Chandler Regional Medical Center

2025 - 2028 Community Health Implementation Strategy and Plan

Adopted October 2025

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At-a-Glance Summary

Community Served 	Chandler Regional Medical Center (CRMC) is rooted in the heart of Maricopa County, serving a community that blends rich cultural diversity, tribal heritage, and fast-growing cities with unique local needs. CRMC's primary service area (PSA) includes the top 75% of inpatient and outpatient discharges. It spans urban, suburban, and rural areas across Maricopa County—the fourth most populous county in the U.S., with more than 4.4 million residents. Nearly one in three residents identifies as Hispanic/Latino, and more than one in ten is foreign-born (U.S. Census Bureau, 2023). The region also includes portions of tribal lands from the Fort McDowell Yavapai Nation, Gila River Indian Community, Salt River Pima-Maricopa Indian Community, and Tohono O'odham Nation. The community is growing rapidly, including a rising population of older adults, which increases demand for chronic disease management and coordinated care. At the same time, many neighborhoods face challenges such as poverty, housing insecurity, and limited access to care, contributing to persistent health disparities.
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, Stroke Survivor Support Group and Early Childhood Oral Health Program

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

Access to Care: Building Blocks program (hearing & vision screening, referrals), Immunization Clinics and Children's Medical Clinic

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

Social Determinants of Health: Pathways to Wellness Program (Community Health Workers), Children's Dental Clinics, 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 chandler-chna@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

Dignity Health Chandler Regional Medical Center (CRMC) 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.

Chandler Regional Medical Center (CRMC) is one of eight Dignity Health acute care hospitals in the Arizona market. Dignity Health is a member of CommonSpirit Health, one of the largest healthcare systems in the nation. Chandler Regional is a not-for-profit hospital in Chandler, Arizona, which is in the east valley of the greater Phoenix metropolis. It opened in 1961 as a small community hospital and has grown into a robust medical center which includes a Level I Trauma Center, and services in general surgery, cardiology, and many other health care specialties. Chandler Regional recently added a graduate medical education residency program to its campus, training approximately 28 future health care providers each year. As of fiscal year 2024, CRMC had 2,988 employees and 1,335 physicians representing all major specialties.

CRMC also features a Hepatobiliary and Pancreatic Cancer Care Program, combining multidisciplinary expertise and comprehensive strategies to deliver high-quality care and improved patient outcomes. Additional key services include Intensive Care, Breastlink Chandler, and Diagnostic Imaging, ensuring broad access to critical and specialized healthcare services for the community.

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

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

The hospital, CRMC, 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 comprises 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.

CRMC'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 CRMC came from the following zip codes: 85044, 85048, 85121, 85122, 85128, 85138, 85139, 85142, 85147, 85202, 85204, 85210, 85212, 85224, 85225, 85226, 85233, 85248, 85249, 85282, 85283, 85284, 85286, 85295, 85296, 85297, 85298, and 85339. Figure 1 displays a map of CRMC's community.

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

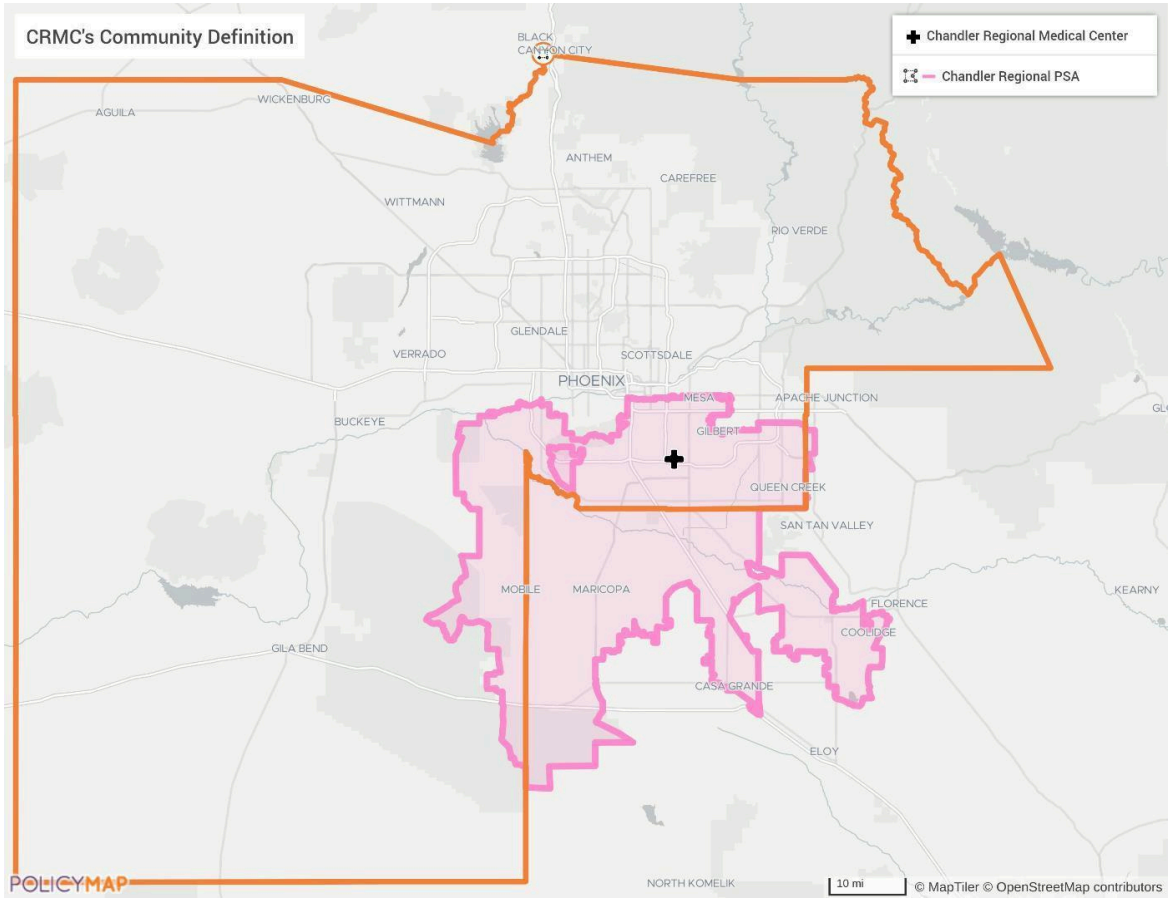


Figure 1. CRMC's Community Definition

Demographic and Socioeconomic Profile

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

	CRMC's PSA	Maricopa County	Arizona
Total Population Size	1,181,286	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)	6%	4%	3%
Black/African American (non-Hispanic)	6%	5%	4%
White (non-Hispanic)	55%	53%	53%
Hispanic/Latino	26%	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	14%	14%	14%
25-44 years	29%	28%	26%
45-64 years	24%	24%	24%
65+ years	13%	16%	18%
Languages, among those 5 years and over			
Non-English Languages Spoken at Home	21%	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over			
Less than 9th grade	3%	5%	5%
9th – 12th grade, no diploma	4%	6%	6%
Employment Status			
Unemployed	5%	5%	5%
Median Household Income			
Income	$98,916	$80,675	$72,581
Poverty (based on income thresholds & family size)			
Below poverty level all ages	9%	12%	13%
Below poverty level all ages under 18 years	3%	16%	18%

Health Insurance Coverage			
Uninsured	9%	11%	11%
Health Insurance Type			
Medicaid	IP: 26%, ED: 35%	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	11	66	138

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

Phase Two – CHNA Prioritization Workshops
CRMC 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
CRMC's 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 Chandler Regional Medical Center 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.

CRMC 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, CRMC 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.

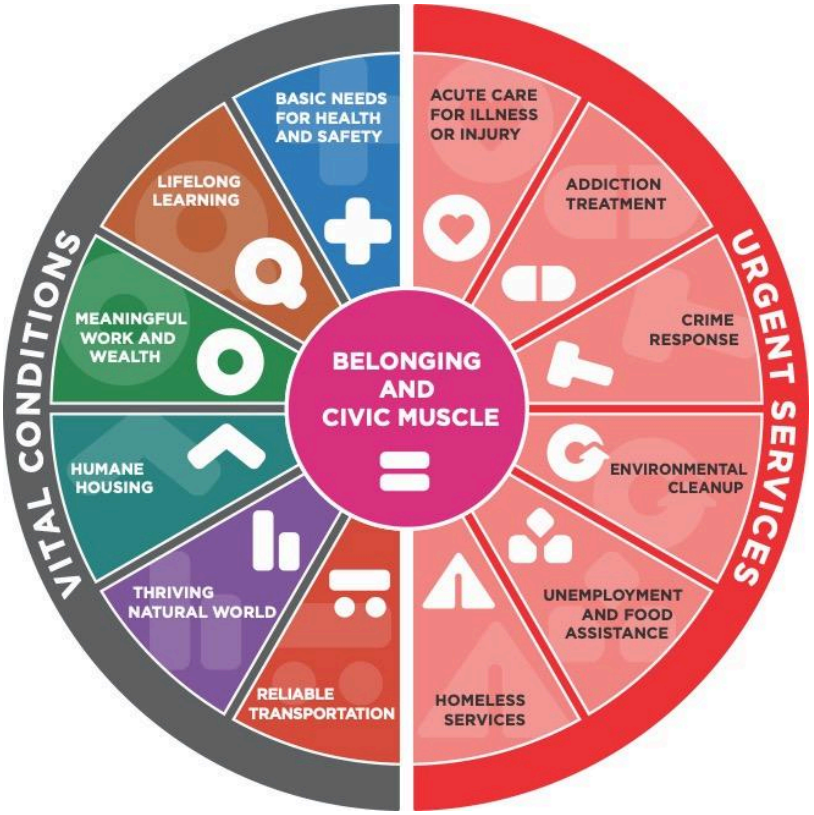
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of 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 CRMC's 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)**
Wranglers for Freedom in Mental Health	Offers equine-assisted therapy for underserved youth in collaboration with the Chandler Unified School District. Pilot evaluates impact and potential expansion to additional schools.	☐	☑	☐	VC: Basic Needs for Health and Safety
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	☐	☐	☑	VC: Basic Needs for Health and Safety

Health Need:	**Mental Health,** including All Mental and Behavioral Disorders				
	illness.				
Planned Resources:	Internal hospital departments and staff, including CRMC Maternal and Child Health, Care Coordination, Emergency Department, Mission Integration, Quality and Compliance, Executive Leadership, and CommonSpirit Community Health Executive Leaders.				
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 (including CRMC Community Benefit Data via C.B.I.S.A.) 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 CRMC'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:	Adults and children in CRMC'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 Children's Medical Clinic	Access to medical care for children 18 and under in Chandler, including well visits and education, supported by volunteer providers and Dignity Health partnerships.	☐	☐	☑	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

Health Need:	**Chronic Conditions,** including Cardiovascular Disease, Diabetes, and Obesity
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 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 and ADHS).

Health Need:	**Social Determinants of Health,** including Housing, Homelessness and Access to Food				
Population(s) of Focus:	Individuals and families in CRMC'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 in Chandler Unified School District through counseling, meals, stipends, and essential resources.	☐	☑	☐	US: Food Assistance
East Valley FrescaZona Medical Food Box Program	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

Health Need:	**Social Determinants of Health,** including Housing, Homelessness and Access to Food				
Dignity Health Pathways to Wellness	Community Health Worker provides 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.	☑	☐	☐	VC: Lifelong 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.), Community Health Improvement Grants 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; and social service data (e.g.,

		MCDPH, ADHS).

Health Need:	**Access to Care,** including Dental Health				
Population(s) of Focus:	Individuals and families in CRMC'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's Children's Medical Clinic, Dental Clinics and Early Childhood Oral Health Program	The Dental clinics offer exams, cleanings, fluoride varnish, and oral health education. The Medical clinic provides care, education, and resources. Serves uninsured youth 18 and under; Early Childhood Oral Health, also provides dental screenings for expecting mothers and oral health education for children 0–5 in community settings.	☐	☐	☑	VC: Basic Needs for Health and Safety
Dignity Health Transitional Care Center	Supports chronically ill patients recently discharged from the	☑	☐	☐	VC: Basic Needs for Health and

Health Need:	**Access to Care,** including Dental Health				
	hospital by connecting them to providers, facilitating orders, and helping navigate post-discharge care to ensure successful transitions and reduced readmissions.				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
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	Number of care	Community Health

equity for vulnerable populations.	transitions completed, referrals coordinated, and participation in community-based programs.	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 CRMC'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			
		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	Expands access to primary care, case management, and supportive services for survivors through	☐	☐	☑	US: Crime Response

Health Need:	**Violence and Injury**				
Trafficking	coordinated community-based partnerships.				
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 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				
Population(s) of Focus:	Adults and families in CRMC'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 services, including counseling, family support, and safe play areas designed to promote emotional and physical well-being.	☑	☑	☑	VC: Basic Needs for Health and Safety
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 Chandler	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

Health Need:	**Cancer,** including Breast Cancer				
East Valley Cancer Supportive Care Services	Together CRMC 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.				
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.