Chandler Regional Medical Center

2022 Community Health Implementation Strategy

Adopted October 2022

Dignity Health
Chandler Regional Medical Center

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At-a-Glance Summary

Community Served 	Dignity Health Chandler Regional Medical Center is located in Maricopa County, the fourth most populous county in the United States. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations and it is home to more than 1.3 million Hispanic/Latino individuals; 302,042 African Americans; 233,328 Asian Americans; and 124,128 American Indians. In 2019, according to the U.S. Census Bureau, the population of Chandler was over 252,692 residents. The city of Chandler is primarily served by Chandler Regional Medical Center (CRMC). During fiscal year 2020 the following Chandler zip codes were in the top 75% of patient encounters both for acute care and emergency services: 85225, 85224, 85248, 85138 and 85226. The target population in the Implementation Strategy plan are the "Broader Community," those "Living in Poverty" and the "Most Vulnerable Population," including persons with disabilities, racial, cultural and ethnic minorities; this corresponds with federal community benefit reporting requirements.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: ○ Behavioral & Mental Health / Suicide ○ Substance Abuse ○ Cancer ○ Chronic Disease/ Diabetes / Cardiovascular Disease / Obesity/ Oral Health ○ Injury Prevention ○ Access to Care/ Immunization ○ Housing/ Homelessness ○ Violence Prevention/ Human Trafficking ○ Equity ○ Nutrition/ Food Access/ Exercise
Strategies and Programs to Address Needs 	Chandler Regional Medical Center, intends to take several actions and to dedicate resources to these needs, including: **Behavioral & Mental Health /Suicide** • Continue to provide access to behavioral health services with national patient safety initiative Zero Suicide. • Conduct perinatal depression screening during prenatal visit, while inpatient for delivery and at postpartum visit. • Appoint a certified Community Health Worker (CHW) to coordinate services and referrals to community-based organizations with focus on closed loop referral process.

Substance Abuse

- Identify opportunities to address alcohol and substance abuse and increase support for services focused on vulnerable populations.

Cancer

- Explore opportunities to partner with the CRMC cancer clinics nurse navigator.
- Identifying opportunities to partner with the American Cancer Society of Arizona (ACSAz) and provide cancer prevention and early detection programs to the hospital, while overcoming cancer patient transportation needs by utilizing the ACSAz grant funding provided to Dignity Health.

Chronic Disease /Diabetes /Cardiovascular Disease /Obesity /Oral Health

- Support the integration of critical care dental hygienists as part of the ICU teams at CRMC.
- Continue to support the growth of the ACTIVATE program services provided to vulnerable patients.
- Increase awareness of the no cost Dignity Health Healthier Living programs offered in English and Spanish instruction.
- Explore local CBO programs dedicated to trauma informed nutrition initiatives.
- Collaborate efforts with the hospital's WomenHeart health support group.

Injury Prevention

- Explore opportunities to promote trauma informed programs practices within the care coordination department and community health education and outreach.

Access to Care/ Immunization

- Connect the hospital faith community nurse to the immunization program.
- Partner with local CBOs to provide a Dignity Health immunization clinic day.

Housing / Homelessness

- Partner with Maricopa County Affordable Housing Projects.
- Participate in community coalitions exploring opportunities to increase safe, affordable workforce housing in the hospital's primary service area.

Violence Prevention/ Human Trafficking

- Provide funding to CBOs delivering Human Trafficking education and training to local schools, hospitals, care centers, resources centers, etc..
- Explore opportunities to promote trauma informed programs practices within the care coordination department.
- Quarterly department participation in CSH and Dignity Health Human Trafficking Task Force meetings/trainings.

Equity /Health, Social & Racial Equity

- Lead and participate in CommonSpirit Health's (CSH) collective commitment to health equity.
- Support advancing WomenHeart programs for equal access to quality care and provides information and resources to help women take charge of their heart health.
- Participate in Arizona's Health Information Exchange (HIE) to increase social needs screenings for early identification of patients with limited access to care.

Nutrition/ Food Access / Exercise

- Provide financial and in-kind support for local (CBO) efforts to expand healthy food access to low-income residents, such as exploration of Double Up Food Bucks Program.
- Collaborate with a local food bank and the hospital nutrition services to create a food prescription program pilot.
- Collaborate with local CBO to spread awareness of health benefits by participating in Yoga of the Heart and Mommy Fit Camp.

Anticipated Impact

Behavioral & Mental Health /Suicide

- Increase the capacity of health care workers and community organizations who are able to identify behavioral health needs and connect people with services.
- Improve continuum of care models to ensure access and utilization of mental health services.

Substance Abuse

- Increase resilience and support recovery of families affected by substance abuse.

Cancer

- Increased cancer screenings for early detection and health care intervention.
- Improvements in health insurance coverage enrollment and process.
- Increased in healthcare system navigation with utilization of patient navigators.

Chronic Disease/Diabetes /Cardiovascular Disease /Obesity /Oral Health

- Management of chronic conditions.
- Increase disease prevention and health promotion education.
- Increased oral care practices across hospital service lines.

Injury Prevention

- Reduction of patient emergency department visits.

Access to Care/ Immunization

- Lowered readmissions and improved use of preventive care due to improved collaboration across healthcare providers and community-based support services.

Housing/ Homelessness

- Reduced percentage of patient readmission to the emergency department by continuing collaborations with local CBO medical clinics for routine health services and needs.
- Continue to collaborate with the ACTIVATE program to resource for the low income, vulnerable patients at time of discharge.

Violence Prevention/ Human Trafficking

- Reduced the percentage of victims who delay obtaining resources and services. Increases the awareness of resources and services offered.

Equity

- Increased education, information and awareness of social, health and racial equity throughout service lines.
- Escalated healthcare system and social needs navigation with utilization of community health workers and promotoras.

	• Strengthened women's heart health advocacy, community education and patient support. **Nutrition/ Food Access / Exercise** • Reduction in mortalities and morbidities and an improvement in overall health and well-being of our communities.
Planned Collaboration 	Dignity Health Chandler Regional Trauma Services Outreach programs/ Dignity Health East Valley Residency programs/ Care Coordination service line/ Community Health & Outreach services and programs/ CSH Connected Community Network/ NaviHealth/ Unite Us/ Pathways Community HUB Institute/ CommunityCares/ Catholic Health Association/ City of Chandler/ City of Mesa/City of Tempe/ Town of Gilbert/ Town of Queen Creek/ City of Maricopa/ East Valley Resource Coalition/ Mission of Mercy of Arizona/ Foundation for Senior Living (FSL)/ Valley of the Sun United Way/ 2022 Dignity Health East Valley Community of Care Grant recipients/ American Cancer Society/ CRMC Cancer Clinic/ CRMC Women's Imaging Center and Maricopa County Department of Public Health. A full list of partners can be located at https://www.dignityhealth.org/arizona/locations/chandlerregional/about-us/community-benefit-outreach/benefits-reports

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

Our Hospital and the Community Served

About the Hospital

Chandler Regional Medical Center is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 1,000 care sites in 21 states coast to coast, serving 20 million patients in big cities and small towns across America.

Chandler Regional Medical Center is a member of Dignity Health, which is a part of CommonSpirit Health. Chandler Regional Medical Center is a comprehensive acute-care hospital that provides a full spectrum of services including a Level I Trauma Center verified by the American College of Surgeons, open heart surgery program, neurosurgery, orthopedics, and high risk obstetrics, cardiac rehabilitation and newborn services. With more than 3,004 employees, 429 beds and 1,192 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 Mission

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

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay. This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

Dignity Health (DH) defines the community served by a hospital as those individuals residing within its Primary and Secondary Service Areas. For this report, the focus will be on the Primary Service Area (PSA) of CRMC. The Primary Service Area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

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 top three highest needs include 85122 Casa Grande, 85202 Mesa and 85210 Mesa.

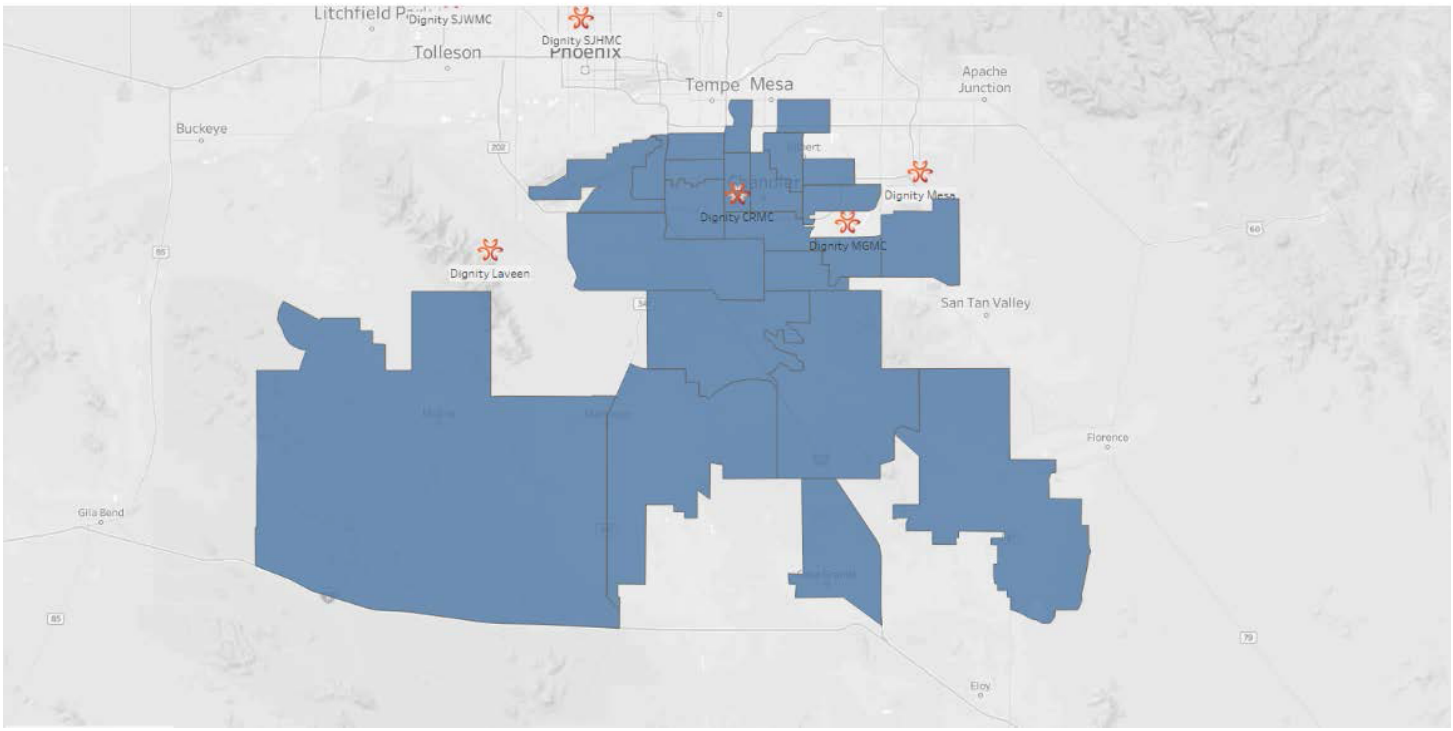
Maricopa County is the fourth most populous county in the United States. Based on 2019 American Community Survey (ACS) five-year estimates, Maricopa County has an estimated population of over 4.3million and growing, home to well over half of Arizona's residents. Maricopa County encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations.

During FY20 the following Chandler zip codes were in the top 75% of patient encounters both for acute care and emergency services: 85225, 85224, 85248, 85138 and 85226. The hospital serves a majority of Maricopa County, and will include information gathered from residents at the county-level.

Figure 1 below displays the PSAs serviced by CRMC. A summary description of the community is below, and additional details can be found in the CHNA report online.

FIGURE 1

CRMC PSA



During fiscal year 2020 Chandler zip codes were found to be the largest percent of patients served for acute care and emergency services at CRMC. Chandler's population in 2019 was 252,692 with a median age of 36.3 years. The city of Chandler is made up of predominantly Caucasian/White individuals (78.2%), followed by Latino/Hispanic (20.8%), Asian (12.5%), Black/African American (7.1%), American Indian/Alaska Native (2.6%) and Native Hawaiian and Other Pacific Islander (0.4%).

In 2019, the median household income in Chandler was $82,925 with a poverty rate of 7.6%. The educational attainment in 2019 for Chandler were as follows: less than high school graduate (13.6%), high school graduate (31.6%), some college/associate's degree (40.4%) and bachelor's degree or higher (14.4%).

Table 1 provides the specific age, sex, race/ethnicity distribution and data on key socio-economic drivers of health status of the population in the CRMC's primary service area compared to Maricopa County and the state of Arizona.

TABLE 1

	CRMC PSA	Maricopa County	Arizona
Population: estimated 2019	579,952	4,328,810	7,050,299
Gender			
• Male	49.0%	49.4%	49.7%
• Female	51.0%	50.6%	50.3%
Age			
• 0-9 yrs	12.6%	13.0%	12.6%
• 10-19 yrs	13.3%	13.8%	13.4%
• 20-34 yrs	21.3%	21.3%	20.6%
• 35-64 yrs	39.0%	37.2%	36.3%
• 65-74 yrs	8.4%	13.1%	15.2%
• 75+ yrs	5.4%	1.7%	1.9%
Race			
White	*77.8%	*77.6%	*77.2%
Asian/Pacific Islander	*4.0%	*4.2%	*3.3%
Black/African American	*5.5%	*5.6%	*4.5%
American Indian/Alaska Native	*2.5%	*2.0%	*4.5%
Other/Unknown	*6.5%	*6.7%	*6.5%
Ethnicity			
Hispanic	*30.9%	*31.0%	*31.3%
Median Income	$76,233	$64,468	$58,945
Uninsured	9.1%	10.6%	10.4%
Unemployment	4.7%	5.0%	5.9%
No HS Diploma	9.0%	12.3%	12.9%
% of Population 5+ non-English speaking	21.6%	27.0%	27.1%
Renters	34.7%	*37.8%	*35.6%
CNI Score	2.9	3.4	-
Medically Underserved Area	Yes	-	-

Source: PolicyMap; Census ACS 2019 5-Year Estimates

Health needs were identified through the combined analysis of primary and secondary data with four rounds of community input. Primary data sources include the 2019 and 2021 community surveys and focus groups. Secondary data sources include health and social indicators from local, state, and sources that encompass health outcomes, economic factors, health behaviors, physical environment, and health care. CRMC partnered with MCDPH to recruit members of diverse communities to take the surveys and participate in focus groups.

Focus groups included representatives of minority and underserved populations who identified community concerns and assets. Resources potentially available to address identified needs include services and programs available through hospitals, government agencies, and community based-organizations.

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 Health Resources and Services Administration (HRSA), the Chandler PCA has been federally designated as a Medically Underserved Area. Medically Underserved Areas are areas or populations designed by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and programs were identified in the most recent CHNA report, which was adopted in May 2022. The CHNA contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

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

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Mental Health and Suicide	**Mental Health** includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act. **Suicide** and suicide attempts cause serious emotional, physical and economic impacts.	☑
Substance Abuse	**Substance Abuse** is caused by multiple factors, including genetic vulnerability, environmental stressors, social pressures, individual personality characteristics, and psychiatric problems.	☑
Cancer	**Cancer** is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.	☑
Chronic Diseases/ Diabetes/ Cardiovascular Disease/ Obesity/ Oral Health	**Chronic Diseases** are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both. **Diabetes** is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). **Cardiovascular Disease** is a class of diseases that affect the heart or blood vessels. **Obesity** is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. **Oral Health, Oral Diseases** ranging from dental cavities to oral cancers.	☑
Injury Prevention	**Injury Prevention** is activities to prevent, ameliorate, treat, and/or reduce injury-related disability and death.	☑
Access to Care/ Immunization	**Access to Care** means having the timely use of personal health services to achieve the best health outcomes. Access to health care consists of four components; coverage, services, timeliness, and workforce.	☑

Significant Health Need	Description	Intend to Address?
	Immunization is a key component of primary health care and is critical to the prevention and control of infectious diseases.	
Housing / Homelessness	**Homelessness / Housing** social determinant of health due to the range of ways in which a lack of housing, or poor-quality housing.	☑
Domestic Violence Human Trafficking	**Domestic Violence** is abuse or aggression that occurs in family relationships. **Human Trafficking** is a crime that involves exploiting a person for labor, services, or commercial sex.	☑
Racial Equity/ Health Equity/ Social Equity	**Racial Equity** is the systemic fair treatment of all races that produces equitable opportunities and outcomes for all people. **Health Equity** means that "everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care". **Social Equity** refers to all people experiencing impartiality, fairness, and justice in their daily lives. Social equity takes into account systemic inequalities to ensure everyone in a community has access to the same opportunities and outcomes.	☑
Nutrition/ Exercise/ Food Access/	**Nutrition**, the process of providing or obtaining the food necessary for health and growth. **Food Access** is an important element of food security, which is having constant access to adequate nutritious food to support healthy eating patterns. **Exercise** is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes, and several cancers. It also can improve physical/mental health, quality of life and well-being.	☑

2022 Implementation Strategy

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

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

Creating the Implementation Strategy

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

Hospital and health system participants included: CommonSpirit Health Community Health Department, Dignity Health East Valley; Community Health, Executive Leadership, Mission Integration, Trauma Services, Maternal Child Health, Care Coordination, Center for Transitional Care and Emergency Departments, Arizona General Hospitals Mesa and Laveen, Director External Affairs and Dignity Health Foundation - East Valley.

The hospitals' community health programs involve departments beyond Community Health and Mission in their planning and operation.

Community input or contributions to this implementation strategy included: Dignity Health East Valley Community Hospital Board, Community Health Committee (CHC) and Community Grants Committee comprised of members in the community and Dignity Health, community leaders, community educators, program managers from local nonprofit's, Maricopa County Department of Public Health, previously grant funded East Valley Communities of Care and current grantee recipients, East Valley Resource Coalition, FSL and other stakeholders in the East Valley service area.

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

The health needs prioritization process began with an initial review and analysis of primary and secondary data sources. Primary sources included data that was derived from the 2019 and 2021 community survey and focus group sessions. Secondary sources included data that was derived from County inpatient hospitalization, emergency department, and death rates to assemble 12 total health indicators. Compiled primary and secondary data sources were presented at three meetings with the CHC. Data presentations were interactive, embedding virtual polling and breakout sessions which opened an opportunity for the community to share their voices into the refinement and prioritization process of significant health needs for CRMC.

During these meetings the following were examples to aid in consideration of significant health need; trends in data, the population impacted (making special consideration to disparities and vulnerable populations), existing partnerships, available resources, the hospital's level of expertise, existing initiatives (or lack thereof), potential for impact, and the community's interest in the hospital engaging in that health area. All feedback received from CHC meetings was compiled and evaluated through a health equity lens, which led to the prioritization of ten significant health needs, several of which included multiple sub-priorities.

This process can be reviewed in more detail in the CHNA posted at https://www.dignityhealth.org/arizona/locations/chandlerregional/about-us/community-benefit-outreach/benefits-reports.

Community Health Strategic Objectives

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

CommonSpirit Health has established four core strategic objectives for community health improvement activities. These objectives help to ensure that our program activities overall address strategic aims while meeting locally-identified needs.

Create robust alignment with multiple departments and programmatic integration with relevant strategic initiatives to optimize system resources for advancing community health.

Scale initiatives that complement conventional care to be proactive and community-centered, and strengthen the connection between clinical care and social health.

Work with community members and agency partners to strengthen the capacity and resiliency of local ecosystems of health, public health, and social services.

Partner, invest in and catalyze the expansion of evidence-based programs and innovative solutions that improve community health and well-being.

Strategies and Program Activities by Health Need

Health Need: Mental Health / Suicide					
Anticipated Impact (Goal)	Increase in number of individuals who feel confident they can identify signs of mental health crisis and respond appropriately with resources.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH Heaven's Hummingbirds Support Group	MCH Perinatal Bereavement Services care for parents from hospital to home, with trained & certified facilitators grief support.	☑	☑	☑	☑
DH Zero Suicide Initiative	A toolkit with training and utilization of practical framework for hostpial-wide transformation toward safer suicide care.	☑	☑	☑	☑
DH Pregnancy & Postpartum Support Group (PPSG) / Let's Talk	PPSG is a peer based support group that provides a safe, judgment-free place to connect other moms experiencing similar challenges. Let's Talk is a closed perinatal therapeutic group 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.	☑	☑	☑	☑
Planned Resources	The hospital will provide trained registered nurses, community health educators, philanthropic grants, outreach communications and program management support for these initiatives.				
Planned Collaborators	Southwest Behavioral and Health Services, Women's Health Innovations, Life Force Community Services, Youth Mental Health Coalition, East Valley Resource Coalition (EVRC) and Dignity Health MCH, Emergency and Care Coordination departments and Chandler Children's Medical Clinic.				

Health Need: Substance Use					
Anticipated Impact (Goal)	Provide relevant and timely care for those in need of substance abuse recovery.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Youth Mental Health Coalition	Evidence-based and evidence-informed programming includes culturally inclusive prevention that educates youth.	☑	☐	☑	☐
Mesa Prevention Alliance	Empowering Mesa community members' health & substance use awareness through education, advocacy and connection.	☑	☐	☑	☐
Hushabye Nursery - Peer Support	Peer Support Program, recognizes people with lived/living substance use disorder (SUD) and can provide participants first-hand knowledge of systemic barriers & meaningful coaching work in the area of resilience/coping skills as a means to address and overcome the challenge.	☑	☑	☑	☐
Planned Resources	The hospital will provide trained registered nurses, community health educators, philanthropic grants, outreach communications and program management support for these initiatives, improve education and outreach.				
Planned Collaborators	DH Community Health, ED, Care Coordination department and Chandler Children's Medical Clinic, City of Chandler, Town of Gilbert, Town of Queen Creek, City of Tempe, City of Maricopa and City of Mesa PD and community based organizations (CBOs); Youth Mental Health Coalition, EVRC members.				

Health Need: Cancer

Anticipated Impact (Goal)	Improve education and awareness leading to increased prevention practices and access to resources and support.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Amanda Hope Rainbow Angels (AHRA)	Supports needs of families impacted by childhood cancer & other life-threatening illnesses through Comfort and Care counseling.	☑	☐	☑	☐
American Cancer Society / Desert Cancer Foundation Az.	Provides cancer education, screenings, and secures treatment resources and transportation for the uninsured and underinsured.	☑	☐	☑	☐
DH Cancer Care Clinic	Newly diagnosed cancer patients and their families and/or caregivers receive support to manage appointments, record keeping and communication between providers.	☑	☑	☑	☑
Planned Resources	Hospital and community based orgs. collaborate to provide : access to care, early detection, treatment and/or resources, transportation and support for patients, caregivers and families.				
Planned Collaborators	DH East Valley Community Health Improvement Grants Program recipients, CBOs, Arizona Cancer Society, EVRC, Dignity Health's Care Coordination & Women's Imaging Center.				

Health Need: Chronic Diseases / Diabetes / Cardiovascular Disease (CVD) / Obesity / Oral Health					
Anticipated Impact (Goal)	Increase in primary care and clinic use for care of chronic conditions, increase in education prevention efforts.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH Yoga of the Heart / WomenHeart Health Support Group	Breathing exercises and meditation,scientifically proven to lower blood pressure, lower blood cholesterol and blood glucose levels, as well as heart rate. WomenHeart Program advocates for equal access to quality care and provides information and resources to help women take charge of their heart health.	☑	☑	☐	☑
DH Healthier Living Program	Dignity Health's Healthier Living programs instructed in English /Spanish serve participants with chronic conditions and pain, diabetes or fall risk, to self-manage their conditions at no cost.	☑	☑	☑	☑
DH Chandler Children's Medical and Dental Clinics / First Teeth First (FTF) Program	Dental clinic provides dental exams, dental cleanings, fluoride varnish treatments and oral health education. Medical clinic provides care, well visits, education and resources. Both clinics serve youth 18 and under, currently uninsured. CRMC FTF provides dental screenings, for expecting moms and fluoride varnish and oral health education for kids ages 0-5 in the community, child care centers and medical offices.	☑	☐	☑	☑
Planned Resources	Partnering with a faith health nurse who promotes health as wholeness of the faith community. The extension of the nurse can support the reduction of hospital stays and readmissions.				
Planned Collaborators	DH Care Coordination, Community Health departments, ED and Transitional Care Clinics, EVRC, FSL ACTIVATE, Women's Heart Health Program & Chandler Children's Medical Clinic.				

Health Need: Injury Prevention					
Anticipated Impact (Goal)	CRMC Trauma Injury Prevention and Outreach Education programs increase; survivability & capacity to treat severe hemorrhaging from incidents and teach fall prevention to vulnerable communities & educate the public on the dangers of distracted / impaired driving.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH Stop the Bleed / D4: Dignity Doesn't Drive Distracted	Nationally recognized courses teach hemorrhage control to aid in saving lives. The driving simulation curriculum teaches the dangers of distracted/impaired driving.	☑	☑	☑	☑
DH Matter of Balance program/ Walk with a Doc program	Evidence-based group intervention to reduce fear of falling & increase activity levels for senior citizens. A community based education program incorporates a physician from CRMC to keep the participants active & mobile to limit the risk of falls and injury.	☑	☑	☑	☑
DH Car Seat Clinic and Car Seat donation	Car seat clinics provide education inspection for safe installation. New seats are donated/recommended when need is identified	☑	☑	☑	☑
Planned Resources	Maintain our existing relationship with Gilbert and Chandler Fire in an effort to ensure child passenger safety for the surrounding communities. Additional Stop the Bleed courses planned for Gilbert Public School District staff, along with supply kit distribution to each school will be supported by CRMC Trauma Services. Expansion of Fall Prevention into an increasing number of new senior living facilities within the East valley.				
Planned Collaborators	DH Care Coordination, MCH and Community Health department, EVRC, FSL ACTIVATE, Chandler Children's Medical Clinic and Maricopa County Department Public Health and East Valley school districts.				

Health Need: Access to Care / Immunization					
Anticipated Impact (Goal)	Increase the patient's ability to continue to receive the care they need within their community. Promote health equity for all across all priorities and significant health needs. To help maintain childhood immunization rates in our community and administer vaccinations to children and adults with emphasis on medically underserved communities and families while providing education and awareness on the importance of immunizations.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH Children's and Adult's Vaccine Program	Provides no cost immunizations for people who are un/underinsured, AHCCCS, American Indian or Alaskan Native. Free clinics are at the Chandler CARE & Gilbert Heritage Center and mobile sites/events throughout the East Valley service areas.	☑	☑	☑	☑
DH East Valley Community Health Outreach	Based on the significant health/social needs identified in the CHNA programs with a variety of support/resource services to address the social and economic needs of patients.	☑	☑	☑	☑
DH FSL, ACTIVATE / DH Community Health Worker (CHW)	ACTIVATE, is a patient enrolled program to access medication education for patient and family and follow-up time of discharge. CHW is a patient navigator/link between health/social services and the community to facilitate access to services and improve the quality & cultural competence of service delivery.	☑	☑	☑	☑
Planned Resources	Community based organizations in partnership with DH Community Wellness vaccine program and the State Vaccines for Children/Adult Program, educate and support the vulnerable population in East Valley.				
Planned Collaborators	Arizona Korean Nurses Association, local school districts, community based organizations, Tempe Unified School District, Thew Elementary at Thrive To Five Resource Center, CUSD and Gilbert Unified School Dist.				

Health Need: Housing / Homelessness					
Anticipated Impact (Goal)	Through internal processes, key stakeholders and partnership with CBOs to create an increased awareness of resources, increase in accessing/connection of workforce development and housing resources connection to community-based services.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH Homeless Initiative / Taxi Vouchers	Care Coordination, Emergency departments and MCH providing clothing, transportation and referrals to needed social services.	☑	☑	☑	☑
Maricopa County Board of Supervisors	Maricopa County will fund the acquisition and rehabilitation of four rental units with a primary focus within the 85201, 85210, 85202, 85203, and 85204 zip codes. The targeted housing units will feature two or three bedrooms, within the City of Mesa.	☑	☐	☑	☑
One Small Step: Clothing Cabin	Connects homeless clients with access to care; mental health resources through case manager. It operates out of Gilbert: Serves all of East Valley. Provides free quality clothing for men, women and children. Back to work program and services; mailbox, storage lockers, laundry, personal hygiene.	☑	☐	☑	☐
Planned Resources	The hospital will provide philanthropic grants and outreach communications to support these initiatives.				
Planned Collaborators	House of Refuge, AZCEND, I-HELP, VSUW, Tempe Community Action Agency, Lutheran Social Services of the Southwest, Destination Diploma program, Chandler CARE Center, One Small Step:Clothes Cabin, Matthew's Crossing, Circle the City, Open Arms Care Center, Mission of Mercy of AZ and ACTIVATE.				

Health Need: Violence / Domestic Violence / Human Trafficking					
Anticipated Impact (Goal)	Increase healthcare workforce education to provide trauma informed care for victims of violence and prevent future violence.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH Healthy Families Program	License medical social worker screens charts of new high risk mothers of newborns to refer for child abuse prevention programs in the community and provides parenting resources for parents.	☑	☑	☑	☐
DH Human Trafficking Taskforce	Provide health care professionals with tools on how to identify and appropriately assist patients whose health, safety, and well-being may be affected by trafficking or other types of violence.	☑	☑	☑	☑
CeCe's Hope Center	The collaboration; CeCe's Hope, Project25, Faithful City and Horses Help educate the community about sex trafficking, train law enforcement, identify victims and connect them to services.	☐	☐	☑	☐
Planned Resources	The hospital will provide philanthropic grants and outreach communications to support these initiatives.				
Planned Collaborators	ACTIVATE, Human Trafficking Taskforce, Chandler Children's Medical Clinic, Hope Women's Center, Compassion Connect Az., and EVRC.				

Health Need: Equity / Racial Equity / Health Equity / Social Equity					
Anticipated Impact (Goal)	Improve access to care and promote health equity for all across all prioritized significant health needs.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
DH WomenHeart Health Support Group	This group is the only national organization dedicated to advancing women's heart health through advocacy, community education and patient support. WomenHeart advocates for equal access to quality care and provides information and resources to help women take charge of their heart health.	☑	☑	☐	☑
DH/CSH Connected Community Network (CCN)	This network uses a trusted community convener, together with a technology platform for referrals and coordination, to connect multiple health plans with community-based organizations providing a range of social services.	☑	☑	☑	☑
DH/SCH Financial Assistance Policy	Providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay.	☑	☑	☐	☐
Planned Resources	CSH Dignity Health launched a new partnership with Pathways Community HUB Institute (PCHI), a national nonprofit that has developed an effective model to help communities work together to support their underserved populations.				
Planned Collaborators	City of Chandler's Diversity, Equity & Inclusion, Youth Mental Health Coalition, EVRC, one-n-ten.				

Health Need: Nutrition/ Food Access / Exercise					
Anticipated Impact (Goal)	Support community efforts to address nutrition, food access, and exercise through effective service referrals, resource navigation and Community Health department outreach programs.				
Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkages	Capacity for Equitable Communities	Innovation & Impact
Mission of Mercy of AZ	Uninsured and underinsured patients with diabetes will be able to receive comprehensive care via regular medical exams, prescription medications, diabetes education, monitoring of the key indicators of diabetes, and increased access to fresh produce.	☑	☑	☑	☑
DH Mommy Fit Camp	A low to moderate paced exercise class for moms during pregnancy and postpartum. Exercise can be modified to each individual fitness level. Virtual classes are offered.	☑	☐	☐	☑
DH Healthy Eating, Active Living HEAL	A seven month program that focuses on making sustainable healthy lifestyle changes. It addresses the key community needs of nutrition, exercise and obesity. Virtual classes are offered.	☑	☑	☐	☑
Planned Resources	Participate in community events and health fairs to reach uninsured patients to support these initiatives.				
Planned Collaborators	March of Dimes, Pinnacle Prevention, Maricopa County Department of Public Health, AZCEND and Chandler CARE Center.				