth Development UMOM New Day Center United Way – Valley of the Sun University of Arizona Valle Del Sol Valley Center of the Deaf Virginia G. Piper Charitable Trust Vitalyst Health Foundation Wesley Community Health Center Women's Health Coalition of Arizona YMCA YWCA *This is a sample of the current list of partners and may not reflect all of the current partners.*

Financial Assistance for Medically Necessary Care

St. Joseph's Hospital and Medical Center delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital's Financial Assistance Policy is in Appendix C.

The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital's web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

St. Joseph's Hospital and Medical Center and our joint venture hospitals inform the community of their Financial Assistance Policy by posting it in areas throughout the hospital, both in the inpatient and outpatient areas; provides information on its website; provides information on Facebook, Linked In, Twitter, and by e-mail to the broader community.

Program Digests

The following pages include Program Digests describing key programs and initiatives that address one or more significant health need from most recent CHNA report. 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.

Maternity Outreach Mobile (MOMobile)	
Significant Health Needs Addressed	☑ Access to Care ❑ Mental/Behavioral Health ❑ Chronic Diseases ❑ Cancer ❑ Trauma/Injury Prevention ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Core Principles Addressed	☑ Focus on Disproportionate Unmet Health-Related Needs ❑ Emphasize Prevention ☑ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ☑ Demonstrate Collaboration
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 SJH, and the OB/GYN Department of SJMG, funded through SJH Foundation which covers all operating costs, including staffing
Community Benefit Category	A2-f. Community-based clinical services – Mobile Units
Planned Actions for 2019 - 2021	
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. Mobile clinic travels to 4 different locations within Maricopa County weekly. Supported by SJH, and the OB/GYN Department of SJMG, funded through SJH Foundation which covers all operating costs, including staffing
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 Things First, First Teeth First, The Nurse Partnership, Southwest Human Development, March of Dimes, Mission of Mercy, and St Vincent de Paul.

Women's Wellness Center	
Significant Health Needs Addressed	☑ Access to Care ❑ Mental/Behavioral Health ❑ Chronic Diseases ☑ Cancer ❑ Trauma/Injury Prevention ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Core Principles Addressed	☑ Focus on Disproportionate Unmet Health-Related Needs ☑ Emphasize Prevention ❑ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ☑ Demonstrate Collaboration
Program Description	Provide low income and uninsured/underinsured women with free female cancer screening exams, including mammogram and breast ultrasounds for breast cancer screening; pap's for cervical cancer screening, as well as health exams and assessing patient risk factors.
Community Benefit Category	C3. Hospital Outpatient Services
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Provide approximately 1000 free cancer screening exams per fiscal year, for early detection and increasing women's chance of survival, and decreasing overall health costs associated with advanced disease.
Measurable Objective(s) with Indicator(s)	Measurements include tracking number of women served, number of tests provided, as well as outcomes of all testing.
Intervention Actions for Achieving Goal	Well woman exams will be provided by a Women's Health Nurse Practitioner 24 hours per week in a welcoming and safe environment. Provide information on services available at women's health fairs as well as with community partners.
Planned Collaboration	Patients will be referred to our community partners (Mission of Mercy, St Vincent de Paul, Wesley Health Center) for all other coincidental findings, such as hypertension, diabetes, or any findings which required further evaluation and possible treatment.

Diabetes Empowerment Education Program (DEEP)	
Significant Health Needs Addressed	❑ Access to Care ❑ Mental/Behavioral Health ☑ Chronic Diseases ❑ Cancer ❑ Trauma/Injury Prevention ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Core Principles Addressed	☑ Focus on Disproportionate Unmet Health-Related Needs ❑ Emphasize Prevention ❑ Contribute to a Seamless Continuum of Care ☑ Build Community Capacity ☑ Demonstrate Collaboration
Program Description	DEEP is a community course for people with type 2 diabetes and/or their caretakers. Small group courses are 6 weeks long, meeting once a week for 2 – 2.5 hours. The sessions are highly interactive, focusing on building skills, sharing experiences and support. The course teaches the life skills needed in the day-to-day management of diabetes.
Community Benefit Category	A1-a. Community Health Education – Lectures/Workshops
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Planned actions for 2019 -2021 revolve around expanding the program infrastructure to reach more people. Operating under a Dignity Health license and creating our own program materials will allow the program to be more sustainable going forward. With new community partnerships, we can now offer more workshops to the community and effectively reduce the burden of diabetes on the community.
Measurable Objective(s) with Indicator(s)	Program coordinator will increase the number of workshops offered in order to increase the number of workshop completers in a year. Program coordinator will increase the number of workshop completers by 50% for a total of 300 completers each year.
Intervention Actions for Achieving Goal	Promote the program widely. Increase community and hospital based referrals. Create and maintain relationships with community agencies where workshops can be held and promoted.
Planned Collaboration	We will continue collaborating with Keogh Health Connection and Maricopa County Dept. of Public Health to sustain the program.

Health / Housing of Medically Vulnerable People (HOMeVP)	
Significant Health Needs Addressed	☑ Access to Care ❑ Mental/Behavioral Health ❑ Chronic Diseases

	❑ Cancer ❑ Trauma/Injury Prevention ❑ Safety & Violence ☑ Homelessness & Housing Insecurity
Core Principles Addressed	☑ Focus on Disproportionate Unmet Health-Related Needs ☑ Emphasize Prevention ☑ Contribute to a Seamless Continuum of Care ☑ Build Community Capacity ☑ Demonstrate Collaboration
Program Description	The mission of HOMeVP is to address the relationship between medically vulnerable people and homelessness in Maricopa County with a model that supports a variety of care transitions. HOMeVP recognizes that housing is critical to the health of vulnerable individuals, namely the homeless, and strives to enable access to housing and to address the medical, social and psychological needs of homeless people.
Community Benefit Category	F7a. Advocacy for Community Health Improvement/Safety – Local community organizing/advocacy
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	HOMeVP aims to enable access to housing and to address the medical, social and psychological needs of homeless people.
Measurable Objective(s) with Indicator(s)	HOMeVP hosts annual educational events on a variety of topics relating to homelessness as well as monthly meetings for group members. We will measure our success by analyzing the turnout and feedback from these events.
Intervention Actions for Achieving Goal	For 2019-2021 HOMeVP will work closely with the community and St. Joseph's Hospital and Medical Center to seamlessly incorporate California's SB 1152 discharge law in Arizona. In 2019 HOMeVP plans to host an education event surrounding the eviction crisis in Maricopa County and determine what we can do to help end the crisis.
Planned Collaboration	HOMeVP has a variety of collaborators including housing agencies, first responders, hospitals, health / mental health agencies and providers, advocacy, funders, and state / city / local agencies.

Barrow Concussion Network	
Significant Health Needs Addressed	❑ Access to Care ☑ Mental/Behavioral Health ❑ Chronic Diseases ❑ Cancer ☑ Trauma/Injury Prevention ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Core Principles Addressed	❑ Focus on Disproportionate Unmet Health-Related Needs

	☑ Emphasize Prevention ❑ Contribute to a Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Barrow Concussion Network provides concussion prevention education to the community and other allied 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 sport. Health profession presentations are given to Athletic Trainers from the state during the Barrow Concussion Network "Train the Athletic Trainer" events in May and August. General public presentations are given during events, as well as private presentations to parents, coaches and teachers.
Community Benefit Category	A1-a. Community Health Education – Lectures/Workshops B3. Other Health Professions Education
Planned Actions for 2019 - 2021	
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)	Our goal is to reach at least 15,000 students for Barrow Brainbook, at least 200 Athletic Trainers for professional education, and at least 150 general public.
Intervention Actions for Achieving Goal	For high school students we provide an interactive online learning module for them to complete prior to participation in sports. For health professionals we provide conferences for them to attend. For the general public information is provided through health fairs and presentations.
Planned Collaboration	None

Muhammad Ali Parkinson's Center (MAPC) Promotores	
Significant Health Needs Addressed	☑ Access to Care ❑ Mental/Behavioral Health ☑ Chronic Diseases ❑ Cancer ❑ Trauma/Injury Prevention ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Core Principles Addressed	☑ Focus on Disproportionate Unmet Health-Related Needs ☑ Emphasize Prevention ☑ Contribute to a Seamless Continuum of Care ☑ Build Community Capacity

	☑ Demonstrate Collaboration
Program Description	Trained community health volunteers (Promotores) deliver in-home educational program for Hispanics with Parkinson's disease (PD) who have barriers to access healthcare and lack information about PD management and research opportunities. Promotores will also provide training to other community health care workers (outside of MAPC).
Community Benefit Category	A1-c. Community Health Education – Individual health education for uninsured/under-insured
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	Provide in-home education to Hispanics living with Parkinson's disease (PD) and their families who experience barriers to health education. Education is focused on chronic disease self-management, research awareness and information about available resources and research opportunities at the MAPC. Increase PD awareness among community health workers and community organizations.
Measurable Objective(s) with Indicator(s)	Number of families participating and number of those who connect to the MAPC with further involvement in outreach programs. Number of participants who seek information about MAPC research studies after receiving education from the promotores. Number of promotores' teaching activities and conferences.
Intervention Actions for Achieving Goal	Hispanics living with PD can be referred to the MAPC Promotores program, regardless of where they receive medical care, and are assigned to a dedicated promotor who will deliver educational program. Promotores will attend and participate in educational conferences and trainings and share their expertise in the areas of chronic disease management, education and research awareness.
Planned Collaboration	Promotores HOPE Network, Parkinson's Foundation, and Arizona State University.

Human Trafficking Committee	
Significant Health Needs Addressed	☐ Access to Care ☐ Mental/Behavioral Health ☐ Chronic Diseases ☐ Cancer ☐Trauma/Injury Prevention ☒ Safety & Violence ☒ Homelessness & Housing Insecurity
Core Principles Addressed	☒ Focus on Disproportionate Unmet Health-Related Needs ☐ Emphasize Prevention ☐ Contribute to a Seamless Continuum of Care ☐ Build Community Capacity

	☒ Demonstrate Collaboration
Program Description	The Human Trafficking committee is comprised of a multidisciplinary team that oversees and has the authority and capacity to make decisions on behalf of the department/discipline they represent on education/training and removing barriers to the identification and treatment of those who have been victims of human trafficking.
Community Benefit Category	A5. Initiative – Human Trafficking Community Response
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	The program goal is to provide guidance to patient and client care staff on assessing vulnerable persons for concerns of human trafficking victimization through education and training within Arizona Dignity Health care sites and Community Partner networks. Through this initiative resources will be identified and aligned to provide guidance for these victims if they chose help.
Measurable Objective(s) with Indicator(s)	Education and training for all St. Joseph's Hospital and St. Joseph's Hospital Westgate provided through MyJourney Modules. Goal of 85% completion rate by all staff. At the end of the 2018 there was a compliance of 88%. These modules are now assigned to all new hires and annual assignment to all clinical departments.
Intervention Actions for Achieving Goal	Program initiatives and activities include: • Education and training to Community Partners and on-site staff. • Review and Update Resources for our victims. • Networking with Community Partners for on-site support for victims. • Quarterly case reviews and debriefs for ongoing learning and identification of needs.
Planned Collaboration	Partnership with Catholic Charities to provide on-site support for identified victims. MOU in progress to allow this partnership. Education with Community Navigator Teams, HOMEVP group. Investigating AZ Division opportunities to combine steering committee and resources.

Balance Masters	
Significant Health Needs Addressed	❑ Access to Care ❑ Mental/Behavioral Health ❑ Chronic Diseases ❑ Cancer ☑ Trauma/Injury Prevention ❑ Safety & Violence ❑ Homelessness & Housing Insecurity
Core Principles Addressed	❑ Focus on Disproportionate Unmet Health-Related Needs

	❑ Emphasize Prevention ☑ Contribute to a Seamless Continuum of Care ☑ Build Community Capacity ☑ Demonstrate Collaboration
Program Description	A group class developed to address the fear or risk of falling, through balance and strength exercises. The class is voluntary and free of charge to those 65 years and older. St. Joseph's Hospital provides the physical therapist as an instructor, the logistics of classroom space on campus twice/week for 1 hour, and the online or phone registration through Resource Link.
Community Benefit Category	A1-a. Community Health Education – Lectures/Workshops
Planned Actions for 2019 - 2021	
Program Goal / Anticipated Impact	St. Joseph's Hospital created a program that allows providers from Family Medicine, Outpatient Rehab and Trauma patients at risk for falling to a free weekly class as a layer of support. In addition, the class is open to the entire community to allow for those at risk of falling to build strength, balance, and knowledge surrounding fall prevention.
Measurable Objective(s) with Indicator(s)	300 flyers (#will increase as they run out) have been given to Family Medicine. Trauma Administration plans to track the number of referrals given to its patient population and determine the number of patients that enroll in the program. Also Outpatient Rehab recommends a series of 8 classes. Surveys or evaluations from instructors will be given upon the completion of the series to measure self-reported reduction in fear of falling and/or strength and balance gained from 1st class to final class.
Intervention Actions for Achieving Goal	The 1 hour class held twice weekly will incorporate balance and strength exercises. The class includes aerobic activity to music that creates a fun environment that creates interaction with the staff physical therapist. A series of 8 classes is recommended. Participants can come as often as they like and the program is free to any community member 65+ that is able to walk on their own.
Planned Collaboration	Currently collaborating with Trauma Administration, Family Medicine, and Barrow Outpatient Rehab. Planned collaborations are with Foundation for Senior Living and/or other surrounding senior care/retirement communities.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS –
COMMUNITY BOARD - 2019 St. Joseph's Westgate Medical Center

BAYLESS, Justin CEO of Bayless Integrated Healthcare
DAVIS, 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
EGBO, M.D., Obinna Physician, President/CEO of Zion Medical Group, PLLC
GARCIA, M.D., Robert (ex-officio member) Chief of Medical Staff; St. Joseph's Hospital
GENTRY, Patti Commercial real estate broker
GONZALEZ, Sarah Consultant for local non-profit organizations
HEREDIA, Carmen *(Board Vice Chair)* Chief of Arizona Operations, Valle del Sol (non-profit organization)
HORN, Rick *(Board Chair)* Independent financial and retail advisor and corporate board member
HUNT, Linda (ex-officio member) President/CEO, Dignity Health Arizona Service Area
JONES, Sister Gabrielle Marie Sister of Mercy, retired hospital executive and nurse
KEARNEY, R.S.M., PsyD., Sister Kathleen Sister of Mercy, clinical psychiatrist
MORALES, Joanne Director of Refugee Programs, Catholic Charities Community Services
PALMER, Tom President, Claremont Capital Management, LLC (investment firm)
SCHEMBS, Jim Retired corporate CEO
SHARP, O.P., Sister Noreen Adrian Dominican Sister, retired attorney
SILVA, Margarita Immigration attorney; M. Silva Law Firm, PC
SIMKIN, Gayle Retired Infection Control Preventionist
SPELLERI, Maria *(Board Secretary)* Executive V.P. & General Counsel, Chicanos Por La Causa, Inc.
WHITE, Patty (ex-officio member) President/CEO, St. Joseph's Westgate Medical Center

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS – COMMUNITY HEALTH INTEGRATION NETWORK 2019
ST. JOSEPH'S HOSPITAL AND MEDICAL CENTER & ST. JOSEPH'S WESTGATE MEDICAL CENTER

- **Aguilar, Eileen,** Community Health Impact Analyst, Maricopa County Dept. of Public Health
- **Albright, Rosanne**, Brown Space Manager, City of Phoenix
- **Alice, Patricia,** USPI
- **Alonzo, Anna,** Manager of 2MATCH Program, St. Joseph's Hospital and Medical Center
- **Battis, Eric**, Chief Operations Officer, Adelante Healthcare
- **Bauer, John**, Director of Finance, St. Joseph's Hospital and Medical Center
- **Bethancourt, Bruce,** Chief Medical Officer, St Joseph's Hospital Medical Center
- **Brucato-Day, Tina,** Hospital Administrator, St. Joseph's Westgate Hospital
- **Cardenas, Lilliana,** Community Empowerment Office Manager, Maricopa County Dept. of Public Health
- **Crittenden, Sonora,** Program Manager, St. Joseph's Hospital and Medical Center
- **Dal Pra, Marilee**, Vice President of Programs, Virginia G. Piper Charitable Trust
- **Denstone, Damon,** Clinical Manager, St. Joseph's Westgate Medical Center
- **Garganta, Marisue**, Director of Community Health Integration & Community Benefit, St. Joseph's Hospital and Medical Center
- ***Gonzalez, Sarah,** Isaac School District
- **Graham, Julie,** Director of External Affairs, Dignity Health Arizona
- **Hassler, Andrea,** Senior Director of Nursing Services, St. Joseph's Hospital and Medical Center
- **Hillman, Deborah,** Chief of Staff, Mercy Care Plan
- **Hoffman, Terri,** President, St. Joseph's Foundation
- ***Horn, Rick,** Chair of St.Joseph's Hospital and Medical Center Community Board
- **Jewett, Matt**, Grants Manager, Mountain Park Health Center
- **Jones, Ashley,** Community Benefit Specialist, St. Joseph's Hospital and Medical Center
- **Krush, Leanne,** Vice President, Dignity Health Arizona General Hospitals
- **Mascaro, CarrieLynn,** Sr. Director of Programs, Catholic Charities
- **McBride, Sr. Margaret**, Vice President of Organizational Outreach, Dignity Health
- **McClain, Brett,** Chief Operating Officer, St. Joseph's Hospital and Medical Center
- **McWilliams, Barbara,** OASIS
- **Millard Hoie, Joyce,** Retired Nonprofit CEO in health and human services field
- **Mitros, Melanie**, Director of Strategic Community Partnerships, Vitalyst
- **Roberts, Mark,** Director of Care Coordination, St. Joseph's Hospital and Medical Center *****
- **Sklar, David,** Professor, School for the Science of Health Care Delivery, Senior Advisor to the Provost, Arizona State University
- ***Spelleri, Maria,** Executive V.P. & General Counsel, Chicanos Por La Causa, Inc.
- **Smith, Carrie**, Chief Operating Officer, Foundation for Senior Living
- **Smith, Vanessa,** SBMC
- **Tarango, Patricia,** Bureau Chief of Health System Development**,** Arizona Department of Health Services
- **Unrein, Serena,** Director, Arizona Partnership for Healthy Communities
- **VanMaanen, Pat**, Health Consultant, PV Health Solutions
- **Wilkinson, Tanya,** Director of Embedded Care, Arizona Care Network

**Indicates St. Joseph's Hospital Community Board Member and/or chair of CHIN*

APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs 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.

St. Joseph's Hospital and Medical Center (SJHMC) and St. Joseph's Westgate Medical Center (SJWMC), has three pillars: patient care, medical education and research. Physicians and researchers at St. Joseph's are dedicated to investigating and discovering new and powerful therapies with one ultimate goal - to enhance patient care. With both basic research laboratories as well as hundreds of clinical trials, patients have access to state-of-the-art treatments.

Medical education at St. Joseph's includes both educations for medical students through our partnership with Creighton University School of Medicine as well as post-medical school training through residency and fellowship programs. Creighton University School of Medicine started their Accelerated Nursing Program in 2018. Medical education at St. Joseph's includes both education for medical and nursing students through our partnership with Creighton University School of Medicine as well as post-medical school and nursing education training through residency and fellowship programs, with a specific emphasis on recruiting individuals who are culturally and linguistically diverse to serve the communities reflected within the community. These students, as part of their education, are in the community through their course work and volunteer opportunities providing assistance to the most vulnerable. As an example, the Creighton Nursing Students are providing clinical assessments, education and disease prevention at Maggie's Place, a residential setting for pregnant homeless mothers. Medical students are engaged at St. Vincent's de Paul's Adult and Pediatric Continuity Health Clinic providing health services to the working poor and those who are uninsured.

APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Summary Of Financial Assistance Programs

Dignity Health's Financial Assistance Policy describes the financial assistance programs available to uninsured or underinsured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care

- If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care

- If you are uninsured or underinsured with an annual family income between 200-500% of the Federal Poverty level, you will be charged the Amount Generally Billed (AGB), which is an amount set under federal law that reflects the amounts that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services that you received.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan.

You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital's Financial Assistance Policy and financial assistance application forms are available online at your hospital's website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to "Admitting" or "Registration"). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital's website, in your hospital's Admitting area, or by calling your hospital's telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital's Admitting area and can be reached at the telephone number listed below for your hospital.

Chandler Regional Medical Center 1955 W. Frye Road, Chandler, AZ 85224 | **Financial Counseling** 480-728-3564
Patient Financial Services 855-892-2400 | www.dignityhealth.org/chandlerregional/paymenthelp

Mercy Gilbert Medical Center 3555 S. Val Vista Drive, Gilbert, AZ 85297 | **Financial Counseling** 480-728-7281
Patient Financial Services 855-892-2400 | www.dignityhealth.org/mercygilbert/paymenthelp

St. Joseph's Hospital & Medical Center 350 W Thomas Road, Phoenix, AZ 85013 | **Financial Counseling** 602-406-4923
Patient Financial Services 877-877-8345 | www.dignityhealth.org/stjosephs/paymenthelp

St. Joseph's Westgate Medical Center 7300 N 99th Avenue, Glendale, AZ | **Financial Counseling** 866-556-8221
Patient Financial Services 877-877-8345 | www.dignityhealth.org/stjosephs/paymenthelp

Arizona_2016

Dignity Health.

Footnotes

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[ix] Arizona Department of Health Services (2018). Retrieved from https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php.
[x] Alzheimer's Association (2018). Retrieved from https://www.alz.org/alzheimers-dementia/what-is-alzheimers.
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[xiii] Center for Disease Control and Prevention (2018). Retrieved from https://www.cdc.gov/media/releases/2017/p0718-diabetes-report.html.
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[xv] Behavior Risk Factor Surveillance System (BRFSS), ADHS/CDC, analysis by MCDPH.
[xvi] Hospital Discharge Data from ADHS, analyzed by MCDPH
[xvii] Arizona Department of Health Services (2016). Analyzed by Maricopa County Department of Public Health.
[xviii] Center for Disease Control and Prevention (2017). Retrieved from https://www.cdc.gov/nchs/fastats/accidental-injury.htm.
[xix] Healthify is the leading software solution for addressing individuals' social determinants with care coordination between health care and community services.
[xx] The project described was supported by Funding Opportunity Number CMS- 1P1CMS331609-01-00 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.