# Arizona General Hospital - Mesa

# 2025 - 2028 Community Health Implementation Strategy and Plan

**Adopted October 2025**


Dignity Health®
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## At-a-Glance Summary

**Community Served**

Arizona General Hospital Mesa (AGHM) serves Maricopa County, the fourth most populous county in the U.S. with over 4.4 million residents. This vast county spans 9,202 square miles and includes significant Indigenous land, home to the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and the Tohono O'odham Nation.

The City of Mesa, guided by "The Mesa Way" principles of Innovation, Inclusion, and Outstanding Services, is committed to providing equitable and transparent services. Mesa's Strategic Priorities emphasize community trust, transparency, engagement, and collaboration with residents and partners.

Insights from the 2023 Maricopa County Community Health Needs Assessment, which surveyed 1,657 residents, highlight the diverse strengths and health priorities within Mesa's service area. The survey also identified key challenges impacting quality of life, including:

- Access to affordable housing (37%)
- Ability to communicate with local leadership and feel heard (30%)
- Access to quality, affordable childcare (28%)

**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, Spiritual Care for those with Mental Illness & Support Group and Journey of Motherhood

**Chronic Conditions**: Healthier Living Program Workshops and Stroke Survivor Support Group

**Cancer**: Wellness Classes (Chair Yoga, Tai Chi), Support Groups (prostate cancer and breast cancer)

**Access to Care**: Building Blocks program (hearing & vision screening, referrals) and Immunization Clinics

**Violence and Injury Prevention**: Medical Safe Haven, Trauma Survivors Network and Fall Prevention

**Social Determinants of Health**: Pathways to Wellness Program (Community Health Workers) and Community Health Improvement Grant Program

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 mercy-chna@commonspirit.org.

# Our Hospital and the Community Served

## About the Hospital

Dignity Health Arizona General Hospital Mesa (AGHM) 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 Mesa (AGHM) 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. AGHM is a 90,000-square-foot facility featuring new approaches to health care utilizing the most innovative materials and technology to promote patient safety, patient satisfaction, and medical efficiency. AGHM operates eight hospital satellite emergency departments throughout the East Valley. It has four operating rooms, a 14-bed 24/7 emergency department and an intensive care unit. As of fiscal year 2024, AGHM had 550 employees and 650 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

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

The hospital, AGHM, 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.

AGHM'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 AGHM came from the following zip codes: 85212, 85209, 85339, 85041, 85207, 85142, 85225, 85208, 85215, 85205, 85120, 85282, 85044, 85204, 85143, 85283, 85048, 85138, 85296, 85043, 85042, 85233, 85301, 85206, 85201, 85147, 85286, 85033, 85203, 85338, 85234, 85249, 85119, 85213, 85132, 85298, 85302, 85140, 85037. Figure 1 displays a map of AGHM's community.

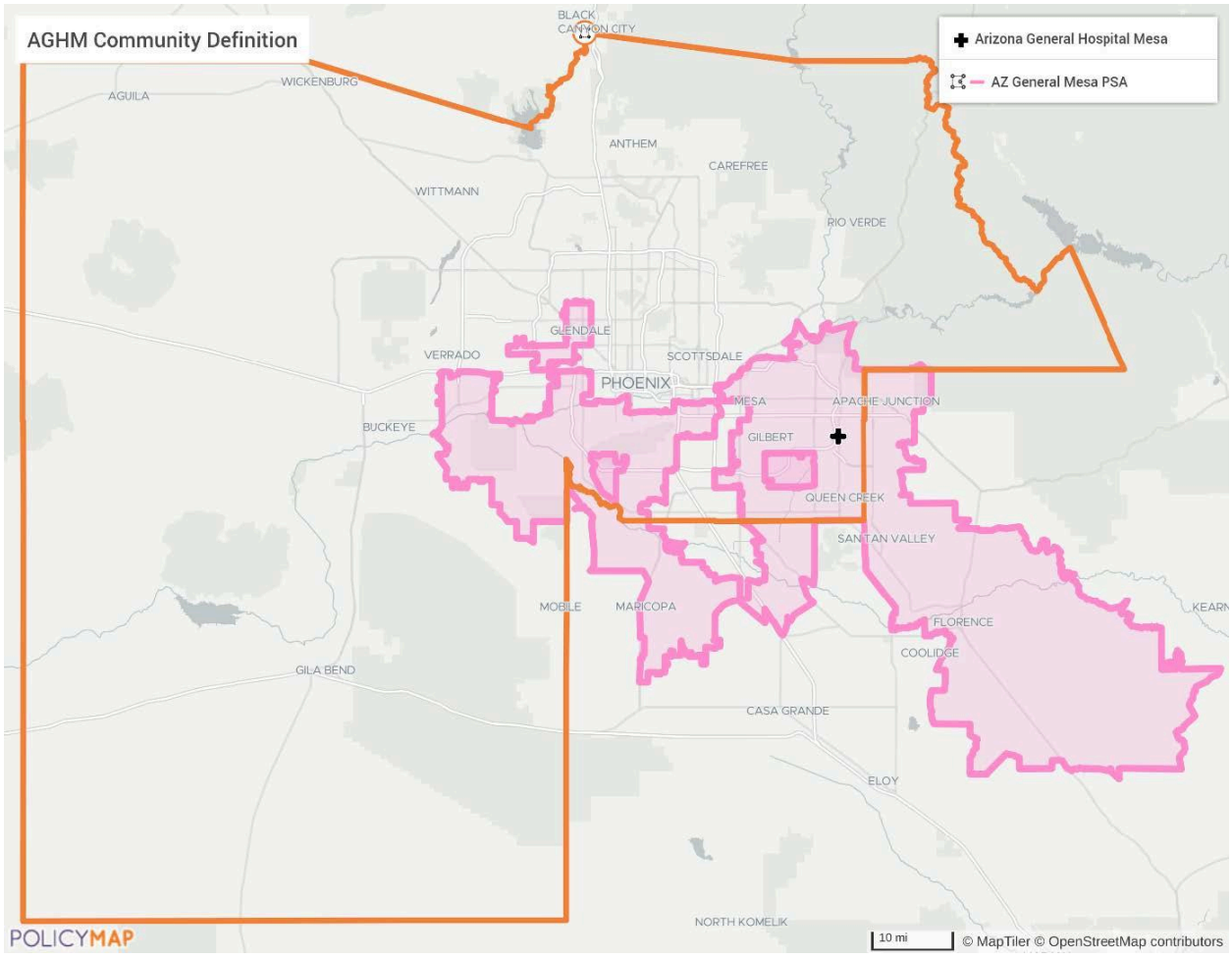



Figure 1. AGHM's Community Definition

## Demographic and Socioeconomic Profile

Table 1 describes the 2022 demographic and socioeconomic profile of residents in AGHM'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). AGHM's PSA is predominantly an urban and suburban community, while Maricopa County and Arizona are both urban and rural.

| | AGHM's PSA | Maricopa County | Arizona |
|---|---|---|---|
| Total Population Size | 1,781,556 | 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) | 4% | 4% | 3% |
| Black/African American (non-Hispanic) | 6% | 5% | 4% |
| White (non-Hispanic) | 52% | 53% | 53% |
| Hispanic/Latino | 33% | 32% | 32% |
| **Population by Sex** | | | |
| Male | 50% | 50% | 50% |
| Female | 50% | 50% | 50% |
| **Population by Age Group** | | | |
| 0-14 years | 21% | 19% | 18% |
| 15-24 years | 13% | 14% | 14% |
| 25-44 years | 28% | 28% | 26% |
| 45-64 years | 24% | 24% | 24% |
| 65+ years | 14% | 16% | 18% |
| **Languages, among those 5 years and over** | | | |
| Non-English Languages Spoken at Home | 26% | 26% | 26% |
| **Population by Educational Attainment (Less than a high school diploma), among those 25 years and over** | | | |
| Less than 9th grade | 5% | 5% | 5% |
| 9th – 12th grade, no diploma | 6% | 6% | 6% |
| **Employment Status** | | | |
| Unemployed | 5% | 5% | 5% |
| **Median Household Income** | | | |
| Income | $88,339 | $80,675 | $72,581 |
| **Poverty (based on income thresholds & family size)** | | | |
| Below poverty level all ages | 11% | 12% | 13% |
| Below poverty level all ages under 18 years | 4% | 16% | 18% |

| Health Insurance Coverage | | | |
|---|---|---|---|
| Uninsured | 11% | 11% | 11% |
| **Health Insurance Type** | | | |
| Medicaid | IP: 31%, ED: 43% | 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 | 17 | 66 | 138 |

**Table 1. AGHM'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, AGHM's focus areas, and relevance to local needs.

### Phase Two – CHNA Prioritization Workshops
AGHM 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 Mesa 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.

AGHM 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, AGHM 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.

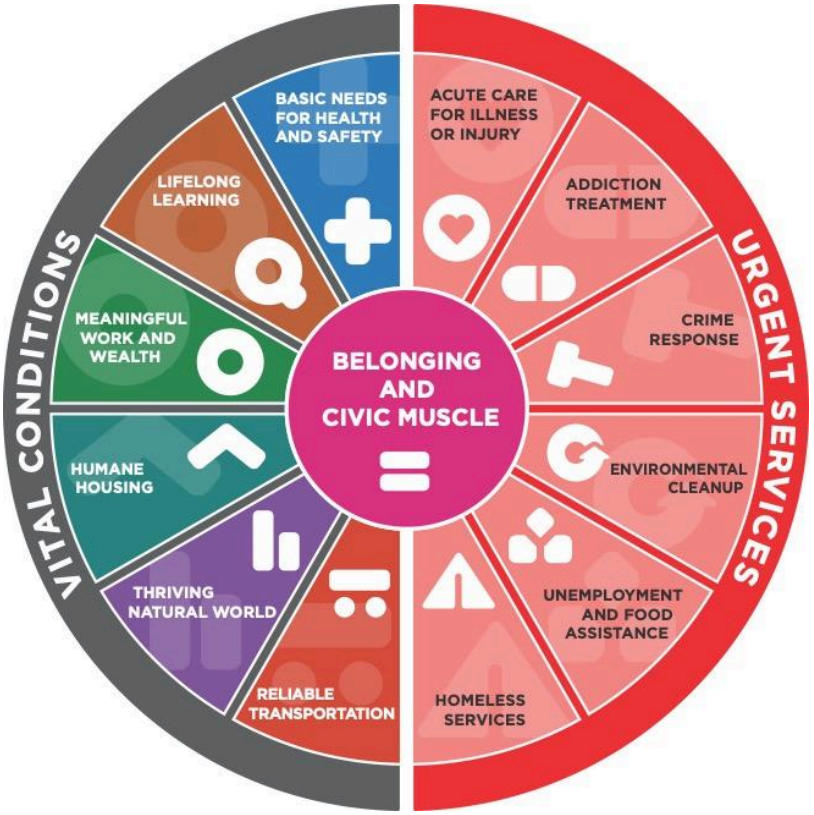
**What are Vital Conditions?**
**These are characteristics of places and institutions that all people need all the time to be healthy and well.** The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions 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 in AGHM primary and secondary service areas who experience barriers to accessing timely, affordable, and culturally appropriate mental health services. | | | | |
| 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)** |
| Nurtured Beginnings: Bridging Access to Behavioral Health in Maternal Care | Provides bedside support, referrals, and NICU-focused support groups. Certified Perinatal Peer Coaches assist mothers before discharge to ensure continuity of care. | ☑ | ☐ | ☐ | VC: Basic Needs for Health and Safety |
| Dignity Health Zero Suicide Initiative | Implements a hospital-wide transformation toward safer suicide care using a practical toolkit, training, and evidence-based framework to prevent suicide and improve patient safety. | ☐ | ☑ | ☐ | US: Acute Care for Illness or Injury |
| Dignity Health Spiritual Care Support Groups | Offers 8-week group sessions integrating spirituality with mental health, promoting well-being, and providing support and referrals for individuals with general or serious mental illness. | ☐ | ☐ | ☑ | VC: Basic Needs for Health and Safety |
| **Planned Resources:** | Internal hospital departments and staff, including AGHM Maternal and Child Health, Care Coordination, Emergency Department, Mission Integration, Quality and Compliance, Executive Leadership, and CommonSpirit Community Health Executive Leaders. | | | | |

| | |
|---|---|
| **Health Need**: | **Mental Health,** including All Mental and Behavioral Disorders |
| **Planned Collaborators:** | External partners advancing community mental health initiatives, including advocacy organizations, civic groups, community agencies, chambers of commerce, school administrators, student leaders, hospital associations, residency programs, healthcare providers, and Community Health Improvement Grants awardees focused on mental health. |

| Anticipated Impacts (overall long-term goals) | Measure | Data Source |
|---|---|---|
| Increased access to and utilization of mental and behavioral health services, improved community awareness, and reduced stigma. | Number of individuals served, screened, or referred, and participation rates in support groups and community interventions. | Hospital and Care Coordination program data and Community Health Improvement Grants reports. |
| Strengthened coordination between healthcare providers and community-based resources, enhancing mental well-being and quality of life for residents in AGHM's service areas. | Number of collaborative partnerships and changes in community-level mental health indicators (e.g., self-reported well-being, crisis encounters). | Community Health Needs Assessment (CHNA) data and local/state public health data (e.g., Maricopa County Department of Public Health MCDPH, Arizona Department of Health Services ADHS). |

| **Health Need**: | **Chronic Conditions,** including Cardiovascular Disease, Diabetes, and Obesity | | | | |
|---|---|---|---|---|---|
| **Population(s) of Focus:** | Individuals in AGHM's primary and secondary service areas, with emphasis on those at risk for or living with chronic conditions, including 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)** |
| Dignity Health Yoga of the Heart / WomenHeart Health Support Group | Offers meditation to reduce blood pressure,blood glucose, and heart rate. WomenHeart provides education and resources to help women manage heart health. | ☑ | ☐ | ☐ | VC: Basic Needs for Health and Safety |
| Dignity Health Healthier Living Program | Provides programs for participants with chronic conditions, pain, diabetes, or fall risk, teaching self-management skills at no cost. | ☐ | ☑ | ☐ | VC: Lifelong Learning |
| Dignity Health Pathways to Wellness | CHWs partner with adults 50+ post-discharge to provide care navigation, support chronic condition management, connect participants to community resources, and promote long-term well-being. | ☑ | ☐ | ☐ | VC: Lifelong Learning |
| **Planned Resources:** | Internal hospital departments and staff, including the Dignity Health Foundation East Valley, Care Coordination, Executive Leadership, and Chandler Transitional Care Center, along with CommonSpirit Health initiatives such as the Pathways Community HUB (PCH) through the Pathways to Wellness program. | | | | |
| **Planned Collaborators:** | External partners, including community-based organizations, agencies, school districts, chambers of commerce, residency programs, healthcare providers, and Community Health Improvement Grants | | | | |

| | |
|---|---|
| **Health Need**: | **Chronic Conditions,** including Cardiovascular Disease, Diabetes, and Obesity |
| | awardees focused on chronic condition interventions. |

| Anticipated Impacts (overall long-term goals) | Measure | Data Source |
|---|---|---|
| Increased adoption of healthy behaviors, improved chronic condition management, and reduced cardiovascular, diabetes, and obesity-related complications, with streamlined care coordination emphasizing prevention. | Number of participants enrolled in programs, screenings, or support groups, and participation rates in self-management and educational activities. | Hospital and Care Coordination program data (including Community Benefit Data via C.B.I.S.A.), Community Health Improvement Grants and partner reports. |
| Strengthened coordination between healthcare providers and community programs, enhancing quality of life, health outcomes, and financial protection by reducing out-of-pocket expenditures for vulnerable populations. | Number of partners, referrals, and changes in clinical or community-level health indicators (e.g., blood pressure, blood glucose, cholesterol, readmissions). | Program-specific evaluation reports, CHNA data, and local/state public health data (e.g., 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 AGHM's primary and secondary service areas experiencing housing instability, homelessness, or barriers to accessing sufficient, 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)** |
| East Valley Senior Home Sharing Program | Prevents senior homelessness by matching at-risk older adults to safely share housing, improving stability, financial security, and social connection. | ☑ | ☐ | ☐ | VC: Humane Housing |
| Destination Diploma | Supports high school students experiencing homelessness East Valley schools through counseling, meals, stipends, and essential resources. | ☐ | ☑ | ☐ | US: Food Assistance |
| East Valley FrescaZona Medical Food Box | Provides medically tailored food boxes, nutrition plans, and food prescriptions to patients referred by Dignity Health Medical Group Family Medicine Residents. | ☐ | ☑ | ☐ | VC: Basic Needs for Health and Safety |
| ACTIVATE (AllThrive365) | Offers one-on-one support through Patient Care Advocates, connecting patients to community resources, educational materials, and durable medical equipment (DME). | ☐ | ☐ | ☑ | VC: Lifelong Learning |
| Dignity Health Pathways | Community Health Worker provides | ☑ | ☐ | ☐ | VC: Lifelong |

| **Health Need**: | **Social Determinants of Health**, including Housing, Homelessness and Access to Food | | | | |
|---|---|---|---|---|---|
| to Wellness | home visits for adults 50+ with chronic disease, partnering to create action plans and connect patients to housing, food, and community resources, promoting long-term well-being. | | | | Learning |
| **Planned Resources:** | Internal hospital departments and staff, including Care Coordination, Executive Leadership, and Chandler Transitional Care Center, along with hospital initiatives such as Mission and Ministry Fund & Pathways to Wellness and Patient Financial Assistance. | | | | |
| **Planned Collaborators:** | Community agencies, advocacy organizations, civic groups, school districts, healthcare providers, and Community Health Improvement Grants awardees addressing housing, homelessness, and food access. | | | | |

| Anticipated Impacts (overall long-term goals) | Measure | Data Source |
|---|---|---|
| Improved access to safe housing, nutritious food, and essential resources, reducing priority risk factors for non-communicable and communicable diseases, violence and injury, and poor nutrition through multi-sector approaches. | Number of individuals connected to housing, food, or essential resources, and participation rates in navigation or support programs. | Hospital and Care Coordination program data (including Community Benefit Data via C.B.I.S.A.)and partner agency reports. |
| Populations are empowered to control their health through health promotion programs and community engagement. | Number of partnerships, referrals, and community collaborations addressing social determinants of health. | Program evaluation data from Pathways to Wellness, ACTIVATE, and Connected Community Network; CHNA data; local and state public health and social service data. |

| **Health Need**: | **Access to Care,** including Dental Health, | | | | |
|---|---|---|---|---|---|
| **Population(s) of Focus:** | Individuals and families in AGHM'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)** |
| Dignity Health Children's and Adult's Vaccine Program | Provides no-cost immunizations for uninsured, underinsured, AHCCCS, or American Indian/Alaskan Native populations. Clinics are located at Chandler CARE & Gilbert Heritage Center and mobile sites/events throughout the East Valley. | ☑ | ☐ | ☐ | VC: Basic Needs for Health and Safety |
| Dignity Health Transitional Care Center | Supports chronically ill patients recently discharged from the hospital by connecting them to providers, facilitating orders, and helping navigate post-discharge care to ensure successful transitions and reduced readmissions. | ☑ | ☐ | ☐ | VC: Basic Needs for Health and Safety |
| Compassion Connect | In partnership with Hope Heart Heal, Compassion Connect Arizona, and Amore Senior Support Network, expands access to primary care, dental, pharmacy, and case management services for underserved community members. | ☐ | ☐ | ☑ | VC: Basic Needs for Health and Safety |

| | |
|---|---|
| **Health Need**: | **Access to Care,** including Dental Health, |
| **Planned Resources:** | Internal hospital departments and staff, including Care Coordination, Executive Leadership, and Community Health department outreach programs, Hospital initiatives such as Pathways to Wellness, Connected Community Network, Patient Financial Assistance, and Health Equity Plan activities. |
| **Planned Collaborators:** | Community-based organizations, advocacy groups, school districts, healthcare providers, dental associations, and Community Health Improvement Grants awardees focused on access to care and preventive health. |

| Anticipated Impacts (overall long-term goals) | Measure | Data Source |
|---|---|---|
| Improved access to preventive, primary, and dental care, including vaccinations and oral health services. | Number of individuals served, vaccinated, or receiving preventive/dental care. | Hospital and Care Coordination program data (including Community Benefit Data via C.B.I.S.A.) and program reports. |
| Strengthened care transitions, reduced readmissions, and enhanced health equity for vulnerable populations. | Number of care transitions completed, referrals coordinated, and participation in community-based programs. | Community Health Needs Assessment (CHNA) data and local/state public health data (e.g., MCDPH, ADHS). |

| | | |
|---|---|---|
| **Health Need**: | **Violence and Injury** | |
| **Population(s) of Focus:** | Individuals in AGHM's primary and secondary service areas affected by or at risk for violence, including human trafficking, domestic violence, and other trauma-related injuries. | |
| 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 Medical Safe Haven | Provides trauma-informed care within the Dignity Health Family Medicine Clinic tailored to the complete physical, emotional, and social needs of human trafficking survivors. | ☑ | ☐ | ☐ | US: Crime Response |
| CommonSpirit Health's Human Trafficking Response Program | Offers educational modules, reference guides, and victim outreach resources to equip providers and staff with trauma-informed approaches to identify and support survivors. | ☐ | ☑ | ☐ | VC: Basic Needs for Health and Safety |
| Compassion Connect: East Valley Collaborative Response to Human Trafficking | Expands access to primary care, case management, and supportive services for survivors through coordinated community-based partnerships. | ☐ | ☐ | ☑ | US: Crime Response |
| Matter of Balance Class | Award-winning program designed to prevent falls, improve balance, and increase activity levels among older adults in the East Valley. | ☐ | ☑ | ☐ | VC: Basic Needs for Health and Safety |
| **Planned Resources:** | Internal hospital departments and staff, including the Trauma Services Department, hospital-based Multidisciplinary Human Trafficking Task Force, and initiatives focused on advancing health equity and trauma-informed care. | | | | |
| **Planned Collaborators:** | Community-based organizations, advocacy groups, school districts, chambers of commerce, healthcare | | | | |

| **Health Need**: | **Violence and Injury** |
|---|---|
| | providers, law enforcement, social service agencies, youth service programs, and Community Health Improvement Grants awardees focused on violence and injury. |

| Anticipated Impacts (overall long-term goals) | Measure | Data Source |
|---|---|---|
| Strengthened access to trauma-informed care and supportive services for survivors of violence and human trafficking. | Number of individuals screened, referred, or served through violence and trafficking programs. | Program impact reports, hospital and Care Coordination data. |
| Improved coordination among healthcare, law enforcement, and community partners to prevent and respond to violence, enhancing safety and long-term well-being. | Number of partnerships, training completed, and community interventions. | Community Health Needs Assessment (CHNA) data and local/state public health data. |

| **Health Need**: | **Cancer**, including Breast Cancer, | | | | |
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| **Population(s) of Focus:** | Adults and families in AGHM's primary and secondary service areas, particularly those who are uninsured, underinsured, or at risk for late-stage cancer diagnosis and barriers to timely 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 | Supports children battling cancer and other life-threatening illnesses by offering holistic mental health | ☑ | ☑ | ☑ | VC: Basic Needs for Health and Safety |

| **Health Need**: | **Cancer**, including Breast Cancer, | | | | |
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| | services, including counseling, family support, and safe play areas designed to promote emotional and physical well-being. | | | | |
| Desert Cancer Foundation of Arizona | This program provides cancer education, lifesaving screenings, and works with Dignity Health to link uninsured and underinsured individuals with treatment resources | ☑ | ☑ | ☐ | VC: Basic Needs for Health and Safety |
| Maddy Mobile Mammography / Breastlink Mercy Gilbert | The coach is operated by Dignity Health and Arizona Diagnostic Radiology. It provides state-of-the-art breast cancer screening to underserved populations across the East Valley, expanding access to early detection and promoting equitable, community-based care | ☑ | ☑ | ☐ | VC: Basic Needs for Health and Safety |
| East Valley Cancer Supportive Care Services | Together Dignity Health East Valley and Ironwood Cancer Center offer comprehensive supportive care services including the Breast Cancer Support Group, Prostate Support Group, and Wellness Classes; Chair Yoga and Sound Bath promoting, education, holistic care and social connection for patients and survivors. | ☐ | ☑ | ☑ | VC: Lifelong Learning |
| **Planned Resources:** | Internal hospital departments and staff, including Oncology, Imaging, Women's Health, along with support from the Dignity Health Foundation East Valley, Dignity Health Medical Group, Patient Financial Assistance, Ironwood Cancer Center, and Arizona Diagnostic Radiology. | | | | |

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| **Health Need**: | **Cancer**, including Breast Cancer, |
| Planned Collaborators: | Community-based organizations , American Cancer Society in Arizona, Cancer Action Network, and Community Health Improvement Grants awardees supporting early detection, treatment access, advocacy and survivorship. |

| Anticipated Impacts (overall long-term goals) | Measure | Data Source |
|---|---|---|
| Increased early detection, improved access to treatment, and reduced disparities in cancer care for underserved populations. | Number of screenings, diagnostic follow-ups, and participants in cancer support and education programs. | Program data (including Community Benefit Data via C.B.I.S.A.), partner and grant reports. |
| Enhanced survivorship, quality of life, and community awareness through education, prevention, and supportive care. | Participation rates in support services and wellness programs; improvements in screening compliance and follow-up care. | Community Health Needs Assessment (CHNA) data, public health data (MCDPH, ADHS), and program evaluation reports. |