Arizona General Hospital - Laveen

2025 - 2028 Community Health Implementation Strategy and Plan

Adopted October 2025

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At-a-Glance Summary

Community Served 	Arizona General Hospital Laveen (AGHL) serves residents of Maricopa County, Arizona—the fourth most populous county in the United States, with over 4.4 million people. Spanning 9,202 square miles, Maricopa County includes nearly five percent of Indigenous land and is home to several tribal nations, including the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation. Within AGHL's primary service area (PSA), many urban and suburban neighborhoods face significant health care access challenges. In 2023, areas such as Phoenix, Avondale, Laveen, and parts of the Gila River Indian Community were designated Health Professional Shortage Areas (HPSAs) due to limited provider availability and higher rates of infant mortality and low birth weight. The region also experiences shortages in mental health services, influenced by substance use prevalence and the large proportion of youth and older adult residents. Redeem Neighborhoods, a nonprofit 501(c)(3) organization, helped develop the Laveen Coalition under its fiscal sponsorship. As the community's first coalition, it serves a growing population of more than 80,000 residents. The Laveen Coalition is dedicated to improving community quality and strengthening neighborhoods by addressing issues such as youth substance misuse and related challenges. Through these efforts, the coalition works to enhance public health and promote the overall well-being of the Laveen community.
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 the hospitals intends to address with strategies and programs are: • **Mental Health** (Including All Mental and Behavioral Disorders) • **Chronic Conditions** (Including Cardiovascular Disease, Diabetes, Obesity) • **Cancer** (Including Breast Cancer) • **Access to Care** (Including Dental Health) • **Violence and Injury Prevention** • **Social Determinants of Health** (Including Housing and Homelessness, Access to Food)
Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including: **Mental Health**: Zero Sucide Initiative, Mission of Mercy of Arizona

Chronic Conditions: Chronic Disease Self-Management|DEEP(Diabetes Empowerment Education Program) and Dignity Health Healthier Living Program

Cancer: Hope & Healing Project and Maddy Mobile Mammography

Access to Care: Community Health Improvement Grants and Dignity Health Transitional Care Center

Violence and Injury Prevention: CommonSpirit Health's Human Trafficking Response Program, Stop the Bleed Classes and THRIVE|Violence Intervention Program

Social Determinants of Health: ACTIVATE: AllThrive365 and Circle the City

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the Community Health Department at 1750 E. Northrop Blvd., ste. #200, Chandler, AZ 85286 or by e-mail to chandler-chna@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

Dignity Health Arizona General Hospital Laveen (AGHL) is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Arizona General Hospital Laveen (AGHL) is one of eight acute care Dignity Health hospitals in the Arizona market. Dignity Health is a member of CommonSpirit Health, one of the largest health care systems in the nation. AGHL spans 39,000 square feet featuring 16 inpatient rooms, two state-of- the-art operating rooms for inpatient and outpatient surgical procedures, an emergency department, high complexity laboratory and a full radiology suite. It also operates four hospital satellite emergency departments throughout the west valley. AGHL provides 24/7 access to emergency medical care plus on-site digital X-ray, CT and ultrasound imaging technology. As of fiscal year 2024, AGHL had 311 employees and 463 physicians representing all major specialties.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

AGHL's community is defined as individuals residing within the primary service area (PSA) of AGHL. The PSA is defined by the top 75% of AGHL's inpatient and outpatient discharges and is outlined by zip codes that encompass all populations, including low-income and underserved populations.

The hospital, AGHL, is located in Maricopa County (outlined in orange below), the fourth most populous county in the U.S., with a population of over 4.4 million people. Covering 9,202 square miles, Maricopa County is comprised of nearly five percent of Indigenous land from tribes such as the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima Maricopa Indian Community, and Tohono O'odham Nation.

AGHL's PSA is unique in that it overlaps with the Gila River Indian Community (GRIC).During fiscal year 2023, the top 75% of patient encounters at AGHL came from the following zip codes: 85339, 85041, 85043, 85302, 85042, 85033, 85301, 85037, 85040, 85338, 85051, 85035, 85353, 85323, 85009, 85395, 85029, 85015, 85303.
Figure 1 displays a map of AGHL's community.

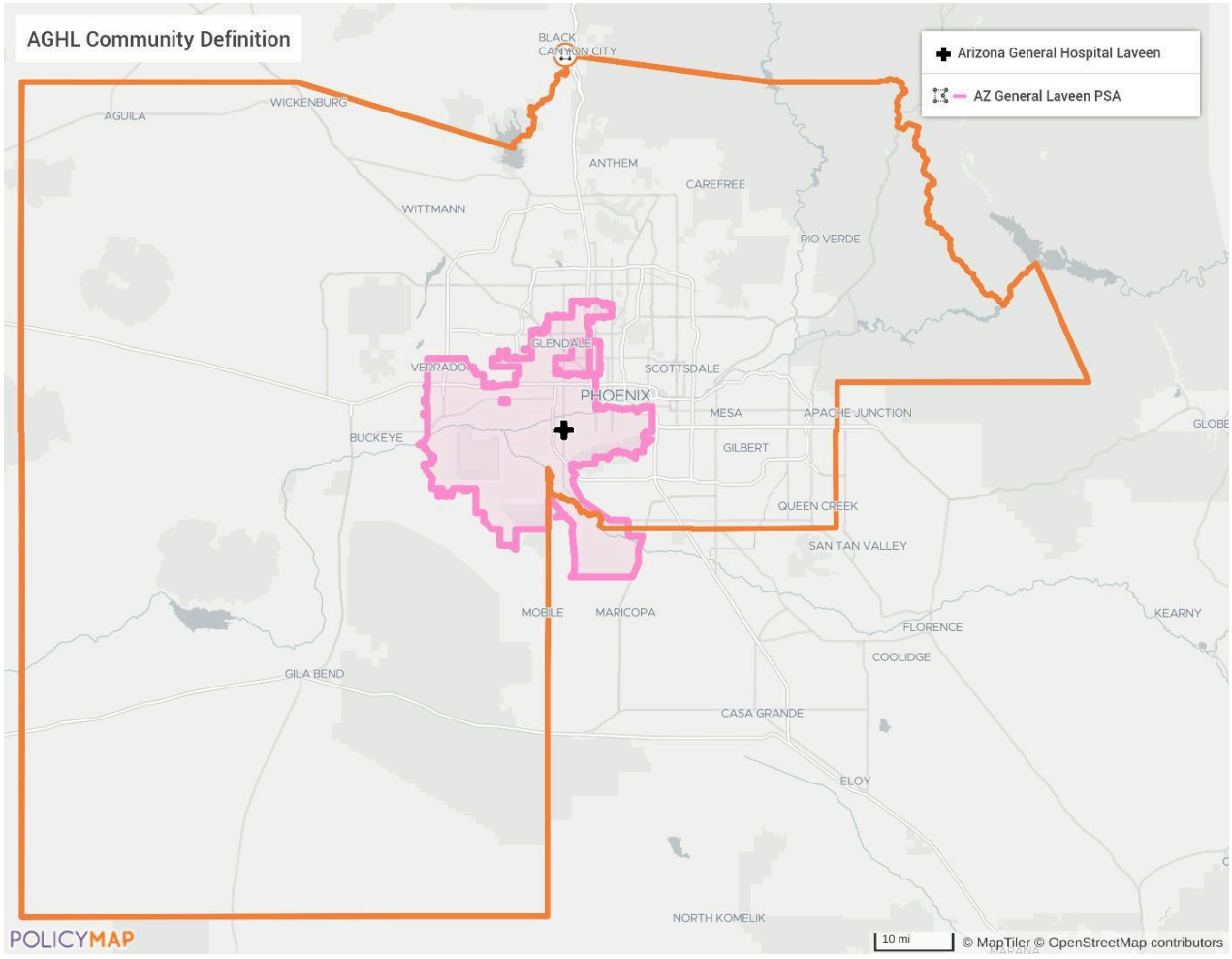


Figure 1. AGHL's Community Definition

Demographic and Socioeconomic Profile

Table 1 describes the 2022 demographic and socioeconomic profile of residents in AGHL's PSA, Maricopa County, and Arizona. For data related to health insurance type, only the PSA has Medicaid coverage specific to inpatient hospitalization (IP) and emergency department (ED).viii AGHL's PSA is predominantly a rural community, while Maricopa County and Arizona are both urban and rural.

	AGHL's PSA	Maricopa County	Arizona
Total Population Size	919,201	4,430,871	7,172,282
Population by Race/Ethnicity			
American Indian/Alaska Native (non-Hispanic)	2%	1%	4%
Asian and Native Hawaiian/Pacific Islander (non-Hispanic)	3%	4%	3%
Black/African American (non-Hispanic)	10%	5%	4%
White (non-Hispanic)	24%	53%	53%
Hispanic/Latino	59%	32%	32%
Population by Sex			
Male	50%	50%	50%
Female	50%	50%	50%
Population by Age Group			
0-14 years	23%	19%	18%
15-24 years	16%	14%	14%
25-44 years	30%	28%	26%
45-64 years	21%	24%	24%
65+ years	10%	16%	18%
Languages, among those 5 years and over			
Non-English Languages Spoken at Home	47%	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over			
Less than 9th grade	11%	5%	5%
9th – 12th grade, no diploma	11%	6%	6%
Employment Status			
Unemployed	6%	5%	5%
Median Household Income			
Income	$70,254	$80,675	$72,581
Poverty (based on income thresholds & family size)			
Below poverty level all ages	17%	12%	13%
Below poverty level all ages under 18 years	7%	16%	18%

Health Insurance Coverage			
Uninsured	17%	11%	11%
Health Insurance Type			
Medicaid	IP: 50%, ED: 58%	18%	21%
Health Professional Shortage Area	No	Yes	Yes
Medically Underserved Area	No	Yes	Yes
Medically Underserved, Low Income, Minority Populations	Not available	Medically Underserved, Low Income	Medically Underserved, Low Income
Number of Other Hospitals Serving the Community - 2023	8	66	138

Table 1. AGHL's PSA, Maricopa County, and Arizona Demographic and Socioeconomic Profile – 2022 ACS Census, HRSA MUA Finder, PolicyMap

Medically Underserved Areas

Medically underserved groups are those experiencing health disparities or inadequate access to care, often due to being uninsured or underinsured, or facing barriers, such as language, geographic location, financial constraints, and stigma. This also includes people with limited English proficiency and those who encounter difficulties in accessing care due to transportation issues or cost. The Arizona Medically Underserved Areas report, prepared biennially by the Arizona Department of Health Services, helps plan the delivery of primary care services.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Mental Health, including all Mental and Behavioral Disorders	Mental health conditions affect how individuals think, feel, and function in daily life. Many face barriers to timely care due to stigma, workforce shortages, limited resources, and lack of access to culturally appropriate mental health services.	☑
Chronic Conditions, including Cardiovascular Disease, Diabetes, and Obesity	Chronic conditions such as heart disease, diabetes, and obesity remain leading health concerns. These conditions often require long-term management and are influenced by lifestyle, access to care, and social determinants of health.	☑
Social Determinants of Health, including Housing and Homelessness and Access to Food	Stable housing, access to nutritious food, and supportive social environments are essential to health. Housing instability and food insecurity increase vulnerability to chronic disease and poor overall well-being.	☑
Access to Care, including Dental Health	Access to affordable, comprehensive healthcare—including preventive and oral health services—is vital for early detection, disease management, and improved health outcomes across all populations.	☑
Violence and Injury	Violence and injury are significant concerns, including human trafficking, other forms of exploitation, domestic violence, falls, and accidents. Prevention efforts emphasize trauma-informed education, early intervention, and the creation of safe, supportive environments for healing and resilience.	☑
Cancer, including Breast Cancer	Cancer continues to be a leading cause of illness and death, often resulting in significant physical, emotional, and financial strain. Early detection, treatment access, and survivorship support are critical to improving outcomes	☑

2025 Implementation Strategy and Plan

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

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

Creating the Implementation Strategy

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

Hospital and health system participants included CommonSpirit Health Community Health Department, Dignity Health East Valley; Community Health, Executive Leadership, Mission Integration, Trauma Services, Maternal Child Health, Care Coordination, Center for Transitional Care and Emergency Departments, Arizona General Hospitals Mesa and Laveen. Additional contributors included External Affairs, Communications, Marketing, Strategy, and Dignity Health Foundation - East Valley. The hospitals' community health programs involve departments beyond Community Health and Mission in their planning and operation.

Community input or contributions to this implementation strategy included Dignity Health East Valley Community Hospital Board, Community Health Committee (CHC) and Community Health Improvement Grants Program Committee composed of members in the community and Dignity Health. Community input included community leaders, community educators, executives and program managers from local nonprofit's, Maricopa County Department of Public Health, previously grant funded East Valley Community Health Improvement Grant Program recipients, and representatives of local municipalities and coalitions.

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

The prioritization process occurred in three phases:

Phase One – Indicator Review and Simplification
The East Valley Community Health team reviewed 73 health and social indicators provided by the Maricopa County Department of Public Health. To focus efforts, the team reduced the list to 30 indicators that best reflected community disparities, AGHL's focus areas, and relevance to local needs.

Phase Two – CHNA Prioritization Workshops
AGHL and the County Health Department convened two workshops. In the first, stakeholders scored all 30 indicators against criteria such as population impact, community voice, feasibility, organizational alignment, and partner fit. The second workshop refined the list to 15, and then through discussion and analysis to six priority needs.

Phase Three – Final Consensus of CHNA Priorities
The East Valley Community Health team and Community Health Committee reviewed the results and reached consensus on six primary health and social priorities (with sub-priorities). These recommendations were approved by the CHC and adopted by the hospital board.

This process can be reviewed in more detail in the CHNA posted on the Arizona General Hospital Laveen website.

Basis for Selecting Programs and Initiatives

The programs and initiatives in this plan are designed to respond to the identified priorities and are guided by CommonSpirit's Well-Being Portfolio and the Vital Conditions for Health and Well-Being framework, which emphasize both addressing urgent service needs and investing in the long-term conditions that allow people and communities to thrive.

AGHL will use the following criteria and strategies to select and design programs:

Alignment with Vital Conditions & Well-Being Portfolio
Programs will be developed or adapted to strengthen vital conditions such as social connectedness, basic needs, and access to meaningful work and education, ensuring that strategies not only address illness but also foster long-term community well-being.

Use of Evidence-Based and Research-Supported Interventions
Initiatives will be grounded in interventions supported by research and national best practices. For example, Exercise for Preventing Falls in Older People Living in the Community (Cochrane review) demonstrates that targeted exercise programs can reduce falls in community-dwelling older adults (ODPHP resource).

Adaptation and Expansion of Partner Programs
When effective programs are already operating in the community, AGHL will collaborate with partners to adapt, expand, or replicate them to achieve greater reach and sustainability.

Feasibility and Organizational Capacity
Programs have been selected with consideration of available staff expertise, funding, and infrastructure to ensure realistic and sustainable implementation.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs.

Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

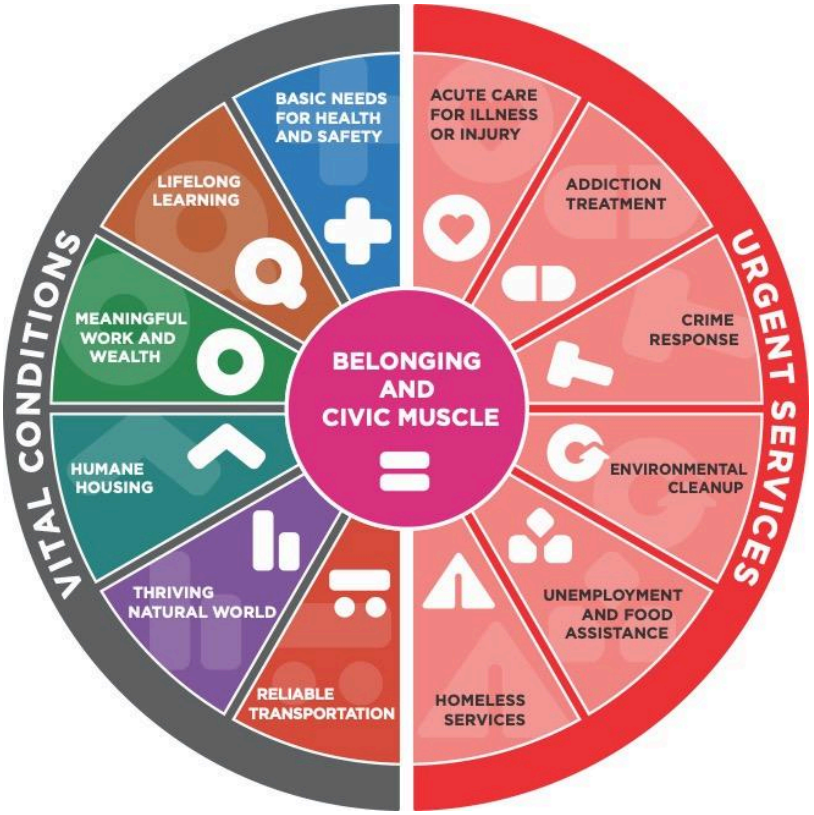
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan

The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.



[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

Strategies and Program Activities by Health Need

Health Need:	**Mental Health,** including All Mental and Behavioral Disorders				
Population(s) of Focus:	Individuals and families living in AGHL's primary and secondary service areas who encounter barriers to timely, affordable, and culturally appropriate mental health and substance use care.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Mission of Mercy of Arizona	Operating free, mobile primary care clinics across Maricopa County, serving medically underserved and uninsured populations.	☑	☐	☑	VC: Basic Needs for Health and Safety
MIND 24-7	A 24-hour urgent psychiatric clinic that accepts walk-in visits, offering crisis stabilization and referral services.	☐	☑	☐	US: Acute Care for Illness or Injury
Planned Resources:	Internal departments and local coalition support, including Emergency Department, Care Coordination, Mission Integration, and Redeem Neighborhoods Laveen Coalition and volunteers. Resources include limited funding, meeting space, and training to strengthen behavioral health outreach and coordination efforts in Laveen.				
Planned Collaborators:	External collaborators may include Mission of Mercy, Mountain Park Health Center, and Adelante Healthcare for primary care access; NAMI Arizona for peer support and education; and Maricopa County Community Resources and 211 for public health coordination and crisis services across the Laveen and Phoenix areas.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased access to and utilization of mental and behavioral health services; improved awareness and reduced stigma.	Number of individuals served, screened, referred; participation rates in support groups, outreach events, and community interventions	Hospital program data and Care Coordination metrics.
Strengthened coordination between healthcare providers and community-based resources; improved mental well-being of residents	Number of formalized partnerships; changes in community-level mental health indicators (e.g. self-reported well-being, crisis encounters, ED mental health visits).	CHNA surveys, Maricopa County and Arizona Department of Health Services data, partner reporting.

Health Need:	**Chronic Conditions,** including Cardiovascular Disease, Diabetes, and Obesity				
Population(s) of Focus:	Individuals in AGHL's primary and secondary service areas, with emphasis on those at risk for or living with chronic conditions such as cardiovascular disease, diabetes, obesity, and related risk factors.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**

Health Need:	**Chronic Conditions,** including Cardiovascular Disease, Diabetes, and Obesity				
Chronic Disease Self-Management / DEEP (Diabetes Empowerment Education Program)	Offers self-management workshops offered in both English and Spanish, through community partnerships, empowering individuals with pre-diabetes and diabetes to understand their condition, make healthy choices, and prevent complications.	☑	☐	☐	VC: Lifelong Learning
Dignity Health Healthier Living Program	A free, evidence-based program that provides tools and strategies to help participants manage chronic conditions and improve their overall health and quality of life, offered in both English and Spanish for broader accessibility.	☐	☑	☐	VC: Lifelong Learning
Planned Resources:	Internal departments, community health educators, SJHMC Cardiovascular Clinic and care coordination department.				
Planned Collaborators:	External collaborators AllThrive365, and Mountain Park Health Center will help expand education, screening, and referral pathways to address obesity, diabetes, and cardiovascular disease in the community.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased adoption of healthy behaviors, improved chronic condition management, and reduced complications related to cardiovascular disease, diabetes, and obesity.	Number of participants enrolled in programs, screenings, or support groups; participation rates in self-management	Hospital and Care Coordination data (including CBISA), Community Health Improvement Grant

	and educational activities.	reports, and partner evaluations.
Strengthened coordination between healthcare providers and community programs, improving quality of life and reducing financial burdens for vulnerable populations.	Number of partnerships and referrals; changes in clinical and community-level health indicators (e.g., blood pressure, blood glucose, readmissions).	Program-specific evaluation reports, CHNA data, and local/state public health data (MCDPH, Arizona Department of Health Services).

Health Need:	**Social Determinants of Health,** including Housing, Homelessness and Access to Food				
Population(s) of Focus:	Individuals and families in AGHL's primary and secondary service areas—including Laveen, South Phoenix, and surrounding communities—experiencing housing instability, homelessness, or barriers to accessing affordable, nutritious food.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
ACTIVATE | AllThrive365	Offers personalized case management through Patient Care Advocates who connect individuals to community-based services, such	☑	☑	☐	VC: Basic Needs for Health and Safety

Health Need:	**Social Determinants of Health,** including Housing, Homelessness and Access to Food				
	as housing, food, and transportation resources, helping address barriers to stability and self-sufficiency.				
Circle the City	Provides medical respite and transitional housing for individuals experiencing homelessness, offering comprehensive care coordination and supportive services to promote long-term recovery and housing stability.	☐	☑	☑	VC: Basic Needs for Health and Safety
Planned Resources:	Internal hospital departments and staff, including Care Coordination, Mission Integration, and Community Health outreach programs. Additional support will come from hospital initiatives such as ACTIVATE, Community Health Workers, the Financial Assistance Program, and Health Equity Plan activities to strengthen access and resource navigation for residents in Laveen and South Phoenix.				
Planned Collaborators:	Key partners include Chicanos por la Causa / Keogh Health Connection for care navigation, insurance enrollment, and SNAP benefits assistance, as well as Helping Families in Need at Cesar Chavez Library, which supports residents with benefits enrollment and resource connections.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved access to safe housing, nutritious food, and essential social services, reducing risk factors for chronic disease, poor nutrition, and other health disparities.	Number of individuals connected to essential resources; participation rates in navigation and support programs.	Hospital and Care Coordination program data (including CBISA), partner agency reports, and CHNA data.
Enhanced community capacity and empowerment to address social determinants of health, supporting long-term well-being.	Number of partnerships, referrals, and community collaborations addressing	ACTIVATE, and local/state public health and social service data.

	SDOH; self-reported improvements in access to services.	

Health Need:	**Access to Care,** including Dental Health				
Population(s) of Focus:	Individuals and families in AGHL's primary and secondary service areas, who are uninsured, underinsured, or face barriers to accessing preventive, primary, dental, or specialty care.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Health Improvement Grants	Programs that expand access to medical and dental services, provide transportation vouchers for healthcare appointments, and promote education around prevention and chronic disease management.	☑	☑	☐	VC: Basic Needs for Health and Safety
Dignity Health Transitional Care Center	Assists recently discharged patients by linking them to primary and specialty care providers, coordinating follow-up appointments, and improving continuity of care to reduce hospital readmissions.	☑	☐	☑	VC: Basic Needs for Health and Safety
Planned Resources:	Internal hospital departments and staff, including Care Coordination, Executive Leadership, and Community Health department outreach programs, Hospital initiatives, Patient Financial Assistance, and Health Equity Plan activities.				
Planned Collaborators:	Community-based partners and healthcare providers in the Laveen and South Phoenix areas, including				

Health Need:	**Access to Care,** including Dental Health
	Wesley Community & Health Centers, Mountain Park Health Center, Adelante Healthcare, and local dental associations, along with advocacy groups and school-based health initiatives focused on preventive care and oral health access.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Expanded access to preventive, primary, and dental health services for underserved residents.	Number of individuals receiving preventive care, dental services, or vaccinations.	Hospital and Care Coordination program data (including Community Benefit Data via C.B.I.S.A.) and partner program reports.
Improved health equity and continuity of care for vulnerable populations, reducing avoidable hospital visits and improving long-term health outcomes.	Number of coordinated referrals, follow-up appointments, and care transitions completed.	CHNA data, MCDPH/ADHS public health data, and program evaluation results.

Health Need:	**Violence and Injury**	
Population(s) of Focus:	Individuals and families in Laveen and South Phoenix who are affected by or at risk for violence, including human trafficking, domestic violence, and trauma-related injuries. This population includes youth, women, and vulnerable adults who experience barriers to safety, trauma recovery, and access to supportive services.	
Strategy or Program	Summary Description	Strategic Alignment

Health Need:	**Violence and Injury**				
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
CommonSpirit Health's Human Trafficking Response Program	Provides trauma-informed training, screening tools, and outreach resources to help healthcare providers identify and support survivors of human trafficking and connect them to safe, coordinated care.	☑	☑	☐	VC: Basic Needs for Health and Safety
Stop the Bleed Classes	Offers free community training in emergency bleeding control, teaching participants how to apply pressure, pack wounds, and use tourniquets—empowering residents to respond to injuries and save lives.	☐	☑	☑	VC: Basic Needs for Health and Safety
THRIVE Violence Intervention Program	Provides hospital- and community-based support for individuals recovering from violent injury, connecting them to counseling, case management, and community resources to promote healing and break cycles of violence.	☑	☐	☑	VC: Basic Needs for Health and Safety
Planned Resources:	Hospital Trauma Services Department, Emergency Department staff, Multidisciplinary Human Trafficking Task Force, and Community Health and Health Equity teams providing trauma-informed training, education, and coordination of care.				
Planned Collaborators:	Local partners in the Laveen and South Phoenix areas, including A New Leaf, Chicanos por la Causa, Jewish Family & Children's Service, Phoenix Dream Center, faith-based organizations, as well as law enforcement and Community Health Improvement Grants awardees focused on violence prevention				

Health Need:	**Violence and Injury**
	and trauma recovery.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Expanded access to trauma-informed and survivor-centered care for individuals impacted by violence and human trafficking.	Number of individuals screened, referred, or served through hospital and partner programs.	Program reports, CBISA data, hospital and Care Coordination records.
Improved collaboration among healthcare, social services, and public safety agencies to reduce community violence and improve long-term well-being.	Number of training, community interventions, and partnerships established.	CHNA data, MCDPH/ADHS public health data, and program evaluation reports.

Health Need:	**Cancer,** including Breast Cancer				
Population(s) of Focus:	Adults and families in the Laveen and South Phoenix areas who are uninsured, underinsured, or at risk for late-stage cancer diagnoses due to barriers such as cost, transportation, and limited access to screening, treatment, and survivorship support.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Hope and Healing Project	Provides holistic mental health and family support services for children and families impacted by cancer, offering counseling, wellness	☑	☐	☑	VC: Basic Needs for Health and Safety

Health Need:	**Cancer,** including Breast Cancer				
	activities, and emotional care to strengthen resilience.				
Maddy the Mobile Mammography Coach	The coach is operated by Arizona Diagnostic Radiology and Dignity Health. It provides state-of-the-art breast cancer screening to underserved populations across the Laveen and South Phoenix, expanding access to early detection and promoting equitable, community-based care	☑	☑	☐	VC: Basic Needs for Health and Safety
Planned Resources:	Hospital Oncology, Imaging, and Women's Health departments; Community Health Improvement Grants; outreach and education staff; Arizona Diagnostic Radiology; and Patient Financial Assistance programs to support equitable access to cancer screening and treatment.				
Planned Collaborators:	American Cancer Society–Arizona, Cancer Action Network, Desert Cancer Foundation of Arizona, local Federally Qualified Health Centers (FQHCs), and community-based organizations in Laveen and South Phoenix that promote early detection, treatment access, and survivorship support.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increased early detection, improved access to treatment, and reduced disparities in cancer outcomes for Laveen and South Phoenix residents.	Number of screenings, diagnostic follow-ups, and participants in cancer education or navigation programs.	Hospital and partner program data, CBISA, and Community Health Improvement Grant reports.
Improved survivorship, quality of life, and community awareness through education, prevention, and supportive care programs.	Participation rates in support and wellness programs; improvements	CHNA data, MCDPH/ADHS public health data, and

	in screening compliance and follow-up care.	program evaluation reports.