2025 Community Health Implementation Strategy and Plan

Adopted October 2025

St. Joseph's Hospital and Medical Center

Dignity Health.
St. Joseph's Hospital and Medical Center

A member of CommonSpirit

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At-a-Glance Summary

Community Served 	St. Joseph's serves the geographic area of Maricopa County which encompasses 9,202 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations. With an estimated population of 4 million and growing, Maricopa County is home to well over half of Arizona's residents. The community served is ethnically and culturally diverse.

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:
	• Access to Care
	• Cancer
	• Social Determinants of Health
	• Violence and Injury Prevention
	• Mental Health
	• Chronic Health Conditions
	  o Cardiovascular Disease (CVD)
	  o Diabetes
	  o Chronic Kidney Disease (CKD)

Strategies and Programs to Address Needs 	The hospital intends to take several actions and to dedicate resources to these needs, including: • **Access to Car**e – ACTIVATE Program, CATCH Program, Keogh Enrollment Specialist, Hospital-based Community Navigators, Lyft Transportation Services, MOMobile, Community Health Workers, and Patient Financial Assistance • **Cancer** – Cancer Medication Assistance Program, Cancer Resource Navigator, Lifestyle Management Workshops, Prevention activities • **Chronic Conditions** – Diabetes Empowerment Education Program, Healthier Living Programs, Chronic Disease Self-Management Program, Chronic Kidney Disease Awareness, and Muhammed Ali Parkinson's Center Programs. • **Mental Health** – Mental Health First Aid, Anti-Stigma Training, Substance Use Navigator (SUN) • **Social Determinants of Health** - Pathways to Healthier Living, Hospital to Shelter Bed Program, Circle the City Health Resource Navigator • **Violence and Injury Prevention** - THRIVE, Survive the Drive, Stop the Bleed, and Balance Masters

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 St. Joseph's Hospital and Medical Center Community Health Office at 350 W. Thomas Road, Phoenix, AZ 85013 or by e-mail to communityhealth-sjhmc@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

St. Joseph's Hospital and Medical Center (St. Joseph's) 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.

Located in the heart of Phoenix, St. Joseph's is a 571-bed, not-for-profit hospital that provides a wide range of health, social and support services with special advocacy for the poor and underserved. Founded in 1895 by the Sisters of Mercy, St. Joseph's was the first hospital in the Phoenix Area. St. Joseph's is a nationally recognized center for quality quaternary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Norton Thoracic Institute, Center for Women's Health, the Dignity Health – Cancer Institute at St. Joseph's Hospital and Medical Center, and a Level I Trauma Center verified by the American College of Surgeons. The hospital is also a respected center for orthopedics, internal medicine, primary care and many other medical services. U.S. News & World Report routinely ranks SJHMC among the top hospitals in the United States for neurology and neurosurgery. As of 2024, SJHMC has 5,743 employees, 512 employed faculty physicians, 1,135 credentialed community physicians, and 175 volunteers.

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

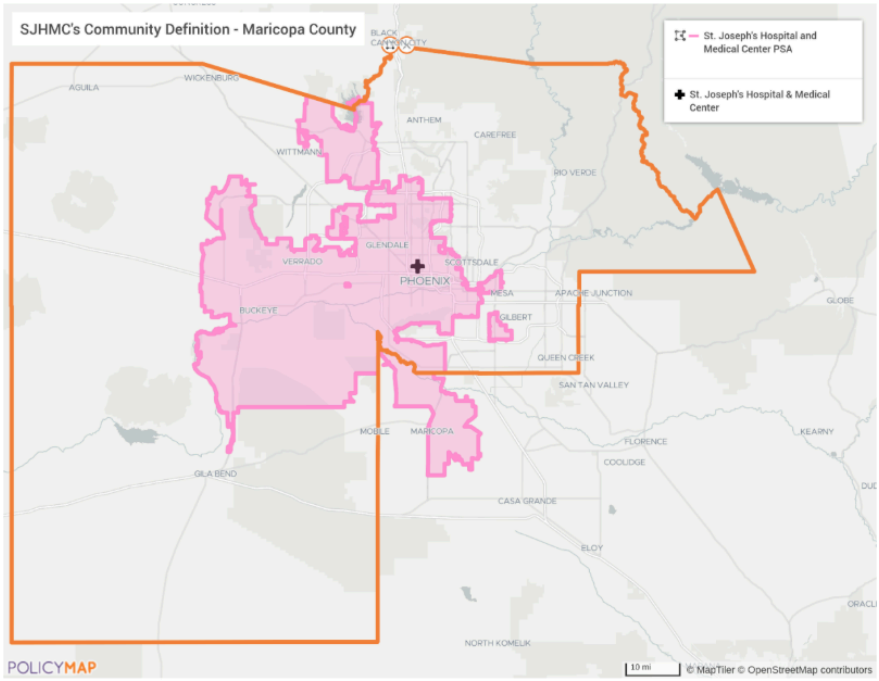
It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

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

The hospital serves Maricopa County. A summary description of the community is below, and additional details can be found in the CHNA report online. The map below displays St. Joseph's defined community.

St. Joseph's is located in Maricopa County, the fourth most populous county in the U.S., with a population of over 4.4 million people. It is home to well over half of Arizona's residents. Covering 9,202 square miles, Maricopa County includes 27 cities and towns and 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.



St. Joseph's serves patients across Maricopa County; hence, the community definition extends beyond its physical location in the City of Phoenix. The table below describes the demographic and socioeconomic profile of residents in Maricopa County and Arizona, for comparison.

	Maricopa County	Arizona
Total Population Size	4,430,871	7,172,282
Population by Race / Ethnicity		
American Indian/Alaska Native (non-Hispanic)	1%	4%
Asian and Native Hawaiian/Pacific Islander (non-Hispanic)	4%	3%
Black/African American (non-Hispanic)	5%	4%
White (non-Hispanic)	53%	53%
Hispanic / Latino	32%	32%
Population by Sex		
Male	50%	50%
Female	50%	50%
Population by Age Group		
0-14 years	19%	18%
15-24 years	14%	14%

	Maricopa County	Arizona
25-44 years	28%	26%
45-64 years	24%	24%
65+ years	16%	18%
Languages, among those 5 year and older		
Non-English Languages Spoken at Home	26%	26%
Population by Educational Attainment (Less than a high school diploma), among those 25 years and over		
Less than 9th grade	5%	5%
9th – 12th grade, no diploma	6%	6%
Employment Status		
Unemployed	5%	5%
Median Household Income		
Income	$80,675	$72,581
Poverty		
Below poverty level all ages	12%	13%
Below poverty level all ages under 18 years	16%	18%
Health Insurance Coverage		
Uninsured	11%	11%
Health Insurance Type		
Medicaid	18%	21%
Health Professional Shortage Area	Yes	Yes
Medically Underserved Area	Yes	Yes
Medically Underserved, Low Income, Minority Populations	Medically Underserved, Low Income	

Maricopa County and Arizona Demographic and Socioeconomic Profile - 2022 ACS Census, HRSA MUA Finder, PolicyMap

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 April, 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?
Access to Care	**Access to Care** is defined as the timely use of health services to achieve the best possible health outcomes. Many people face barriers that prevent or limit access to needed healthcare services. Access to care includes availability, accessibility, affordability, acceptability, and appropriateness.	☑
Cancer	**Cancer** is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.	☑
Chronic Health Conditions • Diabetes • Cardiovascular Disease (CVD) • Chronic Kidney Disease	**Chronic Health Conditions** are health conditions or diseases that are persistent or otherwise long-lasting in their effects. • **Diabetes** is a chronic, metabolic disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine.	☑

Significant Health Need	Description	Intend to Address?
	● **Cardiovascular Diseases (CVDs**) is defined as the primary diagnosis of acute rheumatic fever and the following diseases: chronic rheumatic heart, hypertensive, ischemic heart, pulmonary heart, pulmonary circulation, cerebrovascular, arteries, arterioles, capillaries, and other forms of heart disease. ● **Chronic Kidney Disease (CKD)** is a condition in which the kidneys gradually lose their ability to filter waste products and excess fluid from the blood. This can lead to kidney damage, buildup of harmful substances in the body, and other health problems.	
Maternal and Child Health ● Preterm Births	**Maternal and Child Health** focuses on the well-being of pregnant women, mothers, and children from birth through adolescence. It involves a comprehensive approach to care, including prenatal, childbirth, and postnatal services. ● **Preterm birth**, defined as a live birth before 37 completed weeks of gestation, is a critical component of maternal and child health. Preterm birth can lead to long-term health conditions	☐
Mental Health	**Mental Health** encompasses emotional, psychological, and social well-being. It influences thoughts, feelings, actions and plays a key role in coping with stress, interacting with others, and making decisions. Mental health is a vital component of overall well-being	☑
Social Determinants of Health ● Housing & Homelessness ● Heat	**Social Determinants of Health** are the conditions where people are born, live, work, play, worship, and age that impact their health quality-of-life. ● **Housing & Homelessness** are often identified as important social determinants of health due to the range of ways in which a lack of housing, or poor quality housing, can negatively affect health and wellbeing. ● **Heat** stress, the leading cause of weather-related deaths, can exacerbate underlying illnesses such as cardiovascular disease, diabetes, mental	☑

Significant Health Need	Description	Intend to Address?
	health disorders, and asthma. Prolonged exposure to extreme temperatures can lead to serious health risks.	
Substance Use	**Substance Use** is a broad term that refers to the consumption of any psychoactive substance that can alter mood, consciousness, or behavior. It includes the use of alcohol, nicotine, illicit drugs, as well as the use of prescription medications for non-medical purposes.	☐
Violence and Injury Prevention ● Fall-related Injuries ● Assault-related Injuries	**Violence and Unintentional Injuries** are a significant cause of death and burden of disease, and some people are more vulnerable than others depending on the conditions in which they are born, grow, work, live and age. ● **Fall-related injury** is preventable and includes any physical harm that occurs as a direct result of a fall, ranging from minor issues like bruises or strains to severe injuries such as fractures, head trauma, or even death. ● **Assault-related Injury** is physical harm or bodily damage caused by an act of assault, which is an intentional act or threat by one person that causes another to reasonably fear imminent harmful or offensive contact	☑

Significant Needs the Hospital Does Not Intend to Address

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

- Maternal and Child Health
- Substance Use

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 benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

The overall approach to creating the 2025 Community Health Implementation Plan (CHIP) was collaborative and data-driven. The process began following the adoption of the 2025 Community Health Needs Assessment (CHNA). The primary objective was to clearly define how the hospital would address the identified health needs in our community over the next three years.

The process involved the following key stages.

1. **CHNA Needs Analysis and Focus Selection:** The strategy development process began with a thorough analysis of the health needs identified in the 2025 CHNA. Input from a variety of hospital leaders and key community stakeholders was then gathered to guide our focus and further prioritize which of these identified needs the hospital would concentrate on over the next three years.

2. **Program Identification & Evaluation:** Once priority needs were established, specific programs and initiatives were identified and evaluated. This involved an assessment of existing hospital programs demonstrating evidence of success and impact. The Community Health team also researched evidence-based interventions relevant to the prioritized needs.

3. **Feasibility and Impact:** Each potential program was evaluated based on the hospital's capacity to meet the need (including available resources, existing hospital services, and staff capabilities), its ability to measure impact, and its alignment with internal goals to address urgent community needs. The potential for leveraging and strengthening collaborative partnerships was also considered.

4. **Strategy Formation:** The selected programs and initiatives were then integrated into a strategy and plan, outlining how the hospital will address the identified needs in an achievable and sustainable manner.

Hospital and health system participants included the CommonSpirit Health System Office, the St. Joseph's Community Health & Benefit Team, Executive Leadership Team, Care Coordination Department, and leaders from the following areas: inpatient units, the emergency department, finance, human resources, mission services, philanthropy, and hospital support services. These various hospital departments actively participated in selecting the focus areas for the CHIP. These teams and leaders also discussed existing or upcoming hospital programs and initiatives that could effectively respond to the identified community health needs. These programs form the core of the plan's response to prioritized needs.

Community perspectives were critical in developing this plan, ensuring it genuinely reflects and addresses local needs. Community input and contributions to this implementation strategy included the following.

- **Community Benefit and Health Equity Committee:** Engagement with this hospital committee, composed of both hospital staff and external community stakeholders, provided essential guidance and validated strategic directions.
- **Community Partner Survey:** A survey was disseminated to community partners, soliciting their perspectives on which priority areas the hospital should focus on over the next three years, directly informing our strategic focus.
- **Health Improvement Partnership of Maricopa County (HIPMC):** Active participation in HIPMC, an existing collaborative effort between the Maricopa County Department of Public Health (MCDPH) and other public and private entities, significantly informed our process. Through HIPMC, we participated in the creation of a county-wide CHIP, which is Maricopa County's community-driven action plan to address public health priorities. Recognizing HIPMC's extensive reach and the county-wide community input they gathered, we adopted aspects of their activities to help inform and validate our own selection of health priorities. The health priorities identified in HIPMC's CHIP (mental health, access to health care, access to healthy food, substance use, and housing / homelessness) align very closely with those selected for St. Joseph's.

The programs and initiatives described here were selected on the basis of evaluating existing programs with evidence of success/impact, researching effective interventions, our ability to measure impact, and internal goals to address urgent community needs. The programs and strategies identified that address significant needs are achievable through the hospital's capacity to meet the need, available resources, existing hospital services, and collaborative partnerships.

Community Health 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.

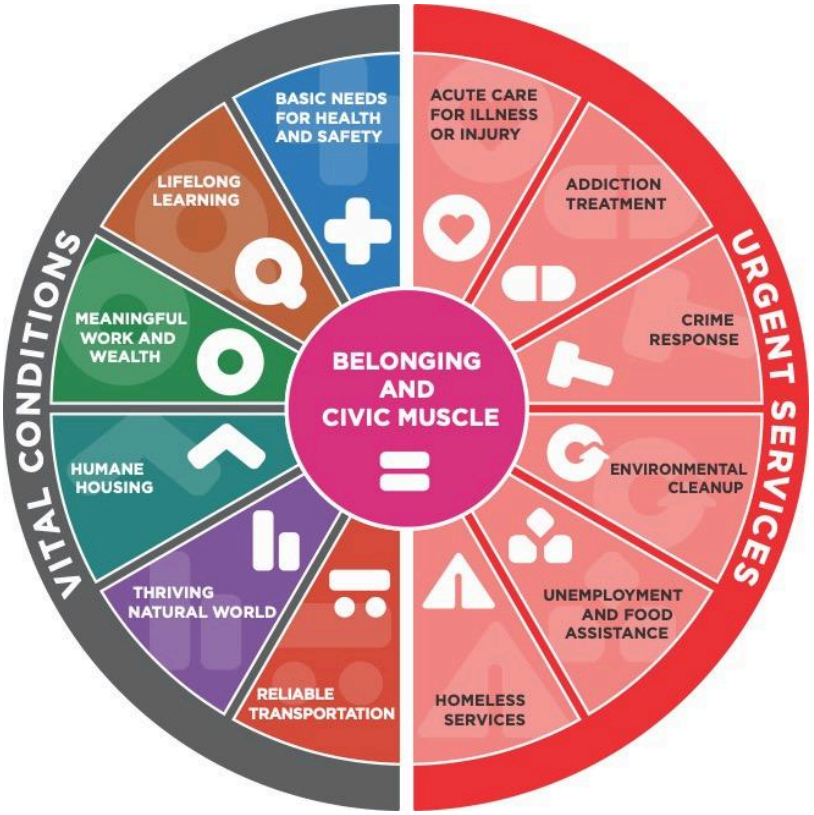
What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of 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:	Access to Care				
Population(s) of Focus:	Under-served groups including but not limited to those who are poverty-stricken, uninsured, underinsured, have multiple chronic conditions, have unmet health-related social needs, experience homelessness, have serious mental illness, have substance use disorder, and/or are justice-involved.				
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)**
Patient Financial Assistance	Financial Assistance Program for uninsured and underinsured patients (free or reduced-cost care). Hospital transition programs with AllThrive 365 (formerly Foundation for Senior Living), Circle the City, and Cancer Support Community Arizona assist with insurance, program enrollment, and other assistance.	☑	☑	☑	• Basic needs for health and safety (VC) • Acute care for illness or injury (US)
Enrollment Specialist	Partnership with Keogh Health Connection to have an enrollment specialist available in-person that offers free enrollment assistance for AHCCCS (Arizona's Medicaid), KidsCare, Marketplace Health Insurance (The Affordable Care Act), SNAP (food stamps), and TANF (emergency cash assistance).	☑	☑	☑	• Basic needs for health and safety (VC) • Unemployment and food assistance (US)
MOMobile	Maternity Outreach Mobile Unit provides prenatal and postpartum care for low-income, uninsured pregnant women. The Mobile clinic travels weekly to four different locations within	☑	☑	☑	• Basic needs for health and safety (VC) • Acute Care for Illness or Injury

Health Need:	Access to Care				
	Maricopa County to provide free care.				(US)
Activate	Partnership with AllThrive 365 is designed to help transition high-risk hospital patients from hospital to home. Community case management is provided to patients with limited or no insurance. Patients are followed up to 90 days. Kindness Closet provides access to free medical equipment.	☑	☑	☑	• Basic needs for health and safety (VC) • Unemployment and food assistance (US) • Lifelong Learning (VC)
CATCH	Partnership with AllThrive 365 is designed to help case-manage high-risk clinic patients with limited or no insurance. Kindness Closet provides access to free medical equipment.	☑	☑	☑	• Basic needs for health and safety (VC) • Unemployment and food assistance (US)
Primary Care / Medical Home Partnerships	• Mission of Mercy - mobile primary care clinic • St. Vincent de Paul - free clinic that serves as a temporary health care home. Provides specialty care and diabetes classes. • Circle the City - medical respite center for people experiencing homelessness	☑	☑	☑	• Basic needs for health and safety (VC) • Unemployment and food assistance (US)
Planned Resources:	The hospital will provide care navigation, community health navigators, community health improvement grants, outreach communications, and programmatic funding support for these initiatives.				
Planned Collaborators:	The hospital will partner with local community based organizations to deliver this access to care strategy. Current collaborators include AllThrive 365, Circle the City, Cancer Support Community Arizona, Keogh Health Connection (Chicanos por la Causa), MOMobile, Mission of Mercy, St. Vincent de Paul, St. Joseph's Foundation, and Arizona State University.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
More patient and community member enrollment in Medicaid/public coverage programs	Total coverage plan enrollments	Navigator reports
Patients will have access to quality health care services, regardless of insurance status or ability to pay for care	Total patients utilizing patient financial assistance program and connected to primary care	Patient financial assistance report and navigator reports

Health Need:	Cancer				
Population(s) of Focus:	Under-served groups including but not limited to those who are poverty-stricken, uninsured, underinsured, have multiple chronic conditions, have unmet health-related social needs, experience homelessness, have serious mental illness, have substance use disorder, and/or are justice-involved.				
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)**
Cancer Support Community Arizona Navigator	Partnership with Cancer Support Community of Arizona to provide onsite community education and navigation for cancer patients and their caregivers. Cancer support navigators are bilingual and meet the cultural and linguistic needs of patients and community members	☑	☐	☑	• Basic needs for health and safety (VC) • Acute Care for Illness or Injury (US) • Unemployment and food assistance (US)
Lifestyle Management	Lifestyle management workshops, support groups, transportation services and other	☑	☑	☑	• Basic needs for health and safety

Health Need:	Cancer				
	classes that support physical, mental, and spiritual wellbeing for cancer patients and their caregivers.				(VC) • Transportation (VC) • Lifelong learning (VC)
Medication Assistance	Dignity Health Cancer Institute (DHCI) assists in completing applications for cancer medications for uninsured and underinsured.	☑	☐	☑	• Basic needs for health and safety (VC) • Acute Care for Illness or Injury (US)
Participate in Cancer Prevention Activities and Develop Educational Resources	Partner with community organizations to promote and participate in cancer prevention programs and activities. Disseminate educational resources that promote prevention.	☑	☐	☑	• Basic needs for health and safety (VC) • Lifelong learning (VC)
Planned Resources:	The hospital will provide care navigation, community health navigators, community health improvement grants, outreach communications, and programmatic funding support for these initiatives.				
Planned Collaborators:	The hospital will partner with Cancer Support Community of Arizona, the American Cancer Society, and independent educators who provide wellness classes to enhance navigation and bridge the gaps in care, linking patients to appropriate resources that address their social and health needs.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Cancer patients will be connected to necessary community resources and learn to navigate them independently.	Total number of patients connected to community resources.	CSCAZ Navigator reports
Patients of the Dignity Health Cancer Institute will experience a comprehensive, integrative, compassionate and multi-dimensional approach to oncology care through various lifestyle management classes.	Total number of participants in lifestyle management classes	

Health Need:	Chronic Conditions				
Population(s) of Focus:	Under-served groups including but not limited to those who are poverty-stricken, uninsured, underinsured, have multiple chronic conditions, have unmet health-related social needs, experience homelessness, have serious mental illness, have substance use disorder, and/or are justice-involved.				
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)**
Diabetes Empowerment Education Program (DEEP)	Free diabetes self-management workshops offered in English and Spanish. Collaboration with community partners providing education on diabetes self-management to meet ongoing needs of individuals living with pre-diabetes and diabetes. 6-week workshop offered in community settings.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC) • Unemployment and food assistance (US)
Chronic Disease Self-Management (CDSMP)	Free chronic disease self-management program offered in English and Spanish that provides strategies and tools to improve health and overall quality of life. 6-week workshop offered in community settings.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC) • Unemployment and food assistance (US)
Healthier Living Programs	Free community wellness classes that promote better health and wellbeing. • Cocinando con Salud en Balance (Spanish healthy cooking series) • Zumba • Gentle Yoga	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC)

Health Need:	Chronic Conditions				
Chronic Kidney Disease – Community Outreach Initiative	This program aims to address health disparities, expand chronic disease awareness, and improve chronic kidney disease (CKD) diagnosis and outcomes. This is an expansion of the initiative started by CommonSpirit Health's Office of Diversity, Equity, Inclusion, and Belonging and is supported by the CommonSpirit Health Mission & Ministry Fund.	☐	☐	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC)
Planned Resources:	The hospital will provide free DEEP and CDSMP workshops, community health workers, community health improvement grants, outreach communications, and programmatic funding support for these initiatives.				
Planned Collaborators:	Collaboration with external partners include Keogh Health Connection (Chicanos Por La Causa), AllThrive 365, Salud en Balance, Unlimited Potential, Aeroterra Senior Living, Marc Atkinson Resource Center, St. Paul's Church, Iglesia Unidos Por Una Vision, Marcos de Niza Learning Center, Fellowship Square, Wilson Community Center, Dysart Community Center, Wesley Community & Health Center, Glendale Elementary School, Isaac School District, Tanner Community Development Corporation, Arizona Faith Network, Arizona Kidney Foundation.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Improved overall health of community members with diabetes and other chronic conditions.	Number of participants the complete DEEP and CDSMP workshops	Workshop completion logs
Increase in knowledge and care for chronic conditions via increased education and disease prevention outreach efforts	Number of educational sessions held and total participants	Internal tracking log

Health Need:	Mental Health				
Population(s) of Focus:	Under-served groups including but not limited to those who are poverty-stricken, uninsured, underinsured, have multiple chronic conditions, have unmet health-related social needs, experience homelessness, have serious mental illness, have substance use disorder, and/or are justice-involved.				
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)**
Mental Health First Aid (MHFA)	Mental Health First Aid is a course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC)
Anti-Stigma "Responding to Addiction" Training	Addiction is one of the most stigmatized health conditions on earth. Stigma prevents people who are struggling from reaching out for help and isolates families affected by the disease who fear being judged by their communities. Responding to Addiction is designed to reduce addiction stigma, including stereotypes, prejudice, and discrimination, and increase knowledge about addiction, as well as helping behaviors.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC) • Addiction treatment (US)
Substance Use Navigator	The Substance Use Navigator (SUN) is a healthcare professional who works in the hospital to help patients with substance use	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning

Health Need:	Mental Health				
	disorders (SUD) connect with treatment and recovery services.				(VC) • Addiction treatment (US)
Planned Resources:	The hospital will provide free Mental Health First Aid classes, free Anti-stigma "Responding to Addiction" training, community health workers, community health improvement grants, outreach communications, and programmatic funding support for these initiatives.				
Planned Collaborators:	To address this health priority, the hospital will collaborate with Mercy Care, National Council for Mental Wellbeing, Addiction Policy Forum, and the St. Joseph's Foundation.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Educate more staff and community members on how to identify, understand and respond to signs of mental illnesses and substance use disorders.	Graduates of MHFA and anti-stigma trainings	Training logs
Connect more patients with SUD to treatment and recovery services.	Connections made by SUN	SUN performance reports

Health Need:	Social Determinants of Health				
Population(s) of Focus:	Under-served groups including but not limited to those who are poverty-stricken, uninsured, underinsured, have multiple chronic conditions, have unmet health-related social needs, experience homelessness, have serious mental illness, have substance use disorder, and/or are justice-involved.				
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:	Social Determinants of Health				
Pathways to Healthier Living *(Community Health Worker Program)*	Community Health Workers (CHWs) identify high-need patients at the hospital and conduct a home-visiting program after discharge to address patient needs and connect them to community resources. CHWs provide several resources, such as food boxes for clients facing food insecurity. CHWs utilize the Pathways Community Hub Institute model.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC) • Addiction treatment (US) • Unemployment and food assistance (US)
Hospital to Shelter Bed Program	Partnership with Central Arizona Shelter Services (CASS) to ensure there are shelter beds available for discharged patients experiencing homelessness. This ensures there is shelter and a bed available for vulnerable patients.	☑	☐	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC) • Homeless services (US) • Unemployment and food assistance (US) • Humane housing (VC)
CTC Health Resource Navigator	Partnership with Circle the City to embed a health resource navigator who specifically works with patients who are experiencing homelessness. The navigator supports care coordination in the discharge process for these patients and ensures they are connected to resources and shelter post discharge.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC) • Addiction treatment (US) • Homeless services (US) • Humane housing (VC)

Health Need:	Social Determinants of Health				
Participate in Heat-Relief Efforts	Build and strengthen partnerships that focus on heat relief. Participate as an active member in the Heat Relief Network, a network of partners providing water, cooling, and donation sites throughout the Valley with the goal of preventing heat-related illnesses and deaths among vulnerable populations	☑	☐	☑	• Basic needs for health and safety (VC) • Thriving Natural World (VC) • Humane Housing (VC)
Planned Resources:	The hospital will provide care navigation, community health workers, community health improvement grants, outreach communications, and programmatic funding support for these initiatives.				
Planned Collaborators:	The hospital will collaborate with several organizations to address SDOHs including Circle the City, Central Arizona Shelter Services (CASS), Pathways Community Hub Institute, Nourish, Keogh Health Connection, and AllThrive 365.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Connect patients and their families with necessary community resources post-discharge	Enrolled participants and closed pathways	PearSuite tracking system, quarterly benchmark reports
Adequately address vulnerable patients' health-related social needs	Number of connections to SDOH resources	Unite Us referral system

Health Need:	Violence and Injury Prevention
Population(s) of Focus:	Under-served groups including but not limited to those who are poverty-stricken, uninsured, underinsured, seniors, have multiple chronic conditions, have unmet health-related social needs, experience homelessness, have serious mental illness, have substance use disorder, and/or are justice-involved.

Health Need:	Violence and Injury Prevention				
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)**
THRIVE	A hospital-based violence intervention program (HVIP) that aims to reduce and prevent violence by supporting victims of community violence (e.g., shootings, stabbings, assaults) receiving hospital care. These patients constitute approximately 20% of annual trauma cases at SJHMC and are a top three mechanism of injury. Key HVIP components include trauma-informed care, peer support, case management, follow-up services, and violence prevention.	☑	☑	☑	• Basic needs for health and safety (VC) • Acute care for illness and injury (US) • Crime response (US) • Lifelong Learning (VC)
Survive the Drive	A free, two-hour program for young drivers and their parents. Developed by Trauma Injury Prevention Program Coordinators from Phoenix's five level-one trauma centers and supported by the Phoenix Fire Department, it educates on distracted and impaired driving dangers through hands-on activities and simulations, aiming to reduce crashes and improve road safety.	☑	☑	☑	• Crime response • Lifelong Learning (VC)
Stop the Bleed	Stop the Bleed is a national awareness campaign and a call to action. The program educates and empowers bystanders to help in a bleeding emergency by teaching them basic techniques of bleeding control.	☑	☑	☑	• Acute care for illness and injury (US) • Lifelong Learning (VC)

Health Need:	Violence and Injury Prevention				
Balance Masters	Balance Masters is a group class that addresses fear or risk of falling, through balance and strength exercises. The classes are free and open to community members who are 65 years or older.	☑	☑	☑	• Basic needs for health and safety (VC) • Lifelong Learning (VC)
Planned Resources:	The hospital will provide care navigation, trauma team staff time, funds from a Mission & Ministry grant, community health workers, community health improvement grants, outreach communications, and programmatic funding support for these initiatives.				
Planned Collaborators:	To address this health priority, the hospital will collaborate with Phoenix Fire Department, Ability 360, Health Alliance for Violence Intervention (HAVI), Phoenix LISC, local high schools, local government agencies, community health centers, nursing students, and general community members who have a higher risk of injury.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Build and maintain a comprehensive injury prevention system that addresses different types of traumas.	Development of robust injury prevention program	Hospital trauma team
Reduce preventable injury, re-injury, and death by cultivating safer community behaviors and equipping the public with critical life-saving skills.	Number of educational classes provided and total participants	Trauma team tracking log