Dignity Health.
Chandler Regional Medical Center

Chandler Regional Medical Center
Community Health Implementation Strategy
2019-2021

TABLE OF CONTENTS

Executive Summary 2

Mission, Vision, and Values 4

Our Hospital and Our Commitment 5

Description of the Community Served 7

Implementation Strategy Development Process
- Community Health Needs Assessment Process 9
- CHNA Significant Health Needs 11
- Significant Health Needs not Being Addressed 12
- Creating the Implementation Strategy 13
- Planning for the Uninsured/Underinsured Patient Population 14

2019-2021 Community Implementation Strategy
- Strategy and Program Plan Summary 15
- Anticipated Impact 20
- Planned Collaboration 20
- Program Digests 22

Appendices
- Appendix A: Community Board and Committee Rosters 37
- Appendix B: Financial Assistance Policy Summary 40
- Appendix C: Current and Planned Collaborative Partnership 41
- Appendix D Other Programs and Non-Quantifiable Benefits 42

EXECUTIVE SUMMARY

Dignity Health defines the community served by a hospital as those individuals residing within its primary and secondary service areas. The primary service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. The city of Chandler is primarily served by Chandler Regional Medical Center (CRMC). Chandler is a growing and diverse city in Maricopa County, Arizona with nearly 253,000 residents of many ethnicities, various incomes and education levels. Surrounding communities include Ahwatukee, Apache Junction, Casa Grande, Gila River Indian Reservation, Gilbert, Guadalupe, Mesa, Pinal County, Queen Creek, Sacaton, and Tempe.
Chandler is home to several major industrial firms that include Intel, Microchip and Northrop Grumman Corporation. However, despite economic growth, there continues to be many factors and social determinants of health in the suburban Chandler Communities that need to be addressed in order to improve the health and wellbeing for the broader community and the underserved. According to the Community Need Index (CNI), a proprietary tool developed by Dignity Health, the primary service area includes both moderate and high-risk areas with significant socio-economic barriers. Zip code areas with the highest risk include 85122, 85128, 85139, 85202, 85225, 85282, and 85283.

The significant community health needs that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA), which is publicly available at: https://www.dignityhealth.org/arizona/locations/chandlerregional/about-us/community-benefit-outreach/benefits-reports. Additional details about identified needs, data collected, community input obtained, and prioritization methods used can be found in the CHNA report.

The significant community health needs identified are:

A. Access to Care

Community members and key informants overwhelmingly felt that access to care is an important issue for the community. Within CRMC's primary service area, community survey respondents reported access to care as the number one most important "Health Problem" that impacts their community. There are also disparities experienced across members of certain racial/ethnic backgrounds, with Hispanics and American Indians being least likely to have insurance and poverty rates among American Indians (30.1%) in the CRMC primary service area, higher than Maricopa County rates (27.4%).

B. Mental Health and Behavioral Health

Mental health was ranked as the most important health problem impacting the community by key informants. This was echoed by participants in the focus groups who believe mental health is one of top health issues impacting community residents. Mental health is ranked 9th in leading causes of emergency department visits and 7th in inpatient hospitalizations for CRMC's primary service area, and the highest rates of visits can be attributed to adults ages 25 to 34.

Substance abuse was one of the top concerns for both focus group participants and key informants. Key informants listed alcohol and drug abuse as two of the riskiest health behaviors community members are engaging in.

Suicide is the tenth leading cause of death in the United States, accounting for more than 1% of all deaths. Suicide was the eighth leading cause of death for Maricopa County and CRMC's primary

service area in 2016 (Appendix A). Although women are more likely to attempt suicide, men have higher rates of death by suicide. In Maricopa County, rates of suicide are highest among age groups 45-54 and 75+, which could indicate a potential health disparity in identification, referral or treatment of suicidal ideation.

C. Diabetes

In 2016, the number of deaths related to diabetes decreased in Maricopa County compared to 2015, but it is still the seventh leading cause of death in both Maricopa County and CRMC's primary service area indicating a sustained health need. In CRMC primary service area diabetes mortality rates are highest among ages 75+ years of age.

D. Breast Cancer

Breast Cancer is the second leading cause of cancer among U.S. women.
About 1 in 8 women in the U.S. will develop invasive breast cancer during their lifetime. While advancements continue to be made in the fight against breast cancer, incidence rates in Maricopa County continue to be highest among white non-Hispanic and blacks. In the CRMC primary service area, breast cancer mortality rates among women ages 35-44 are higher than Maricopa County.

E. Injury Prevention

Injuries are not accidents, they are predictable and preventable. Unintentional injuries, including traffic-related, injuries, falls, burns, poisonings, and drowning were responsible for lost lives in the CRMC primary service area. Unintentional injury is the fifth leading cause of death in Maricopa County and sixth leading cause of death in the CRMC's primary service area. It is also the leading cause of emergency department visits and the second leading cause of inpatient discharges. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females.

F. Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risk. Dignity Health CRMC is dedicated to making a positive impact on the social determinants of health, particularly on the health of those economically-disadvantaged communities. Resources that enhance quality of life can have a significant influence on population health outcomes. CRMC will focus on addressing homelessness, food insecurity, and transportation within their primary service area.

Over the next three years, Chandler Regional Medical Center plans to support current, expanded and new programs through hospital resources, grants, foundation funding, and partnerships. Current programs include:

- ACTIVATE transitional care program
- Building Blocks for Children Hearing and Visions Screening Program
- Center for Diabetes Management
- Center for Faith Health Ministries
- Chronic Disease Self-management
- Community of Care Grants and Investment Programs addressing identified needs
- Prenatal classes and support groups

- Injury prevention
- Community education
- Dignity Health Children's Dental Clinic
- Early Childhood Oral Health Program
- Immunization Program
- Children's Medical Clinic at Chandler Care Center

This report is available upon request, distributed to key community partners, board members and constituents, and is on the Chandler Regional Medical Center and Dignity Health websites at https://www.dignityhealth.org/arizona/locations/chandlerregional/about-us/community-benefit-outreach/benefits-reports
Written comments on this report can be submitted to the Chandler Regional Medical Center's Community Integration Department or by e-mail to Chandler-CHNA@DignityHealth.org

MISSION, VISION AND VALUES

Our Mission

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

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

Our Vision

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

Our Values

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

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

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

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

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

Excellence - Exceeding expectations through teamwork and innovation.

Hello humankindness

After more than a century of experience, we've learned that modern medicine is more effective when it's delivered with compassion. Stress levels go down. People heal faster. They have more confidence in their health care professionals. We are successful because we know that the word "care" is what makes health care work. At Dignity Health, we unleash the healing power of humanity through the work we do every day, in the hospital and in the community.

Hello humankindness tells people what we stand for: health care with humanity at its core. Through our common humanity as a healing tool, we can make a true difference, one person at a time.

OUR HOSPITAL AND OUR COMMITMENT

HOSPITAL DESCRIPTION

Chandler Regional Medical Center (CRMC), a member of Dignity Health, is the longest established hospital in the southeast valley, providing more than 50 years of service to the community. Since the beginning, our commitment to quality patient care and service to our community has been the focus. Established as a small community hospital with 40 beds and 25 employees, Chandler Regional Medical Center has grown into a comprehensive acute-care hospital that provides a full spectrum of services including a Level I Trauma Center, open heart surgery program, neurosurgery, orthopedics, and high risk obstetrics and newborn services. With 338 acute-care licensed beds, more than 2645 employees and 1022 physicians representing all major specialties, Chandler Regional Medical Center provides comprehensive care, from routine check-ups and diagnostic services to a wide range of specialties including advanced diagnostic, surgical, robotics and intensive care services.

OUR COMMITMENT

Rooted in Dignity Health's mission, vision and values, Chandler Regional Medical Center is dedicated to delivering community benefit with the engagement of its management team, Community Board and Community Benefit Committee. The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource.

Chandler Regional Medical Center is committed to meeting the health needs of the community by ensuring implementation of successful programs that meet the specific needs of the people it serves. Success is achieved through assessment of community needs, involvement of key hospital leaders, and implementation of community benefit activities. Organizational and community commitment includes Dignity Health's Executive Leadership Team, Community Benefit Committee, Community Board, and Community Benefit Department.

Executive Leadership Team: The Chandler Regional Medical Center Executive Leadership Team is responsible for reviewing the Community Benefit Report and Plan prior to presentation and approval by the Community Board. The Executive Leadership Team's contribution to the community benefit plan includes reviewing alignment of the Community Benefit Plan with the CHNA, the hospital's overall strategic plan, and budgeting for resources.

Community Benefit Committee: The Community Benefit Committee (CBC), chaired by a board member, assists the community board in meeting its obligations by reviewing community needs

identified in CHNA, recommending health priorities, recommending implementation strategies, presenting the hospital's annual Community Benefit Report and Plan, presenting the hospitals CHNA Implementation Strategy, and monitoring progress. Refer to Appendix A for a listing of the CBC members.

Community Board: The Community Board is responsible for oversight and adoption of the CHNA and, Implementation Strategy, approval of the Community Benefit Report and Plan, and program monitoring. Throughout the fiscal year the community board receives reports on community benefit programs. The chair of the Community Benefit Committee reports to the board regarding strategies, programs, and outcomes. Refer to Appendix A for a complete listing of current board members.

Community Benefit Department: The Community Benefit Department, under the Senior Director of Mission Integration, is accountable for planning, implementing, evaluating, reporting, and ultimately for the success of designated programs. The Community Benefit Department is directly responsible for the CHNA and Implementation Strategy, Community Benefit Report and Plan, Dignity Health Community Grants committee, program implementation, evaluation, and monitoring, community collaboration, and reporting of community benefit activities. Key staff positions include: Director of Community Integration, Senior Coordinator for Community Benefit, Manager of Center for Diabetes Management, Manager of Community Education, Manager of Oral Health Program and Manager of Community Wellness.

Chandler Regional Medical Center's community benefit program includes financial assistance provided to those who are unable to pay the cost of their care, unreimbursed costs of Medicaid, subsidized health services that meet a community need, and community health improvement services. Our community benefit also includes monetary grants we provide to not-for-profit organizations that are working together to improve health on significant needs identified in our Community Health Needs Assessment. Many of these programs and initiatives are described in this report. In addition, we are investing in community capacity to improve health – including by addressing the social determinants of health – through Dignity Health's Community Investment Program.

MISSION STANDARDS

At Chandler Regional Medical Center, we abide by the nine Dignity Health Mission Standards that include Organizational Identity, Spirituality and Culture, Ethical Principles, and Community Health and the Common Good. The Mission standards serve as a foundation and guide as we further our mission of compassion, advocacy and partnership. Standards seven, eight, and nine under Community Health and Common Good align with the scope of work recommended in the Implementation Strategy.

Standard 7: Dignity Health partners with others in the community to improve the quality of life.

Standard 8: Dignity Health employs a variety of approaches, including advocacy, innovation and philanthropy, to address the social, political and economic structures that affect the health of persons, especially those most vulnerable.

Standard 9: Dignity Health exercises responsible stewardship of the environment and partners with others to advance ecological initiatives.

DESCRIPTION OF THE COMMUNITY SERVED

Dignity Health defines the community served by a hospital as those individuals residing within its primary and secondary service areas. The primary service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. The primary service area for CRMC includes the zip codes making up the top 75% of the total patient cases. A summary description of the Chandler community is below, and additional community facts and details can be found in the CHNA report online.

The city of Chandler is primarily served by CRMC for acute care and trauma services. Surrounding communities also being served by CRMC include Gilbert, Mesa, Tempe, Ahwatukee, Sacaton, Apache Junction, Casa Grande, Pinal County, Gila River Indian Reservation, and Guadalupe.

Demographic and Socioeconomic Profile

Primary Care Area (PCA) Statistical Profiles are revised annually and provide detailed information on the demographics, health resources, hospital utilization, and health status indicators in defined geographic areas throughout Arizona. According to the Arizona Department of Health Services (ADHS), the Chandler Central PCA has been federally designated as a Medically Underserved Area.[24] More than half of the population of CRMC's primary service area is adults between 20-64 years of age. Nearly 8.7% of residents do not have a high school diploma, 7.1% are unemployed and approximately 13.6% are without health insurance. This data shows that the population as a whole is majority white, and with a median income above Maricopa County and the state of Arizona. Refer to table 1 below for a more population demographics.

Table 1: Population Demographics *Source U.S. Census American Community Survey, 5 year estimates 2012-2016*

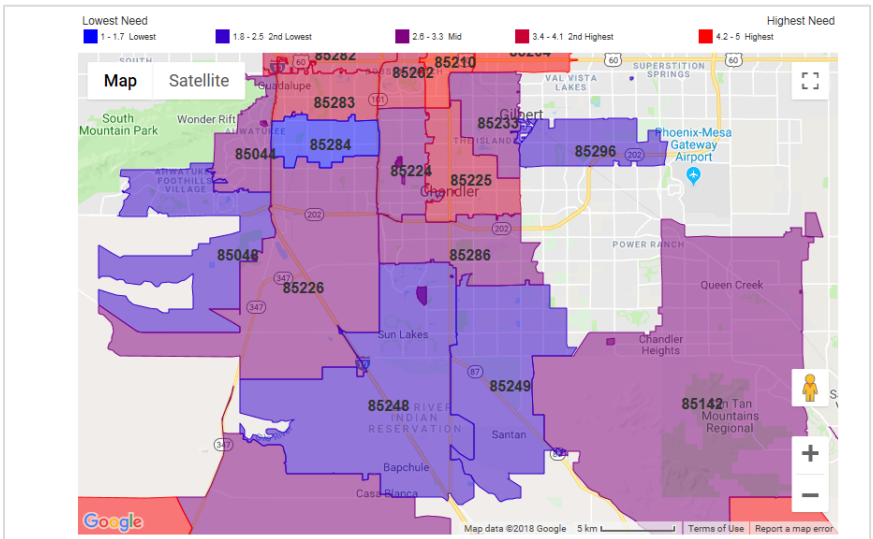
	CRMC PSA	Maricopa County	Arizona
Population: estimated 2015	861,827	4,088,549	6,728,577
Gender			
• **Male**	49.8%	49.5%	49.7%
• **Female**	50.2%	50.5%	50.3%
Age			
• **0 to 9 years**	14.0%	13.8%	13.3%
• **10 to 19 years**	14.1%	13.8%	13.6%
• **20 to 34 years**	22.2%	21.2%	20.5%
• **35 to 64 years**	38.2%	37.3%	36.7%
• **65 to 74 years**	7.0%	8.0%	9.2%
• **75 years and over**	4.5%	5.9%	6.7%
Race			
• **White**	58.6%	56.9%	77.8%
• **Asian/Pacific Islander**	5.4%	4.0%	3.2%
• **Black or African American**	4.4%	5.0%	4.3%
• **American Indian/ Alaska Native**	2.7%	1.5%	4.4%
• **Other**	29.0%	32.6%	10.3%
Ethnicity			
• **Hispanic**	26.0%	30.3%	30.5%
Median Income	$65,654	$53,694	$51,340
Uninsured	11.1%	13.9%	13.6%
Unemployment	4.2%	4.4%	5.4%
No HS Diploma	10.7%	14.0%	13.8%
Limited English Proficiency	6.6%	9.3%	9.1%
Renters	33.7%	39.6%	37.5%
CNI Score	3.1	3.4	-
Medically Underserved Area	Yes	-	-

Chandler is home to several major industrial firms that include Intel, Microchip and Nothrup Grumman. Despite strong economic growth, there continue to be many factors and social determinants of health in the suburban Chandler community that needs to be addressed in order to improve the health and wellbeing for the broader community, and the underserved. Challenges for this community include high rates of poverty, violence-associated injuries, a large non-English speaking population, and low education attainment, all of which create barriers to access. Downtown Chandler has a significant population of uninsured and underinsured non-English speaking persons of all age groups. A large majority of this population is also indigent with their primary source of income through day labor and seasonal work.

Community Need Index

Dignity Health has developed the nation's first standardized Community Need Index (CNI) in partnership with Truven Health Analytics. The CNI identifies the severity of health disparity for every zip code in the United States based on specific barriers to healthcare access. The CNI considers multiple factors that are known to limit health care access such as income, language, educational, insurance and housing barriers. The ability to pinpoint neighborhoods with significant barriers to health care access is an important new advancement for public health advocates and care providers. According to the CNI illustrated below, the primary service area has a mean CNI score of 2.8 and includes both moderate and high-risk areas with significant socio-economic barriers. Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. Zip code areas with the highest risks include 85122, 85128, 85139, 85204, and 85210.

Primary Service Area CNI scores for Chandler Regional Medical Center



Mean(zipcode): 3.2 / Mean(person): 3.2 CNI Score Median: 2.8 CNI Score Mode: 2.6

Zip Code	CNI Score	Population	City	County	State
85044	2.6	40284	Phoenix	Maricopa	Arizona
85048	2.4	35704	Phoenix	Maricopa	Arizona
85122	4.2	57888	Casa Grande	Pinal	Arizona
85128	4.8	21273	Coolidge	Pinal	Arizona
85138	2.6	43214	Maricopa	Pinal	Arizona
85139	4.2	21616	Maricopa	Pinal	Arizona
85142	2.6	64024	Queen Creek	Maricopa	Arizona
85202	4	40636	Mesa	Maricopa	Arizona
85204	4.4	66676	Mesa	Maricopa	Arizona
85210	4.6	39243	Mesa	Maricopa	Arizona
85224	3	46593	Chandler	Maricopa	Arizona
85225	4	75370	Chandler	Maricopa	Arizona
85226	2.6	38868	Chandler	Maricopa	Arizona
85233	2.8	39943	Gilbert	Maricopa	Arizona
85248	2.2	36325	Chandler	Maricopa	Arizona
85249	2	48083	Chandler	Maricopa	Arizona

COMMUNITY HEALTH IMPLEMENTATION STRATEGY DEVELOPMENT PROCESS

The hospital engages in multiple activities to conduct its community benefit and community health improvement planning process. These include, but are not limited to: conducting a Community Health Needs Assessment with community input at least every three years; using five core principles to guide planning and program decisions; measuring and tracking program indicators; and engaging the Community Benefit Committee and other stakeholders in the development and annual updating of the community benefit plan.

Community Health Needs Assessment Process

Development of the Chandler Regional Medical Center Community Health Needs Assessment involved engagement and recommendation from internal and external stakeholders. Internal stakeholders included Community Board, Community Benefit Committee, Grants Committee, and Executive Leadership. External stakeholders included Maricopa County Department of Public Health, Community-Based organizations, Chandler Regional Medical Center's Community Partnership Collaboration, and community constituents.

Beginning in 2017, Chandler Regional Medical Center (CRMC), in partnership with the Maricopa County Coordinated Health Needs Assessment (CCHNA) collaborative and the Maricopa County Department of Public Health (MCDPH) conducted an assessment of the health needs of residents of Maricopa County as well as those in their primary service area.

The process of conducting this assessment began with a review of approximately 100 indicators to measure health outcomes and associated health factors of Maricopa County residents. These indicators were based on the Center for Disease Control and Prevention's (CDC) Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics report. The indicators included demographic data, social and economic factors, health behaviors, physical environment, health care, and health outcomes. Health needs were identified through the combined analysis of secondary data and community input.

Quantitative data used in the report were high quality, population-based data sources and were analyzed by MCDPH, Office of Epidemiology. Data came from local, state, and national sources such as the Maricopa County Department of Public Health, Arizona Department of Health Services, Arizona Criminal Justice Commission, U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System survey, Youth Risk Behavior survey, and Chandler Regional Medical Center's Prevention Quality Indicators.

The broad interests of the community were incorporated through three means. First, data was collected through focus groups engaging members of underserved populations and communities. Second, surveys were conducted with key informants who serve the primary service area. Finally, a series of meetings were held with key stakeholders from CRMC's primary service area.

Based on the review of the secondary data, a consultant team developed a primary data collection guide used in focus groups which were made up of representatives of minority and underserved populations who identified community concerns and assets.

Surveys were collected from key informants who serve the primary service area to help determine community needs and priorities. Additionally, meetings were held with stakeholders from the Community Benefit Committee and Community Partnership Collaboration to assist with the analysis and interpretation of data findings.

Members of the Community Benefit Committee and the Community Partnership Collaboration provided input on the selection of data indicators, provided feedback on data collected, and aided in the selection of final priorities. Membership of the above mentioned committees and collaborations intentionally represent vulnerable and disenfranchised populations including the homeless, uninsured/underinsured, Medicaid, Medicare, immigrant, disabled, mentally ill, and elderly.

Dignity Health's Chandler Regional Medical Center Board of Directors reviewed, approved, and adopted the Community Health Needs Assessment at its January 2019 meeting. The complete CHNA report is publicly available at: https://www.dignityhealth.org/arizona/locations/chandlerregional/about-us/community-benefit-outreach/benefits-reports

Process and Criteria for Prioritization

The process for prioritization included engagement with both internal Dignity Health stakeholders and community partners from the Community Benefit Committee and the Community Partnership Collaboration (See Appendix C for list of participating organizations). The first step of the process was a comprehensive presentation by MCDPH that included an overview of the CHNA findings and key emerging health needs. Throughout the presentation, stakeholders in attendance responded to survey questions that would later be used during strategy sessions to identify health priorities. After completion of the presentation, stakeholders were given the opportunity to provide additional feedback and recommendations.

The second step in the process involved review and prioritization of the key emerging health needs outlined in the MCDPH presentation. Dignity Health and MCDPH staff scheduled the East Valley Community Health Assessment strategy session and partners were invited.
The session entailed assigning participants to groups and instructing them to visit six stations. Each station included data and information on specific health needs. As participants discussed each health need, consideration was given to the size of the problem, disparity and equity, known effective interventions, resource feasibility and sustainability, and community salience. Participants rotated tables until all six health needs had been discussed. Through discussion, participants were able to determine what health need would feasibly results in a greater impact.

Dignity Health and MCDPH staff led the group in an activity using a 4-square grid 'Need' and 'Feasibility' criteria grid. The grid included four quadrants and each quadrant was labeled, 'High Need/High Feasibility,' 'Low Need/High Feasibility', 'High Need/Low Feasibility,' 'Low Need/Low Feasibility'. Participants were then asked to place competing labels on the grid. Information was gathered and a follow up survey was sent to provide another opportunity for feedback and recommendations. Participants were also asked to rank each health priority and/or add more strategies to identified needs, or other issues.

Final CRMC health priority recommendations were made and approved by the Community Benefits Committee and presented to the board on November 20, 2018.

CHNA Significant Health Needs

The following statements from Chandler Regional Medical Center's CHNA summarize each of the areas of priority for CRMC, and are based on data and information gathered through the CHNA.

A. Access to Care

Community members and key informants overwhelmingly felt that access to care is an important issue for the community. Within CRMC's primary service area, community survey respondents reported access to care as the number one most important "Health Problem" that impacts their community. There are also disparities experienced across members of certain racial/ethnic backgrounds, with Hispanics and American Indians being least likely to have insurance and poverty rates among American Indians (30.1%) in the CRMC primary service area, higher than Maricopa County rates (27.4%).

B. Mental Health and Behavioral Health

Mental health and Behavioral health are terms often used interchangeably to refer to a spectrum of health conditions which are each distinct yet often co-occurring and overlapping. Behavioral health includes not only ways of promoting well-being by preventing or intervening in mental illness such as anxiety or depression, but also has an aim preventing or intervening in substance abuse and suicide. Mental health was ranked as the most important health problem impacting the community by key informants. This was echoed by participants in the focus groups who believe mental health is one of top health issues impacting community residents. Mental health is ranked 9th in leading causes of emergency department visits and 7th in inpatient hospitalizations for CRMC's primary service area, and the highest rates of visits can be attributed to adults ages 25 to 34.

Substance abuse was one of the top concerns for both focus group participants and key informants. Key informants listed alcohol and drug abuse as two of the riskiest health behaviors community members are engaging in. Suicide is the tenth leading cause of death in the United States, accounting for more than 1% of all deaths.

Suicide was the eighth leading cause of death for Maricopa County and CRMC's primary service area in 2016. Although women are more likely to attempt suicide, men have higher rates of death by suicide. In Maricopa County, rates of suicide are highest among age groups 45-54 and 75+, which could indicate a potential health disparity in identification, referral or treatment of suicidal ideation.

C. Diabetes

In 2016, the number of deaths related to diabetes decreased in Maricopa County compared to 2015, but it is still the seventh leading cause of death in both Maricopa County and CRMC's primary service area indicating a sustained health need. In CRMC primary service area diabetes mortality rates are highest among ages 75+ years of age.

D. Breast Cancer

Breast Cancer is the second leading cause of cancer among U.S. women. About 1 in 8 women in the U.S. will develop invasive breast cancer during their lifetime. While advancements continue to be made in the fight against breast cancer, incidence rates in Maricopa County continue to be highest among white non-Hispanic and blacks. In the CRMC primary service area, breast cancer mortality rates among women ages 35-44 are higher than Maricopa County.

E. Injury Prevention

Injuries are not accidents, they are predictable and preventable. Unintentional injuries, including traffic-related, injuries, falls, burns, poisonings, and drowning were responsible for lost lives in the CRMC primary service area. Unintentional injury is the fifth leading cause of death in Maricopa County and sixth leading cause of death in the CRMC's primary service area. It is also the leading cause of emergency department visits and the second leading cause of inpatient discharges. Males are more likely to suffer from an unintentional injury with the exception of falls which are more prevalent among females.

F. Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Dignity Health CRMC is dedicated to making a positive impact on the social determinants of health, particularly on the health of those economically-disadvantaged communities. Resources that enhance quality of life can have a significant influence on population health outcomes. CRMC will focus on addressing homelessness, food insecurity, and transportation within their primary service area.

Significant Health Needs Not Being Addressed

The hospital intends to take actions to address all of the prioritized significant health needs in the CHNA report, both through its own programs and services and with community partners. Lists and descriptions of those planned actions are included in this report.

Resources Potentially Available

Additional resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community based organizations. Resources include access to hospital emergency and acute care services, Federally Qualified Health Centers (FQHC), food banks, homeless shelters, school-based health clinics, churches, transportation services, health enrollment navigators, free or low cost medical and dental care, and prevention-based community education. Below is a listing of potential resources to address prioritized community health needs:

Hospitals and Hospital Systems providing emergency care, acute care, outpatient services, and community programs:

- Arizona Heart Hospital
- Banner Health
- Dignity Health • OASIS Hospital • Arizona Orthopedic Surgical Hospital
- Honor Health
- Ironwood Cancer and Research Center
- Maricopa County Integrated Health System
- Phoenix Children's Hospital
- Valley Hospital

Chandler Regional Medical Center works collaboratively with many community organizations to address the need of the community. Refer to Appendix C for a listing of these valuable partners.

The Health Improvement Partnership of Maricopa County (HIPMC) is a collaborative effort between MCDPH and a diverse array of public and private organizations addressing healthy eating, active living, linkages to care and tobacco-free living. The HIPMC provides a forum to share ideas and resources as

well as a data-driven process to identify gaps and barriers to health improvement, especially among vulnerable populations. With more than 100 partner organizations, this is a valuable to resource to help Chandler Regional Medical Center connect to other community based organizations that are targeting many of the same health priorities.

Creating the Implementation Strategy

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

Focus on Disproportionate Unmet Health-Related Needs: Seek to address the needs of communities with disproportionate unmet health-related needs.
Emphasize Prevention: Address the underlying causes of persistent health problems through health promotion, disease prevention, and health protection.
Contribute to a Seamless Continuum of Care: Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities.
Build Community Capacity: Target charitable resources to mobilize and build the capacity of existing community assets.
Demonstrate Collaboration: Work together with community stakeholders on community health needs assessments, health improvement program planning and delivery to address significant health needs.

Creating the Implementation Strategy involved engagement with internal and external stakeholders, including two planning sessions conducted in October 2018 and one session conducted in April, 2019. Agencies represented included:

Gilbert Fire and Rescue, St. Matthew's Episcopal Church, Hushabye Nursery, Tempe Community Action Agency, Women's health Innovations, Community Alliance Against Family Abuse, Y OPAS Senior Outreach Programs Valley of the Sun YMCA, Mission of Mercy, Neighbor Who Care, Lutheran Social Services of the Southwest, Gilbert Police Department, AZCEND, Chandler Fire Department, Chandler Coalition On Youth Substance Abuse, Desert Cross Lutheran Church, Rebuilding Together, Mental Health America of Arizona, About Care, Homeward Bound, Pinnacle Prevention, Addiction Haven, Aura Behavioral Health, Legacy Home Care, Honor Health Forensic, Pan De Vida Foundation, Town of Gilbert, Family Home Care, Hope for Addiction, Circle the City, Foundation for Senior Living, JEM Foundation, House of Refuge, Chandler Human Relations Community, Amanda Hope, City of Maricopa Police Department, ICAN, Desert Cancer Foundation, College Bound, YMCA, P82 Project Restoration, Not My Kid, Advance Care Management, Maricopa Department of Public Health, Dignity Health: Trauma Services, Finance, Executive Leadership, Community Education, Community Health, Volunteers, Hospital Board members, Community Benefit Committee, Community Grant committee, Faith Health nurse, and Compliance.

Throughout the Implementation Strategy planning process, four areas of focus evolved that included: key considerations, approaches, resources, and tools. Table 2 below outlines the recommendations from internal and external stakeholders involved in the Implementation Strategy Process.

Table 2: Implementation Strategy Focus Areas

Key Considerations	Approaches	Resources	Measurement Tools
1.Lean Six Sigma 4-square priority/benefit matrix 2. Consideration to size of the problem, disparity, and equity 3. Known effective interventions 4. Resource feasibility 5. Existing community assets and Dignity Health programs 6. Existing gaps 7. Underlying root causes 8. Timelines for implementation 9. Community Needs Index 10. Identified populations	1.Collective Impact Model 2.Evidenced-Based Practices 3. Health Benefit Model 4. Education 5. Screening 6. Intervention or treatment 7 Providing resources 8. Support 9 Navigation 10.Community of Care Grants Program 11.Continuum of Care 12. CDC 6/18 Initiative	1. MCDPH – including SYNAPSE advisory board 2. Health Improvement Partnership of Maricopa County (HIPMC) 3. CDC, including 6/18 Initiative 4. Healthy People 5. Dignity Health 6. Arizona Department of Public Health 7. Resources and date available through community-based organizations and Dignity Health 8. Association Community Health Improvement (ACHI) 9. Catholic Health Association (CHA) guides and resources 10. Health Services Advisory Group (HSAG) 11. National Prevention Strategy	1.Dignity Health Program Digest reports 2. MCDPH: Healthmatters Tracker reports 3. Dignity Health Community of Care Grantee reports 4. CRMC admission and readmission rates 5. Community partner program outcomes 6. Community Benefit Reporting 7. CRMC grant funded programs reports 8.Dignity Health Prevention Quality Indicators (PQI)

Planning for the Uninsured/Underinsured Patient Population

In keeping with its mission, the hospital offers patient financial assistance (also called charity care) to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay. The hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A plain language summary of the hospital's Financial Assistance Policy is in Appendix B.

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for government programs, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

In addition to staff awareness and education, the community is made aware of the Financial Assistance Policy, including postings throughout the hospital that financial assistance is available. Specifically, signage is in English and Spanish in both the admitting areas and the emergency room, at urgent care, and other outpatient centers. Additionally, the Financial Assistance Policy is posted on the Chandler Regional Medical Center website.

The patient financial services staff works diligently to ensure every underinsured or uninsured patient has the opportunity to apply for financial assistance (AHCCCS, Kidcare, Emergency AHCCCS, and Dignity Health packages).

2019-2021 Implementation Strategy

This section presents strategies, programs and initiatives the hospital is delivering, funding, or on which it is collaborating (or anticipates collaborating) with others to address significant community health needs. It includes planned strategies and programs with anticipated impact and measurable objectives for the next three years.

The strategy and plan specifies significant community health needs that the hospital intends to address in whole or in part, in ways consistent with its mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital's limited resources to best serve the community.

Strategy and Program Plan Summary

Input from internal and external stakeholders resulted in the specified health priorities, strategies, and recommended activities outlined in the tables below. Requests for additional information on the activities and programs listed below can be submitted to the Chandler Regional Medical Center's Community Integration Department or by e-mail to Chandler-CHNA@DignityHealth.org

Table 3: Access to Health Care

Strategy	Program Summary: Current and Planned Activities
School-based healthcare for children and families:	1. Chandler Care Center on Galveston Elementary School campus 2. Chandler Regional Medical Center services provided at school locations
Free and low cost community-based health services:	1. Mission of Mercy: Primary Care for uninsured 2. Chandler and Gilbert AZCEND community health centers 3. Chandler Regional Medical Center community outreach services 4. Gilbert Heritage Wellness, Education, and Resource Center 5. City of Maricopa Family Advocacy Center
Access to healthcare information and available resources:	1. Access to healthcare information and resources: Chandler Care Center, AZCEND, Dignity Health: Gilbert based Heritage Wellness, Education, and Resource Center, Chandler Regional Medical Center Resource Link and website, Chandler and Gilbert CAP 2. Improved awareness of resources such as Find Help Phoenix and 211, Community Action Program 3. Foundation for Senior Living

	4. Keogh Foundation 5. Dignity Health Faith Health Ministry Program
Education on insurance, including eligibility, enrollment, and understanding one's medical bills:	1. Enrollment assistance programs are located at Chandler Care Center, AZCEND, I-HELP, Senior Community Wellness, Foundation for Senior Living, and Keogh Foundation 2. Financial Assistance: Dignity Health Financial Assistance policy 3. Keogh Foundation
Patient continuum of care:	Patient navigation and referrals to community based services before discharge include: 1. Foundation for Senior Living- ACTIVATE 2. Mission of Mercy 3. Circle the City 4 Chandler Regional Medical Center Community of Care grant recipients 5. Chandler Regional Medical Center Patient Referral program: Community Connection Network
Other recommendations from stakeholder sessions:	1. Dental services for adults 2. Mobile dental and immunization services to schools for children 3. Mobile wellness bus for dental and immunization services for adults in high-risk areas 4. Navigation programs 5. Patent and caregiver resource rooms in hospital 6. After hour and weekend services at low cost clinics for poor Expand clinic hours to accommodate working adults (more outside clinics w/ outside hours (9-5pm) 7. Need to provide more after hour access for working poor who cannot afford missing work during business hours 8. Increased education to parents on importance of immunizations
Identified population from CHNA:	Hispanic, American Indian, uninsured

Table 4: Mental Health and Behavioral Health

Strategy	Program Summary: Current and Planned Activities
Improve education and awareness for mental health, drug addiction, suicide, PTSD, trauma informed care, and reducing the stigma:	1. East Valley Behavioral Health Task Force 2. Chandler-Gilbert Substance Misuse and Treatment Task Force 3. Mental Health First Aid 4. Let's Talk 5. Empower Hope' Suicide Prevention Tool Kit 6. RX 360 7. Faith-based Crisis Care Team training
Youth and Adult based prevention services:	1. Partnership to Build Resilient Families; Dignity Health Community of Care grant recipients: ICAN, Chandler CARE Center, Big Brothers and Big Sisters of Arizona, CCYSA 2. Empower Hope' Suicide Prevention Tool Kit – Youth focus 3. Substance Misuse and Treatment Task Force – School based presentations
Access to crisis intervention services:	1. East Valley Behavioral Health Task Force 2. Substance Misuse and Treatment Task Force 3 Family Advocacy Center – City of Maricopa and Chandler 4. Proposed: Dignity Health Peer to Peer Mentoring Program with Hope for Addiction 5. La Frontera 6. Community Bridges

	7. A New Leaf
Pregnant and postpartum adjustment Support:	1. Chandler Regional Medical Center Postpartum Adjustment Support group 2. East Valley Perinatal Network; Dignity Health Community of Care grant recipient: Women's Health Innovation of Arizona, Hushabye Nursery, and Haven 107
Controlled substance prescription monitoring:	Dignity Health Emergency Room: CSPMP (Controlled Substance Prescription Monitoring Participation)
Other recommendations from stakeholder sessions:	1. Social work in ED for mental health 2. Connection to Peer to Peer support in emergency room and inpatient before discharge for drug use or mental health 3. Education on managing emotions without substance abuse 4. Screen for mental health in hospital, physician offices, and schools using Mhaarizona.org MHA's of AZ has a free anonymous MH screening 5. Education on Durable Power of Attorney, care giver support, living will 6. Mass community campaign to normalize seeking treatment for mental health 7. Dementia care 8. Increase Dignity Health advocacy efforts – The Jem Foundation 9. Strengthen partnership with faith community 10. Mental health counselors/experts in schools
Identified Population From CHNA:	1. Suicide: Youth 15-19 and African American 2. Substance Abuse/Opioid overdose: 20-24 year olds 3. Alcohol abuse: American Indian, blacks, Hispanic, and females 4. Mental Health: Women

Table 5: Diabetes

Strategy	Program Summary: Current and Planned Activities
Access to diabetes management and support:	1. Mercy Gilbert Medical Center, Center for Diabetes Management (accredited) 2. Mercy Gilbert Medical Center, Center for Diabetes Management Community based classes and presentations 3. Mercy Gilbert Medical Center, Center for Diabetes Management Sweet Life-Diabetes Outreach Connection support group 4. Mission of Mercy
Access to free Chronic Disease Self-Management education:	1. Chandler Regional Medical Center's Chronic Disease Self-Management Program (CDSMP) Workshops. Stanford model: Chronic Disease, Diabetes, DEEP, Pain Management 2. Safe at Home; Dignity Health Community of Care grant recipient, East Valley Adult Resources, Rebuilding Together Valley of the Sun, and AT Still University
Access to Fitness:	1. Dignity Health Center for Diabetes Management: Diabetes prevention program: Prevent T2 combining fitness and nutrition 2. ICAN 3. Partnership to Build Resilient Families 4. Southwest Valley YMCA
Other recommendations from stakeholder sessions:	1. Creating healthy lifestyle habits as family in schools and community 2. Education with respect to healthy maintenance of their well being 3. Community health workers that are able to connect and build rapport with the patient in order to education about how to manage diabetes 4. Availability of screening

	5. Access to free affordable exercise classes 6. Community-based, school-based and home care education on diabetes management 7. Offer diabetes care kit through carekit.com, tele-monitoring through prohealth, electronic caregiver 8. Expansion of chronic disease self-management education – behavior modification for prevention 9. Consider care kits and tele-monitoring through prohealth for chronic conditions that are often associated with diabetes: ASHMA, COPD, and CHF. Care kits can be obtained through carekit.com 10. Healthy eating cooking classes 11. Inpatient diabetes educators
Identified Population from CHNA:	African American, American Indian , Adults over 75

Table 6: Injury Prevention

Strategy	Program Summary: Current and or Planned Activities
Injury prevention/intervention education for children:	1. Injury prevention education in classrooms and community settings using evidenced-based "Think First" injury prevention program, Safe Sitter, Stop the Bleed, and Distracted Driving. 2. Car seat safety 3. Community based health fair education
Injury prevention/intervention for adults:	1. Conduct Matter of Balance evidenced based fall prevention education to senior populations and caregivers on improving mobility and reducing fall risk 2. Work with organizations that offer home safety equipment and resources 3. Safe at Home: Fall prevention "Matter of Balance" evidenced based program, home safety equipment installation. 4. Family Advocacy Centers
Other recommendations from stakeholder sessions:	1. Higher focus on prevention of texting while driving 2. Continue focus on falls prevention 3. Cell phone – selfie safety 4. More visible cross walks 5. Safe driving education 6. Increase education on prevention of child deaths in hot cars 7. Bloom 365 8. MADD
Identified population From CHNA:	Unintentional injury (male), falls (female), motor vehicle

Table 7: Breast Cancer

Strategy	Program Summary: Current and Planned Activities
Education on importance of early detection and availability of resources:	1. Dignity Health Women's Imaging Center 2. Ironwood Cancer and Research Center 3. Desert Cancer Foundation 4. Thriving and Surviving
Screening:	1. Dignity Health Women's Imaging Center 2. Ironwood Cancer and Research Center 3. Desert Cancer Foundation

Treatment:	1. Dignity Health – diagnostic and surgical treatment 2. Ironwood Cancer and Research Center – chemotherapy and radiation 3. Desert Cancer Foundation – support and referrals
Other recommendations from stakeholder sessions:	1. Mobile mammography at work sites 2. PSA on early detection
Identified population from CHNA:	Women ages 35-44

Table 8: Social Determinants of Health (Housing, Food, Transportation)

Strategy	Program Summary: Current and Planned Activities
Shelter, transitional housing, and permanent housing for the Homeless population:	1. I-HELP (Interfaith Homeless Emergency Lodging Program) - Dignity Health Community of Care grant recipient: AZCEND, Lutheran Social Services of the Southwest, Tempe Community Action Agency (TCAA) 2. Circle the City: Respite, hospice, and case management for the homeless 3. Dignity Health Homeless Initiative to improve resources for homeless patients before discharge 4. House of Refuge 5. Maggie's Place 6. Destination Diploma – Dignity Health Community of Care grant recipient: Homeward Bound, Pappas Kids Schoolhouse Foundation, Fans Across America 7. Circle the City 8. Without Walls Church – Mesa, AZ
Transportation to medical appointments:	Senior Community Wellness - Dignity Health Community of Care grant recipient : About Care, Neighbors Who Care and YOPAS- Ahwatukee Foothills YMCA Outreach Program for Ahwatukee Seniors
Access to healthy food and/or other basic needs:	1. Mathews Crossing 2. Chandler Care Center 3. AZCEND 4. I-HELP 5 Clothes Cabin 6. Boys and Girls Club SNAP enrollment at Chandler Care Center, AZCEND, Heritage Wellness, Education, and Resource Center, Foundation for Senior Living, and Keogh Foundation
Other recommendations from stakeholder sessions:	1. Expand I-HELP 2. Work more formally with farmers markets and community gardens 3. Develop a hospital-based community garden 4. Increase the number of famers markets that accept SNAP and increase the location for "Double Up Food Bucks"
Identified Populations from CHNA:	Low income, homeless, uninsured/underinsured children and families

Anticipated Impact

The anticipated impacts of specific program initiatives, including goals and objectives, are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to care; and help create conditions that support good health. The hospital is committed to monitoring key initiatives to assess and improve impact.

The Community Benefit Committee, hospital executive leadership, Community Board, and Dignity Health receive and review program updates. In addition, the hospital evaluates impact and sets priorities for its community benefit program by conducting Community Health Needs Assessments every three years.

Planned Collaboration

Maricopa County Department of Public Health (MCDPH):
Dignity Health Arizona is part of the SYNAPSE Collaborative Community Health Needs Assessment Partnership with other health systems for the Maricopa County, AZ CHNA. Through this partnership, hospitals work collaboratively with the county identify approaches for the most pressing health needs impacting the community.

MCDPH: Health Improvement Partnership of Maricopa County (HIPMC):
Dignity Health, Arizona is a member of HIPMC, a community-wide action plan for addressing priority health issues identified in Maricopa County's Community Health Needs Assessment.
The Health Improvement Partnership of Maricopa County is a collaborative effort between Maricopa County Department of Public Health and more than 60 public and private organizations addressing priority health issues through the Community Health Improvement Plan (CHIP).

The framework being used by MCDPH aligns with the National Prevention Strategy and falls into four sectors that include: Where We Live, Where We Work, Where We learn, and Where We Seek Care. HIPMC partners, including CRMC, enter their programs and services that align with strategies from each sector. This approach addresses chronic disease in places where people spend significant amounts of time and reflects the importance of wellness and prevention in all aspects of our lives.
Emphasis is placed upon utilizing evidence based-strategies and policy, systems, and environmental approaches to impact health priorities (http://www.arizonahealthmatters.org)

Progress with strategies within the fours sectors is tracked and posted quarterly on the Health Matters website at http://www.arizonahealthmatters.org The CHIP tracker uses a set of indicators for each health priority that can measure progress. Through HIPMIC, partners can work collaboratively to have a large impact on improving the quality of life for all Maricopa County residents, particularly most vulnerable.

Town of Gilbert: Chandler Regional Medical Center, is a lead collaborator with the Town of Gilbert, along with several nonprofit agencies, collaborating on the Heritage Center's Wellness, Education, and Resource Center that opened in May, 2018 to improve access to care and resources. Dignity Health services offered at the center include prevention dental services, immunizations, children's hearing and vision screening, and community education.

Town of Gilbert: Chandler Regional Medical Center is a member of the Town of Gilbert's East Valley Behavioral Health Coalition that focuses on access to care, education and awareness, and emergency response.

City of Chandler: Chandler Regional Medical Center is a collaborative partner with the Chandler Care Center located on the Galveston Elementary School campus. The Care Center offers access to care for underserved children and families in the Chandler Unified School District and community.

Services include Family Resource Center, WIC, Southwest Behavioral Health, food bank, medical clinic for children, and restorative dental services for children in partnership with St. Vincent De Paul. Dignity Health services include a prevention dental clinic, hearing and vision screening, immunizations, and chronic disease self-management.

City of Chandler: Chandler Regional Medical Center is in partnership with the Chandler Substance Misuse and Treatment Task Force that works with hospitals, schools and community stakeholders to provide education, access to treatment and recover, and support for individuals and families experiencing drug addiction.

City of Maricopa: Chandler Regional Medical Center is a lead collaborator with the City of Maricopa for the Family Advocacy Center that opened in April, 2019.
The Family Advocacy Center will provide a holistic approach with comprehensive care and investigative services for victims of crime, including victims of family violence and their children.

Queen Creek: Chandler Regional Medical Center is in partnerships with the Town of Queen Creek in efforts to address increasing numbers of teen suicide. In addition, Dignity Health is an advisor to Pan De Vida nonprofit organizations in Queen Creek such as Pan De Vida in planning for a community center in an underserved community in Queen Creek.

Foundation for Senior Living: Chandler Regional Medical Center is a collaborative partner with Foundation for Senior Living to improve outcomes for high risk patients by providing patient navigation before and after discharge.
Through the partnership the patient receives support through the continuum of care that improves post hospitalization recovery, reduces readmission, and improves patient quality of life.

Chandler Regional Medical Center collaborates with many community agencies, leaders, and partners to address significant health needs through education, intervention, prevention, support, and treatment. Key partners include, but are not limited to, Dignity Health Community of Care grant recipients, local school districts, colleges, and universities, government sponsored agencies, FQHC's and community clinics, nonprofit agencies, churches, and coalitions. Refer to Appendix E for a listing of current and anticipated collaborative partners.

Program Digests The following pages include Program Digests describing key programs and initiatives that address one or more significant health need in the most recently completed CHNA report.

Program Digests

Dignity Health Community Grants Program	
Significant Health Needs Addressed	X Access to Care X Mental Health and Behavioral Health X Diabetes X Breast Cancer X Injury Prevention X Social Determinants of Health
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Emphasize Prevention X Seamless Continuum of Care X Build Community Capacity X Demonstrate Collaboration
Program Description	Each year the hospital allocates a percentage (0.05) of the previous year's expenses to support the efforts of other not-for-profit organizations in the local communities. An objective of the Community Grants Program is to award grants to nonprofit organizations whose proposals respond to identified priorities in the Community Health Needs Assessment and initiative. Additionally, it is required that a minimum of three organizations work together in a Community of Care to address an identified health priority.
Community Benefit Category	E2-a Grants: Community Grants Program
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	1. To award funds to nonprofit organizations whose proposals respond to the priorities identified in the CHNA and/or Implementation Strategy Plan 2. Fund proposals that best align with the community benefit core principle a) disenfranchised populations with unmet health needs b) primary prevention c) continuum of care d) capacity building e) collaborative governance 3. Fund Communities of Care initiatives to address identified needs and provide a more integrated approach and a collective impact on improving health. Specifically to address health priorities of chronic disease, access to health, oral health, mental health, and obesity. 4. Increase membership of community based partners by a least one. 5. Conduct committee and agency survey and consider changes to improve program, including forms and process. 6. Monitor funded initiatives through site visits, six month report, and Dignity Health sponsored networking/workshops.
Measurable Objective(s) with Indicator(s)	1.100% of agencies awarded a community grant will be addressing an identified need as stated in the initiative, CHNA, and community benefit plan. 2.100% of the agencies awarded a community grant will be providing services to underserved/disenfranchised populations and align with the majority of Community Benefit Core Principles.

	3. 100% of the agencies funded will be part of a Community of Care whereas three or more agencies working collaboratively to address an identified need. 4. One to two new members will be added to the community grants committee 5. Survey completed, and at least one program improvement made as a response to survey. 6. Committee members will complete site visits for 100% of awarded agencies, 100% of six month reports will be submitted and reviewed, and Dignity Health will sponsor at least one workshop.
Intervention Actions for Achieving Goal	1. Use the Request for Proposal (RFP) process to fund Communities of Care that address identified needs, align with significant health needs identified in the CHNA, and align with core community benefit principles. 2. Meet and recruit community leaders to participate in the Committee 3. Monitor and support funded agencies through reporting, site visits, and one: one, workshops, and connection to needed resources
Planned Collaboration	Through the grant awards, Dignity Health becomes a collaborative partner with each Community of Care, and associated agencies. To ensure success of the program. Specific planned collaborations over the past three years include: About Care, Neighbors Who Care, Valley of the Sun YMCA/Ahwatukee, AZCEND., Lutheran Social Services of the Southwest, Tempe Community in Action, Chandler Education Foundation, ICAN, My Sister's Place, Hope Community Health Center, Valley of the Sun YMCA/Chandler/Gilbert, Community Alliance Against Family Abuse, Maricopa Police Foundation, Hope Women's Center, Chandler Coalition on Youth Substance Abuse, East Valley Adult Resources, Rebuilding Together Valley of the Sun, AT Still University, Homeward Bound, Pappas Kids Schoolhouse Foundation, Fans Across America

First Teeth First	
Significant Health Needs Addressed	**X** Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention **X** Seamless Continuum of Care **X** Build Community Capacity **X** Demonstrate Collaboration
Program Description	First Teeth First provides oral health education, oral health screening, and fluoride varnish treatment to expectant women, and children up to age 6 years and best practice oral health education to dentists, pediatricians, and other early childhood professionals. First Teeth First is funded primarily through First Things First (Arizona Early Childhood Development and Health Board). Chandler Regional Medical Center supports the program with administrative functions and funding of employee benefits.

Community Benefit Category	A1b Community Based Clinic
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	Dignity Health will work with Maricopa County Department of Public Health to provide a coordinated approach to oral health prevention services in Maricopa County. First Teeth First will provide oral health education, oral health screening, fluoride varnish treatment, and care coordination for expectant women, and children up to age 6 years. First Teeth First will also provide outreach and training to medical and dental professionals that serve the target population. The program will decrease the number of children with early childhood tooth decay and the associated risks for pain and infections that can lead to lifelong complications to health and wellbeing.
Measurable Objective(s) with Indicator(s)	6000 children will receive oral health screenings. 6000 children will receive fluoride varnish application. 900 expectant women will receive oral health screenings. 6000 adults will receive oral health education. 37 education presentation for professionals will be provided in the community.
Intervention Actions for Achieving Goal	1. Oral health education based on the most up-to-date evidence will be provided to expectant women and children up to age 6 years and their families. 2. Children up to age 6 years will be screened for oral health status and provided with fluoride varnish when appropriate. 3. All children receiving services will receive a toothbrush, toothpaste, floss, and educational materials. 4. Care coordination for establishment of a dental home will be provided when appropriate. 5. Clinics will be scheduled at community locations including WIC centers, pediatric medical offices, OB offices, child birth preparation classes and pregnancy support programs, community resource centers, and health fairs. 6. Bilingual staff will provide oral health education in Spanish when appropriate. Other language translation services will be available by phone if needed. 7. Medical providers and staff will be provided with strategies to identify children at risk for tooth decay and encourage establishment of a dental home by age one. 8. Staff at general dental practices will be provided with strategies for working with young children and developing the practice as a dental home for children beginning at age one.
Planned Collaboration	Collaboration with community partners is key to the success of First Teeth First. Dignity Health is developing partnerships with four WIC centers, two community resource centers, three child birth preparation and pregnancy support programs, two pediatric offices, and two OB offices in the East and Southeast Valley. Our collaboration with the Mesa Community College Dental Hygiene program provides an opportunity to engage future dental professionals. Dental hygiene students participate in First Teeth First clinics as part of their community clinic rotations. Dignity Health will work with the Maricopa County Department of Public Health to deliver the First Teeth First program.

Children's Dental Clinic	
Significant Health Needs Addressed	**X** Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention **X** Seamless Continuum of Care **X** Build Community Capacity **X** Demonstrate Collaboration
Program Description	The Children's Dental Clinic utilizes Affiliated Practice Dental Hygienists to provide comprehensive preventive dental care to low-income and uninsured children. Services include dental assessments, radiographic imaging, sealants, fluoride varnish treatments, oral health education, nutrition education, orofacial myofunctional therapy, and coordination of care. Located at a school-based family resource center, the clinic is perceived as a safe-haven, where individuals can seek compassionate, culturally sensitive care. While clinic services are important, behavior change is a critical component of oral health. The dental clinic's bilingual Promotora works with families to complete risk assessments and goals setting for behavior change to improve oral health. The dental clinic's Community Oral Health Liaison strengthens the clinic's connection with the community by providing oral health education and supplies to children, families, and expectant women at community locations. The clinic is grant-funded with additional financial and operational support from Chandler Regional Medical Center and the Dignity Health Foundation- East Valley.
Community Benefit Category	A1b Community Based Clinic
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	The Children's Dental Clinic will improve the oral health of children ages 0 to 21 by reducing barriers to care and increasing awareness of the importance of oral health.
Measurable Objective(s) with Indicator(s)	1. Number of children receiving full preventive dental services 2. Percent of patients with "no new decay" at subsequent clinic appointments. 3. Number of children, pregnant teens, parents, educators, and community leaders who received comprehensive oral health education.
Intervention Actions for Achieving Goal	1. Provide preventive dental health services including dental assessments, professional cleanings, radiographic imaging, sealants, fluoride varnish treatments, oral health education, nutrition education, orofacial myofuntional therapy, and care coordination. 2. Provide care coordination for 100% of children in need of restorative dental care. 3. Increase awareness and improve children's oral and overall health through education for children and parents. 4. Provide dental supplies to children at the clinic and in the community.

	The Dignity Health Children's Dental Clinic uses education and clinical prevention services to address oral health disparities. Reduced plaque scores and decreased decay to indicate that children are incorporating healthy oral health habits at home. These behavior changes, along with restorative care to alleviate pain, have long-lasting impacts on children. Better nutrition and sleep lead to decreased absenteeism and increased attention in school. A positive dental experience for children increases the likelihood of continuing regular dental care which will carry into adulthood.
Planned Collaboration	The Chandler Children's Dental clinic relies on collaborations to improve access to care and continuum of care. The clinic is located at the Chandler CARE Center, a program of the Chandler Unified School District (CUSD). The St. Vincent de Paul Dental Clinic provides restorative dental services at the same location, providing a direct link to services for patients. Additional partnerships with a variety of dental professionals ensure that children in need of restorative care are treated appropriately. Children in urgent need of restorative care with no means to pay are referred to partnering dentists who have agreed to provide free care to a limited number of children. Dental Hygiene students from Mesa Community College Dental Hygiene School have regular rotations through the clinic. The students gain community and public health dental experience and increase the capacity of the clinic, enabling more children to be seen. Through a partnership with Maricopa County Department of Public Health, the clinic educator provides education at schools in four Phoenix East Valley school districts which are scheduled with the County's School-Based Dental Sealant Program.

Immunizations 2019 - 2021	
Significant Health Needs Addressed	**X** Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention ❑ Seamless Continuum of Care **X** Build Community Capacity **X** Demonstrate Collaboration
Program Description	Children's Vaccine Program provides free immunizations (vaccines provided through the State Vaccines for Children Program) for children 18 years and younger who are uninsured, underinsured, on AHCCCS, or American Indian or Alaskan Native. Free clinics are held at the CRMC Licensed Outpatient Treatment Center at the Chandler Care Center and at mobile sites in partnership with Maricopa County Department of Health Services throughout the East Valley service areas. Dignity Health provides staffing and supplies for the clinics.

	Adult Vaccine Program: Offers free adult immunizations (vaccines provided through the State Vaccines for Adults Program) for people 19 years and older who are uninsured, underinsured, on AHCCCS, or American Indian or Alaskan Native. A $15 administration fee is requested but is not mandatory. Free clinics are held at the CRMC Licensed Outpatient Treatment Center at the Chandler Care Center and at mobile sites in partnership with Maricopa County Department of Health Services throughout the East Valley service areas. Dignity Health provides staffing and supplies for the clinics.
Community Benefit Category	A2b Community Based Clinics
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	1. Administer vaccinations to children seeking immunization with emphasis on medically underserved communities and families. 2. Provide access to 100% of our immunization clinics for agencies that assess eligibility of people for government subsidized healthcare programs. 3. Provide education and awareness on the importance of immunizations. 4. Data collection and entry of the data into the state immunization database. 5. Ongoing evaluation of current contracts/partnerships. 6. Increase client base through aggressive marketing 7. Seek grant and donated funds to offset cost of program.
Measurable Objective(s) with Indicator(s)	1. Number of immunization clinics for children and adults. 2. Number of people screened: children and adults. 3. Number of vaccines given: children and adults. 4. Monitor and track revenue and pharmaceutical costs. 5. Percentage of State data entered and up to date by June 30th 6. Number and frequency of marketing contacts.
Intervention Actions for Achieving Goal	1. Seeking grants and funds to help offset costs not covered by Federal government. 2. Continue marketing to the community to increase our vaccination rates and the continued efforts to eradicate communicable vaccine preventable diseases.
Planned Collaboration	Chandler Unified School District, Chandler Care Center, VFC, VFA, Town of Gilbert, Gilbert Heritage Wellness, Education, and Resource Center, AZCEND, Gilbert Fire and Rescue, Maricopa County Department of Health, Tempe School District, The Arizona Partnership for Immunization. Planned collaboration is with Gilbert Public Schools.

Building Blocks Vision and Hearing Screening	
Significant Health Needs Addressed	**X** Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention ❑ Seamless Continuum of Care **X** Build Community Capacity ❑ Demonstrate Collaboration

Program Description	Building Blocks Vision and Hearing offers services to: 1. Help medically prepare under-served children for school. 2. Help medically prepare the adult uninsured, underserved and/or homeless populations to receive vision services that support employment and other program outcomes that help the transition from social assistance. The vision and hearing screening is a portable program targeting children 0-5 years in the East Valley community and serves children up to age 18 years and underserved and homeless adults age 19 and older. The clinics, located in areas of greatest need as identified in the 2018 Community Health Needs Screening for Chandler Regional Medical Center Service Areas, are accessible to those least likely to receive vision/hearing screening from mainstream health care. Dignity Health provides salary for the RN manager of the Community Wellness department and provides the employee benefits for the two BBC program employees. The salaries of the two employees (.6 FTE each) are grant and foundation funded.
Community Benefit Category	A -2 Community Based Clinics
Planned Actions FY 2019-2021	
Program Goal / Anticipated Impact	To provide vision and hearing screening and education to the population of newborn -18 years in the Dignity Health service areas identifying those children requiring intervention and referral and ensuring that each child requiring intervention receives a referral in a timely manner and follows through on the referral. To provide vision screening and accessible and affordable referral for follow-up care to the underserved and homeless adults age 19 and older in conjunction with partners who serve these populations in the Dignity Health service areas.
Measurable Objective(s) with Indicator(s)	1. Number of people screened 2. Number of people educated 3. Number of grants a. submitted b. awarded 4. Number of partners 5. Number of referrals
Intervention Actions for Achieving Goal	Describe the principal program/initiative activities planned 1. Confirm sites for calendar year 2. Maintain adequate staffing and supplies 3. Provide adequate hours of operation 4. Secure new/formal partners 5. Seek grant and other monies toward continuation and growth of BBC V&H
Planned Collaboration	Current collaborations include: City of Chandler, Chandler Care Center, Vision Quest 2020, HEARS for Children, Lions Vision Service Center, Ear Foundation of Arizona, Target Optic Service Center, The Birth Haven, Gilbert Heritage Wellness, Education, and Resource Center, AZCEND

Healthier Living Program	
Significant Health Needs Addressed	**X** Access to Care **X** Mental Health and Behavioral Health **X** Diabetes **X** Breast Cancer **X** Injury Prevention **X** Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention **X** Seamless Continuum of Care **X** Build Community Capacity **X** Demonstrate Collaboration
Program Description	Healthier Living is an evidence-based program comprised of workshops originally developed by Stanford University (now SMRC) and the University of Illinois at Chicago. The 6-week workshops are offered 100% free to participants and help those with diabetes, chronic pain, or any chronic disease to self-manage their conditions. The senior and low income/underserved populations are specifically targeted.
Community Benefit Category	A-1 a Community Health Education
Planned Actions for FY 2019-2021	
Program Goal / Anticipated Impact	The Healthier Living Program will deliver quality Healthier Living Workshops – Chronic Disease (CDSMP), Diabetes (DEEP), Chronic Pain (CPSMP), and Matter of Balance (MOB) workshops to participants, improving their overall health and well-being and ability to manage their chronic conditions resulting in a decrease in hospitalizations and ER visits, thus reducing healthcare costs.
Measurable Objective(s) with Indicator(s)	1. Secure funding sources to insure program sustainability 2. Clearly defined agreements with cost sharing partners in place to insure program sustainability 3. Program budget reflecting accurate expenses, revenues, and cost sharing reimbursements 4. Offer 35 workshops annually serving approximately 500 participants 5. Offer DEEP diabetes workshops to take advantage of HSAG cost sharing 6. Program offerings diversification to include CDSMP, DEEP, CPSMP, and MOB to better serve the community. 7. 25% of total workshops delivered annually will serve the senior population 8. Deliver 2 workshops annually serving the homeless population each year 9. Deliver a minimum of 4 workshops serving low income/underserved population annually 10. Serve community partners who share in program responsibility for success 11. Produce meaningful statistics and analytics demonstrating program efficacy 12. Community partners onboard with desire and capacity to “champion” program and commit to success as demonstrated by program analytics.

Intervention Actions for Achieving Goal	1. Develop annual FY program budget and program strategic plan. 2. Operate program in alignment with program strategic plan and within budgetary constraints 3. Continue to seek and secure funding sources to insure program sustainability 4. Continue to develop and nurture cost sharing partners to insure program sustainability 5. Develop and nurture community partners with desire and capacity to "champion" program and commit to success; Strategically review, add, and eliminate non-performing community partners 6. Promote and deliver a "full service" Healthier Living program model. 7. Deliver workshops in accordance with all Self-Management Resource Center (SMRC) fidelity and University of Illinois at Chicago requirements 8. Continue collecting and reporting meaningful analytics supporting program efficacy. 9. Continue to develop and nurture east valley hospital workshop participant referral sources
Planned Collaboration	Community Partners Include: Lutheran Social Services of the Southwest, St. Mary's/St. Juan Diego Catholic Churches, Mission of Mercy, AZCEND, Tempe Community Action Agency (TCAA), Mercy Housing, Friendship Village A New Leaf, Leisure World, Tempe Pyle Recreation Center, Chandler/Gilbert Senior Centers, Renaissance Luxury Living, The Summit at Sunland Springs, Cal-Am Resorts, Maricopa County Library System, Fellowship Square, Clarendale Chandler Cost Sharing/Funding Partners Include: Maricopa County, Mission of Mercy, AZCEND, Health Services Advisory Group (HSAG), Area Agency on Aging Region One (AAA), National Kidney Foundation, Arizona, Walmart Stores, East Valley Committee on Aging Hospital Partners Include: Dignity Health East Valley Foundation, CRMC and MGMC Volunteer Services, Dignity Health East Valley Rehabilitation Hospital, Dignity Health Medical Group – Chandler, CRMC Neuro floor, Dignity Health East Valley Stroke Survivor's Support Group, Dignity Health Faith Health Ministry

Mommy Fit Camps Program	
Significant Health Needs Addressed	**X** Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention ❑ Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Obesity is on the rise and has significantly increased among women of the childbearing age range and women in the perinatal period. Maternal obesity can lead to a variety of pregnancy, birth, and future complications.

	Mommy Fit Camps – is a preventive program that provides free pregnancy and postpartum fitness classes. Classes are held at Dignity Health, Mercy Gilbert and Rome Towers - Community Education. Lead by a CAPPA Certified Pregnancy Fitness Educator. Staffing and supplies are provided thru Dignity Health. Classes are geared for two populations: pregnant moms, postpartum moms, and their babies. Each class is low to moderate pace and can be modified to each individual fitness level. Exercising during pregnancy and postpartum, reduces general perinatal discomforts, reduces your risk for gestational diabetes, lower incidence of perinatal mental health disorders, and decreases likelihood of future challenges with obesity.
Community Benefit Category	A1-e Community Health Education – Self Help
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	Weekly fitness classes held to improve birth outcomes, manage weight gain in pregnancy and manage weight loss after birth and recovery period.
Measurable Objective(s) with Indicator(s)	Offer weekly classes. Pregnancy Fit Camp – 43 weekly classes held in FY18 Postpartum Fit Camp – 45 weekly classes held in FY18 Track weekly participation Pregnancy Fit Camp served 220 participants FY18 Postpartum Fit Camp served 293 participants FY18
Intervention Actions for Achieving Goal	1. Continue to offer weekly fitness classes: One pregnancy fit camp per week and one postpartum mom and baby fit camp per week. 2. Look at the possibility of adding additional fit camp per week.
Planned Collaboration	1. Collaborated with March of Dimes, to lead participants in the annual March for Babies event in downtown Phoenix 2. Collaborated with Women's Health Innovations, Maternal Mental Health awareness event. Lead a prenatal and postnatal workout during event.

Think First	
Significant Health Needs Addressed	❑ Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer **X** Injury Prevention ❑ Social Determinants of Health
Program Emphasis	❑ Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention ❑ Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	The ThinkFirst for Kids Program was developed by the ThinkFirst National Injury Prevention Foundation to increase awareness and knowledge among children about the risks of brain and spinal cord injury, and the use of good safety habits. The program is designed to enhance students' interest and learning by using four interactive components which include:

	1) curriculum for brain and spinal cord injury prevention containing six subject- integrated lessons, 2) an animated cartoon video that provides an overview of brain and spinal cord injury and safety topics, 3) a set of five comic sheets (one per safety topic), 4) a set of five full-color classroom posters that reinforce key messages presented during classroom instruction. Teaching strategies are used that inspire creativity and learning (e.g., role-play, stories, visual enforcement, hands-on, reading, sharing ideas, etc.). The ThinkFirst for Kids Program's goal is to help students (grade 1-3) develop safety habits that will minimize their risks of sustaining a brain or spinal card injury. This is done in a fun but interactive way, which also involves teachers, parents and the community.
Community Benefit Category	A1 Community Health Education
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	1. Present the ThinkFirst for Kids Program to at least two Title I schools and one afterschool community center 2. Provide bike helmets for each student 3. Continue collaboration with Maricopa School District in order to bring Think First for Kids Program to this new service area 4. Apply for grant to expand the program in high schools teaching ThinkFirst for Teens curriculum
Measurable Objective(s) with Indicator(s)	1. Present ThinkFirst for Kids curriculum to third graders in public schools in the City of Maricopa. 2. Present ThinkFirst for Kids curriculum to third graders in the Gilbert/Chandler public school district. 3. Present ThinkFirst for Teens curriculum to high school students if funding secured. 4. Continue to apply for grants to fund the programs as evidenced by receiving either money or a rejection. 5. Pre and post-tests to be administered to third grade students to assess knowledge transfer. 6. Post-evaluations are to be given to all teachers once the classroom/assembly sessions completed. 7. Continue to collaborative ThinkFirst for Kids outreach events with the East Valley Dignity Health Trauma Department, Safe Kids of Maricopa and St Joseph Hospital and Medical Center/Barrow Neurological Institute. 8. If funding can be secured, provide lessons to children, 8-9 years at ICAN.
Intervention Actions for Achieving Goal	1. Provide education to prevent brain and spinal cord injury at local health fairs and clinics. 2. Continue to provide ThinkFirst for Kids to the third graders in public schools in the City of Maricopa and Gilbert/Chandler School Districts. 3.Provide program in summer to students at ICAN 4. If funding secured expand program to include ThinkFirst for Teens in high schools. 5. Seek grant funding to sustain programs.

Planned Collaboration	The ThinkFirst for Kids collaborates with Chandler Regional & Mercy Gilbert Medical Center's Trauma Department, Gilbert Public Schools and the Maricopa Unified School District #20. The program also collaborates with Safe Kids of Maricopa. The program currently has no grant funding.

CRMC Trauma Services Injury Prevention	
Significant Health Needs Addressed	❑ Access to Care ❑ Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer **X** Injury Prevention ❑ Social Determinants of Health
Program Emphasis	❑ Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention ❑ Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Chandler Regional Trauma Services Department is dedicated to serving our community. "Stop the Bleed" is a national bleeding control course that teaches hemorrhage control to citizens to aid in saving lives. We use a presentation to teach the citizens/students the lifesaving information and then have a hands on portion where they can practice tourniquet application and wound packing. CRMC Trauma Services also supports "Walk With A Doc" Sun Lakes. Walk With a Doc is a community based education program that incorporates education on different health topics as well as exposure to providers from the community. A physician from CRMC goes out into the community of Sun Lakes to provide education and promote a healthy lifestyle and exercise to keep the participants active and mobile to limit the risk of falls and injury. "Matter of Balance" is an evidence based group intervention to reduce fear of falling and increase activity levels for senior citizens. Our goal is to host additional sessions on campus at CRMC and expand the program in the East Valley. We will be launching "D4" (Dignity Doesn't Drive Distracted) driving simulation curriculum to teach the dangers of distracted/impaired driving.
Community Benefit Category	A1 Community Health Education
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	1.) Provide 'Stop the Bleed' kits for participating schools to increase survivability in incidents of mass hemorrhage. 2.) Anticipate to train 1,000 + per year in 'Stop the Bleed' 3.) Continue to support each "Walk With A Doc" event for Sun Lakes with providers and supplies. 4.) Expand Matter of Balance into additional East Valley communities and host a program at CRMC for fall risk patients. This will reduce the number of falls in the community then decreasing fall injury admissions. 5.) Roll out the "D4" distracted driving curriculum focusing on teen drivers to decrease MVC's.

Measurable Objective(s) with Indicator(s)	1.) Teach 'Stop the Bleed' to at least 1,000 community members a year (2019-2021) including multiple school district health office staff, teachers and students. Will collect and track pre and post education evaluations. 2.) Provide (13) providers/speakers for "Walk With a Doc". 3.) Have CRMC host a Matter of Balance class annually for 10-12 identified fall risk patients that have been discharged from CRMC. 4.) "D4" (Dignity Doesn't Drive Distracted) simulation program roll out to community health fairs and school districts (Chandler, Mesa, Tempe).
Intervention Actions for Achieving Goal	1.) Continue existing partnerships with school districts, cities and EMS agencies to provide training. 2.) Seek grant funding through the hospital and foundation to fund programs. 3.) Work with physical/occupational therapy and inpatient units to identify high risk fall patients for enrollment in CRMC hosted Matter of Balance classes.
Planned Collaboration	We are expanding our education/prevention programs by collaborating with Mesa, Tempe, Gilbert and Gila River School Districts. Additionally we also are going to be working with Gila River EMS on Stop The Bleed education on the Gila River Indian Reservation. We will also be collaborating with Tempe Fire Department on education programs for their staff and community.

Pregnancy and Postpartum Support Group & Let's Talk Therapy Group	
Significant Health Needs Addressed	**X** Access to Care **X** Mental Health and Behavioral Health ❑ Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	**X** Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention **X** Seamless Continuum of Care ❑ Build Community Capacity **X** Demonstrate Collaboration
Program Description	Approximately one in five women, and one in 10 men, will experience a perinatal mood disorder. The Pregnancy and Postpartum Support Group is a peer based support group that provides a safe, judgement-free place to connect with other moms in similar stages of life and experiencing similar challenges. This is a free drop-in group that meets weekly. Let's Talk is a closed perinatal therapeutic group that meets for six weeks and is led by a licensed therapist specializing in perinatal mental health. This free group meets for two hours per week for six weeks with the same group of moms.
Community Benefit Category	A1-d Community Health Education – Support Groups

Planned Actions FY2019-2021	
Program Goal / Anticipated Impact	1. To provide pregnant and postpartum mothers (and their partner) services and resources as it relates to perinatal mental health.
Measurable Objective(s) with Indicator(s)	1. After attending the Pregnancy and Postpartum Support Group, participants will report improved success navigating emotional adjustment issues, resources and treatment options, and a sense of community for themselves. 2. After attending the Let's Talk sessions, the participant will experience a decrease in perinatal mental health disorder symptoms as indicated on Pre- and Post-evaluations, and Edinburgh Perinatal Depression Scale. 3. After attending Let's Talk, moms will be able to verbalize one way to have better communication skills with family members. 4. At the completion of Let's Talk, the participant will be able to verbalize two situations with the infant which causes her stress levels to increase and activities she can do to circumvent these stressors.
Intervention Actions for Achieving Goal	1. Provide different and pertinent topic for discussion, or tool each week. 2. Provide education about Maternal Mental Health to increase awareness about the condition, resources, and treatment options. 3. Provide mothers the opportunity to talk, listen, and share experiences, thoughts, and feelings with other women in a safe and nonjudgmental environment.
Planned Collaboration	Dignity Health has contracted with Women's Health Innovations of Arizona to provide the six-week therapeutic program, Let's Talk. Women's Health Innovations is a 501(c)(3) organization and are considered experts in their field and provide a variety of services to families within the community struggling with perinatal mental health. Recent collaboration with AZCEND in Chandler to offer Let's Talk for the Spanish speaking population, beginning in July 2019.

Center for Diabetes Management	
Significant Health Needs Addressed	❑ Access to Care ❑ Mental Health and Behavioral Health **X** Diabetes ❑ Breast Cancer ❑ Injury Prevention ❑ Social Determinants of Health
Program Emphasis	❑ Disproportionate Unmet Health-Related Needs **X** Emphasize Prevention ❑ Seamless Continuum of Care ❑ Build Community Capacity ❑ Demonstrate Collaboration
Program Description	Our comprehensive Center for Diabetes Management (CDM) offers education for a wide variety of patient needs: • Diabetes self-management training for people with type 1 and type 2 diabetes • Gestational diabetes/diabetes and pregnancy classes • Blood glucose meter training • Insulin initiation and management • Pre-diabetes/metabolic syndrome • Continuous glucose monitoring

	• Insulin pump management CDC Prevent T 2 program The center also participates in community events and offers free outreach and support groups and screenings to promote community awareness on lifestyle changes and the prevention and management of diabetes. All classes are taught at Center for Diabetes Management, an outpatient facility of Mercy Gilbert Medical Center. Facilities, expenses and staffing are supported by the hospital.
Community Benefit Category	A-1 Community Health Education
Planned Actions for 2019-2021	
Program Goal / Anticipated Impact	Actively market Center for Diabetes Management to promote our services to patients, hospital staff and health care providers to achieve an average of 360 patient encounters per month. Coordinate with inpatient departments, care coordination, and nursing education to develop an effective system for referrals from inpatient to outpatient. CDM is currently getting referrals through both NaviHealth and Cerner.
Measurable Objective(s) with Indicator(s)	• Number of patient encounters per month • Number of in-house referrals made, if able to accurately track. • Number of community events
Intervention Actions for Achieving Goal	• Form appropriate community partnerships and collaborative efforts to meet our goals related to community outreach and serving the underserved populations. • Continue with collaboration with hospital departments to establish inpatient education and an effective referral process. Currently represented on the hyperglycemia management team • Participate in AZ Diabetes Coalition. • Continue making second calls on referrals as staffing allows improving referral to scheduled percentage and net patients scheduled.
Planned Collaboration	Collaboration is planned with the Gilbert Wellness and Resource Center. One workshop presented during FY 19. We will continue to work with existing community partners and local municipalities.

APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

EAST VALLEY HOSPITALS COMMUNITY BOARD MEMBERS

Name	Occupation/Title	Company
Jason Bagley	Director, State Government Relations	Intel Corporation
Puneet Bhalla, M.D.	Physician (Oncology, Internal Medicine)	Ironwood Cancer & Research Centers
Mark Slyter	Hospital President	Mercy Gilbert and Chandler Regional Medical Center
Helen Davis, J.D.	Attorney (specializing in family law)	The Cavanagh Law Firm
Tom Dwiggins	Fire Chief City of Chandler Fire Department	City of Chandler Fire Department
Linda Hunt	Service Area President/CEO	Dignity Health Arizona Service Area
Rick Kettner- Chair	Senior Director of Engineering	Northrop Grumman Corporation (aerospace)
Sister Mary Kilgariff, R.S.M.	Liaison for Community Health & Senior Programs	Dignity Health St. Mary's Medical Center
Johnathan Hodgson, DO	Neurologist Gilbert Neurology	Gilbert Neurology
Tom Marreel	CEO	Marreel Slater Insurance
JJ Linder, MD	President of Medical Staff	Envision Physician Services/Chandler Regional
Sister Bridget McCarthy, R.S.M.	Sister of Mercy; V.P. Mission Integration Greater Sacramento Area	Dignity Health
W. Les Presmyk	Principal Mine Engineer	Salt River Project
Hector Peñuñuri	Senior Distribution Key Account Manager	Salt River Project
Sandy Cooper	Assistant Superintendent	Chandler Unified School District
Margarita Silva	Ex officio nonvoting member from SJHMC/SJWMC Board	Silva & Fontes
Veena Vats, M.D.	Physician (ear, nose, throat and facial surgery)	Trinity ENT and Facial Aesthetics
Joan Warner, M.D.	Physician (OB/GYN)	Desert Foothills OB/GYN

EAST VALLEY HOSPITALS COMMUNITY GRANTS COMMITTEE

Name	Occupation
Lori Bacsalmasi	Manager Community Education/Lactation, CRMC/MGMC
Jeanne Cahill	Manager Center for Diabetes Management, CRMC/MGMC
Staci Charles	President & CEO, Brain Lab
Kathleen Dowler	Director Community Integration, CRMC/MGMC
James Kern	Dignity Health Volunteer
Susan Ohton	Manager Community Wellness, CRMC/MGMC
Desiree Granillo	Manager of Clinical Social Work Care Coordination, CRMC
John Sentz	Town of Gilbert Board, Community Member
Julie Graham	Director of External Affairs Dignity Health
Ivars Vancers	Owner, Vancers Consulting
Theresa Dettler	Coordinator Community Benefits, CRMC/MGMC
Gia Snooks	Prenatal Program Coordinator, CRMC/MGMC
Michelle Gross-Panico	Dignity Health Manager Community Oral Health
Joyce Cannon	Dignity Health Volunteer
Laurel Vetsch	Dignity Health Grants Manager, East Valley Foundation

EAST VALLEY COMMUNITY BENEFIT COMMITTEE MEMBERS

Name	Occupation
Mark Slyter	CEO President, Dignity Health Mercy Gilbert and Chandler Regional Medical Centers
Milissa Chanice	Director Environment of Care, CRMC/MGMC
Trinity Donovan	CEO, AZCEND
Kathleen Dowler	Director of Community Integration, CRMC/MGMC
Jason Bagley	Intel- Director, State Government Relations
Tom Dwiggins	Fire Chief- Chandler Fire Department
Melanie Dykstra	Town of Gilbert
Sandy Cooper	Chandler Unified School District
Susana Swann	Finance –Dignity Health
Carl Landrum	Retired, Community Member
Dr. Paul McHale	MD Emergency Services, CRMC
Dr. Sandy Indermuhle	MD Emergency Services, CRMC
Wendy Otten	Director Trauma Services
Ivars Vancers	Owner, Vancers Consulting
Sister Bridget McCarthy	VP, Mission Integration Greater Sacramento
Sister Mary Kilgariff, RSM	Liaison for Community Health & Senior Programs Dignity Health St. Mary's Medical Center
Chris Clark	Queen Creek Chamber of Commerce
Jeanene Fowler	Maricopa County Dept. Public Health
Jeanne Cahill	Dignity Health- Center for Diabetes Manger

APPENDIX B: FINANCIAL ASSISTANCE POLICY SUMMARY

SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS

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

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

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

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

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

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

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

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

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

APPENDIX C: CURRENT AND PLANNED COLLABORATIVE PARTNERS

AZCEND	About Care
Chandler /Gilbert Substance Misuse Taskforce	Lutheran Social Services of the South West
Big Brother Big Sisters of Central Arizona	Neighbors Who Care
Brighterway Dental	Desert Cancer Foundation
Chandler CARE Center	Hushabye Nursey
Child Crisis Arizona	Head Start
Dignity Health East Valley Foundation	Keogh Foundation
Faith Health Ministry/Faith community	Maricopa County Department of Public Health
Foundation for Senior Living	Circle the City
Gilbert Senior Center	Mercy Housing in Gilbert and Mesa
Heritage Center- Gilbert	Area on Aging
Heritage Center Wellness, Education & Resource Center	Haven 107
ICAN	Fans Across America
Ironwood Cancer and Research Center	AT Still University
Kyrene Family Resource Center	Birth Haven
Maggie's Place	Sun Lakes Senior Community
Mesa Community College	Mathew's Crossing
Mission of Mercy	Tempe Community Action Agency
Pappas Kids Schoolhouse Foundation	East Valley Adult Resources
School districts: Chandler, Gilbert, Mesa, Kyrene, Tempe, Queen Creek, and City of Maricopa	Living Well Institute
Southwest Behavioral Health	Marc Community Resources
St. Vincent De Paul	Ahwatukee YMCA
Valley of the Sun YMCA Gilbert/Chandler and Tempe	Rebuilding Together Valley of the Sun
Women's Health Innovations	Phoenix Children's Hospital
Women's Infants and Children's (WIC)	Maricopa Family Advocacy Center

APPENDIX D: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

Community Building Activities

Chandler Regional Medical Center Community Leadership: Dignity Health provides valuable leadership beyond the walls of the hospital by participating on community building boards that share our common goals and values. Some boards represented with Dignity Health leadership include the Arizona, Maricopa, Ahwatukee, Chandler, Gilbert, Glendale, Mesa, Greater Phoenix, Peoria, Surprise, and Queen Creek Chambers of Commerce, About Care, American Lung Association, American Medical Group Association, Arizona Alzheimer's Consortium, Arizona Department of Health Services Injury Prevention Advisory Council, Arizona Emergency Medical Services Council, Arizona Falls Coalition Leadership Council, Arizona Highway Safety Strategic Plan, Arizona Motorcycle Safety and Awareness Foundation, Arizona Perinatal Trust, Arizona Rural Health Association, Arizona State University Health advisory, Arizona Zanjeros, Chandler and Gilbert Boys and Girls Club of America, Boxer Luv Rescue, Camp Verde Fire Auxiliary, Cancer Support Community, Catholic Charities Community Services, Central Arizona College of Radiologic Technology, Central Arizona Society for Healthcare Engineers, AZCEND, CeCe's Hope Center, Charter 100, City of Chandler Economic Development Advisory Board and People with Disabilities Mayors Council, Coyote Crisis Collaborative, Desert Cancer Foundation, East Valley Hispanic Chamber of Commerce, Epicenter, Fresh Start Women's Foundation, Gilbert Education Foundation, Gilbert Historical Museum, Hospice of the Valley, House of Refuge, ICAN, Keogh Health Connections, March of Dimes, Mathew's Crossing Food Bank, National Think First Injury Prevention Foundation, Phoenix Healthcare Sector Partnership, Positive Paths for Women, Power of the Purse, Southwest Catholic Health Network dba Mercy Care Plan, State Trauma Advisory Board, Town of Gilbert Mayor's Executive Advisory Team, United Food Bank, Mesa and Gilbert YMCA

Ecology

CRMC exercises responsible stewardship of the environment and partners with others to advance ecological initiatives. Policies are developed and implemented to address waste minimization, energy and water conservation and reduction of greenhouse gas emissions. Environmental initiatives include various interested departments, set goals for improved environmental performance and monitor, report and hold employees accountable for progress toward those goals. Examples include:
Clinical Laboratory- Plastic cuvettes used in coagulation analyzers to a company to be washed for our re-use. Diverts plastic waste from landfill.

- Local department-initiated recycle collection points for cardboard.
- The hospital-owned lab courier car is a Prius – a high mileage and high efficiency vehicle.
- Security/ Plant Operations- Retrofitting parking lot lights with energy saving and longer life LED fixtures
- Installation of solar powered code blue stations in employee parking lots
- Responsible management of construction debris and metals recycling
- Landscaping choices include water minimization considerations

- Water treatment systems have been replaced with a soft water non-chemically treated solution. This replacement also reduces the generation of wastewater.
- Clinical Informatics- Implementation of electronic medical records and managed print equipment and services Environmental from collection locations throughout the facility.
- Chandler Regional Medical Center has partnered with Chandler Gilbert ARC to further our ecology efforts. Employees of Chandler Gilbert ARC with intellectual and developmental disabilities provide many talents and do a great job in completing important recycling tasks. ARC employees are on site every day to collect recyclable materials.