St. Joseph's Hospital and Medical Center

2022 Community Health Implementation Strategy

Adopted October 2022

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At-a-Glance Summary

Community Served

SJHMC serves the geographic area of Maricopa County which encompasses 9,224 square miles, includes 27 cities and towns, as well as the whole or part of five sovereign American Indian reservations. With an estimated population of 4.3 million and growing, Maricopa County is home to well over half of Arizona's residents. The community served is ethnically and culturally diverse.

Significant Community Health Needs Being Addressed

The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are:

- Access to Healthcare
  - Maternal & Child Health
  - Financial Security
- Cancer
- Chronic Health Conditions
  - Obesity
  - Diabetes
  - Cardiovascular Disease

Strategies and Programs to Address Needs

The hospital intends to take several actions and to dedicate resources to these needs, including:

- Access to Care - ACTIVATE, CATCH, Health Equity Initiative, Keogh Enrollment Specialist, Lyft Transportation Services, MOMobile, Patient Financial Assistance, Homeless Discharge Initiative, and Community-Based Patient Navigators.
- Cancer - Cancer Medication Assistance Program, Cancer Resource Navigator, Lifestyle Management Workshops and Support Groups, and Women's Wellness Clinic.
- Chronic Disease - ACTIVATE, Diabetes Empowerment Education Program, Healthier Living, Cocinando con Salud en Balance, Community Fitness Classes, Muhammed Ali Parkinson's Center Programs.

Anticipated Impact

Dignity Health, St. Joseph's Hospital and Medical Center will launch its three-year Community Health Implementation Strategy to address the identified significant health needs: access to care, cancer, and chronic disease with an overarching health equity lens.

Anticipated impact of the hospital's initiative includes social needs screenings for early identification of patients with limited access to care; an increase in cancer screenings for early detection and health care intervention; improvements in health insurance coverage enrollment; increase in healthcare system and social needs navigation with utilization of Community Health Workers, Patient Navigators and Promotoras; increase in access to quality primary care and establishing "medical homes"; management of chronic conditions; increase disease prevention and health promotion education; reduction in emergency department utilization; reduce hospital readmission rates and length of stay; reduction in moralities and morbidities and an improvement in overall health and well-being of our communities.

Planned Collaboration

The hospital will partner with local community-based organizations and internal departments to improve access to care, address chronic health conditions: obesity, diabetes, and cardiovascular disease (CVDs), enhance navigation, bridge gaps in care, linking patients to appropriate resources that address their social and health needs.

Planned collaborations and partnerships include the Foundation for Senior Living, Chicanos por la Causa / Keogh, MOMobile, Mission of Mercy, Get Well Network, SJHMC Cardiovascular Clinic, Cancer Support Community of Arizona, American Cancer Society, CommunityCares - Arizona's Connection for Whole Person Care, Pathways Community Hub Institute, and the National Training Institute on Race & Equity / Morehouse College.

This document is publicly available online at the hospital's website. Written comments on this report can be submitted to the Community Benefit and Health Equity Department located at 350 W Thomas Road, Phoenix, AZ 85013 or by e-mail to CommunityHealth-SJHMC@dignityhealth.org.

Our Hospital and the Community Served

About the Hospital

St. Joseph's Hospital and 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.

Located in the heart of Phoenix and founded in 1895 by the Sisters of Mercy, St. Joseph's Hospital and Medical Center is a 595-bed, not-for-profit hospital that provides a wide range of health, social and support services with special advocacy for the poor and underserved. As of 2020, SJHMC has 5,296 employees, 91 Employed Faculty Physicians, 1,114 Credentialed Community Physicians, 197 residents, and 334 Volunteers. SJHMC is a nationally recognized center for quality tertiary care, medical education and research. It includes the internationally renowned Barrow Neurological Institute®, the Heart & Lung Institute®, Dignity Health Cancer Institute at St. Joseph's Hospital and Medical Center, and a Level 1 Trauma Center verified by the American College of Surgeons.

Our Mission

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

Financial Assistance for Medically Necessary Care

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

Description of the Community Served

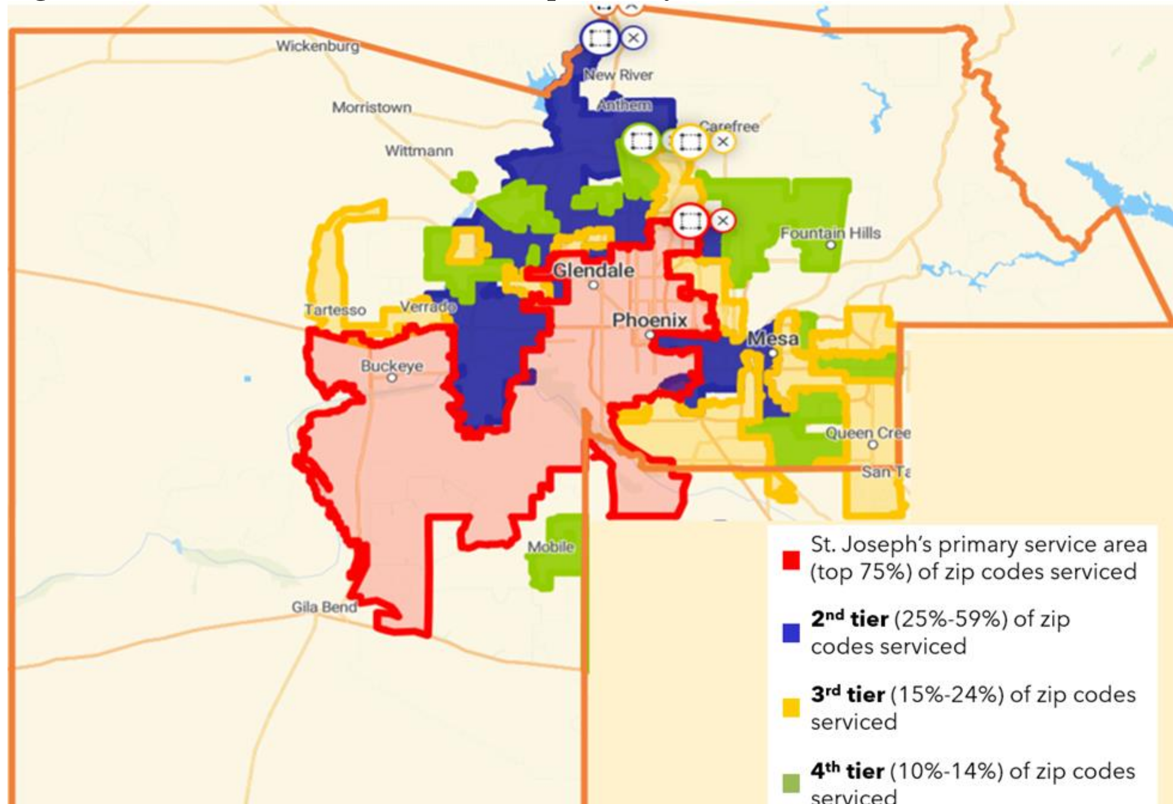
The hospital serves Maricopa County. A summary description of the community is below, and additional details can be found in the CHNA report online.

St. Joseph's Hospital and Medical Center's community is defined as Maricopa County. The entire County was chosen as the community definition due to the broad range of SJHMC's service area. Figure 1 below encompasses the first, second, third, and fourth tier patient zip codes serviced by SJHMC – which span Maricopa County.

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 4.3 million 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.

SJHMC serves patients across Maricopa County, hence the community definition extends beyond its physical location in the City of Phoenix. The City of Phoenix is primarily served by SJHMC for acute care and trauma services. Phoenix is the 5th largest city in the United States by population, making it the most populous state capital. Its population in 2019 was 1,633,017 with a median age of 33.8. The City of Phoenix is made up of predominantly Caucasian/White individuals (76.1%), followed by Latino/Hispanic (42.6%), Black/African American (8.6%), Asian (5.0%), American Indian/Alaska Native (3.0%), and Native Hawaiian and Other Pacific Islander (0.5%). In 2019, the median household income in Phoenix was $57,459 with a poverty rate of 18.0%. The educational attainment statistics in Phoenix in 2019 were as follows: less than high school graduate (18.0%), high school graduate (36.0%), some college/associate's degree (37.6%), and bachelor's degree or higher (8.4%).

Figure 1. SJHMC Service Areas in Maricopa County



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 April 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?
Access to Healthcare • Maternal & Child Health • Financial Security	**Access to healthcare** is defined as the timely use of health services to achieve the best possible health outcomes. Many people face barriers that prevent or limit access to needed health care services. • **Maternal Health** refers to the health of women during pregnancy, childbirth, and postnatal period. There are opportunities at each stage that provide support ensuring women and their babies reach their full potential for health and well-being. • **Financial Security** refers to having the coverage and/or other means necessary for health care expenses.	✓
Addiction / Substance Abuse	**Addiction** is a chronic disorder characterized by compulsive drug use despite adverse consequences. If left untreated, it can cause serious harmful effects and may lead to death. **Substance Abuse** is the repeated harmful use of any substance, including drugs and alcohol, which can lead to addiction.	
Affordable Housing / Homelessness	**Affordable Housing/Homelessness** is often identified as an important social determinant of health due to the range of ways in which a lack of housing, or poor quality housing, can negatively affect health and wellbeing.	
Cancer	**Cancer** is a large group of diseases that can start in almost any organ or tissue of the body when abnormal cells grow beyond their usual boundaries to invade adjoining parts of the body and/or spread to other organs.	✓
Chronic Health Conditions • Obesity • Diabetes • Cardiovascular Disease (CVD)	**Chronic Health Conditions** are health conditions or diseases that are persistent or otherwise long-lasting in their effects. • **Obesity** is a complex health issue resulting from a combination of causes and individual factors such as behavior and genetics. Behaviors can include physical activity, inactivity, dietary, dietary patterns, medication use, and other exposures. • **Diabetes** is a chronic, metabolic disease characterized by elevated levels of blood glucose (or blood sugar). The most common is type 2 diabetes. • **Cardiovascular Diseases (CVDs)** are a class of diseases that affect the heart or blood vessels. The most important behavioral risk factors of heart disease and stroke are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol.	✓
Food Insecurity	**Food Insecurity** refers to the state of being without reliable access to a sufficient quantity of affordable, nutritious food.	

Significant Health Need	**Description**	**Intend to Address?**
Mental Health	**Mental Health** includes emotional, psychological, and social well-being, and affects how individuals think, feel, and act.	
Safety & Violence • Unintentional Injuries	**Safety and Violence** are a significant cause of death and burden of disease, and some people are more vulnerable than others depending on the conditions in which they are born, grow, work, live and age. • **Unintentional Injuries** can be predictable and preventable. Leading causes of nonfatal injury include traffic-related injuries, falls, burns, poisonings, and drownings.	

Significant Needs the Hospital Does Not Intend to Address

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

- Addiction / Substance Abuse
- Affordable Housing / Homelessness
- Food Insecurity
- Mental Health
- Safety & Violence

Using a Health Equity Lens

At SJHMC, we are dedicated to improving access to care and promoting health equity for all across all prioritized significant health needs.

Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

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

Hospital and health system participants include the CommonSpirit Health System Office, the SJHMC Community Benefit and Health Equity Department, Executive Leadership Team, Mission Services, the Care Coordination Department, Dignity Health Medical Group (Internal Medicine and Women's Clinic), and the Community Benefit and Health Equity Committee.

Community input or contributions to this implementation strategy included conducting a Community Health Needs Assessment with community input using five core principles to guide planning and program implementation; measuring and tracking program indicators and their impact; input from the Community Benefit and Health Equity Committee (CBHEC) and the Health Equity Alliance (HEA) and other stakeholders in the development of the annual community benefit plan and triennial implementation strategy.

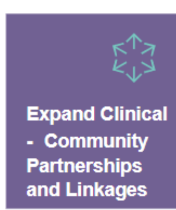
The programs and initiatives described here were selected on the basis of priority as they relate to one or more of the following principles: focus on disproportionate unmet health-related needs; emphasize prevention including activities that address the social determinants of health; build community 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.

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: Access to Healthcare						
Anticipated Impact (Goal)	The hospital's initiatives to address access to care are anticipated to result in: early identification and treatment of health issues; gains in public or private health care coverage; increased knowledge about how to access and navigate the healthcare system; and increase primary care "medical homes"; 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	
Enrollment assistance, outreach activities, health literacy, and financial assistance	● Chicanos Por La Causa/Keogh Health Connection, Foundation for Senior Living, Circle the City along with other community programs assist with insurance, program enrollment, hospital transition services and assistance. ● Financial Assistance Committee ● Work with community partners to increase health literacy among community members	●		●		
Community-based Patient Navigators	● Community Health Improvement Grants to establish medical homes, home visits, and social needs navigation. ● Integration of care navigators within health care facilities to meet the needs of diverse patient populations (i.e., homeless, refugees, asylum seekers, aging, chronically ill, fragile infants and other areas as needed). ● Bridging the gaps and linkage to community resources using internal hospital care navigators and external care navigators and community health workers.	●	●	●		

Health Need: Access to Healthcare					
Community Health Workers	● Muhammed Ali Parkinson's Center Promotoras/Community Health Workers ● Build a sustainable Community Health Worker program at St. Joseph's Hospital and Medical Center operated by the Community Benefit & Health Equity Department		●		●
Maternal and Fetal Health	● MOMobile (Maternal Outreach Mobile Unit) provide prenatal and postpartum care for low-income, uninsured pregnant women ● Mobile clinic travels weekly to four different locations within Maricopa County ● Nurse Family Partnership and home visiting programs for high risk families.	●			
Get Well Network - Docent Navigators	● Virtual navigators who conduct social needs screening to address social determinants of health.		●		●
ACTIVATE & CATCH	● ACTIVATE - Case management of patients in acute care setting with limited or no insurance ● CATCH - Case management of patients in ambulatory care setting with limited or no insurance ● Kindness Closet - Provides access to free medical equipment ● Patients are followed up to 90 days		●		●
Primary Care / Medical Home Partnerships	● Mission of Mercy - mobile primary care clinic ● Mountain Park Health Center - access to affordable ambulatory care ● Adelante Healthcare - access to affordable ambulatory care ● CATCH (Internal Medicine Clinic) ● Homeless patient navigator		●	●	

Health Need: Access to Healthcare	
Planned Resources	The hospital will provide care navigation, community health educators, community health improvement grants, outreach communications, and program management support for these initiatives.
Planned Collaborators	The hospital will partner with local community based organizations to deliver this access to care strategy. Current collaborators include Foundation for Senior Living, Chicanos por la Causa, MOMobile, Mission of Mercy, and Get Well Network.
Addressing Health Equity	In 2019, 14.1% of adults under the age of 65 were uninsured; 10.62% of Maricopa County residents were considered uninsured and 10.4% of Arizona residents were uninsured. Health care expenses can be a major burden for vulnerable communities. At SJHMC, we are committed to addressing health inequities through a systems change approach that improves access to affordable quality health care, addresses health inequities, and eliminates health disparities. Improved access to care is met through an enhanced health and social needs screening, implementation of a closed loop referral system, and Community Health Worker Program, promoting health equity for all.

Health Need: Chronic Health Conditions					
Anticipated Impact (Goal)	The hospital's initiative to address chronic conditions has anticipated results in: improved overall health through a reduction of co-morbidities, decrease in Emergency Department use, increase in primary care utilization, increase in knowledge and care for chronic conditions, reduction of mortalities, increase in education and disease prevention efforts. Reduction in length of hospital stays and readmissions. 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

	Health Need: Chronic Health Conditions				
Chronic Disease Self-Management	● **DEEP (Diabetes Empowerment Education Program)** ○ Self-management workshops in English and Spanish ○ Collaboration with community partners providing education on chronic disease self- management to meet ongoing needs of individuals living with pre-diabetes and diabetes. ● **Healthier Living with Chronic Conditions** ○ Free Chronic Disease Education Program ○ Strategies and tools are provided to improve health and overall quality of life. ○ Offered in English and Spanish		●	●	
Nutrition and Physical Activity Programs	● MOMobile education on nutrition for mother, baby and family ● Advocate for SNAP benefits, access to healthy foods programs using SNAP benefits ● Utilize Community Health Workers/Navigators to bridge access to social services and transportation to food distribution locations ● Cocinando con Salud en Balance (Cooking Class) ● Community Fitness Classes (i.e., Zumba, Yoga, and Tai Chi)	●			●
Chronic Disease Prevention and Assistance Programs	● ACTIVATE ○ Care Management following hospital discharge ○ Home visiting program and increased monitoring for 30 days ○ Social needs being met by program ○ Education and prevention activities		●		●
Cardiovascular Patient Navigation	● Social determinants of health screening ● Patient navigation		●		

Health Need: Chronic Health Conditions	
Planned Resources	The hospital will facilitate community health educators, free chronic disease management classes, cooking classes, care navigation for SNAP benefits, and access to healthy food programs.
Planned Collaborators	Collaboration with internal and external partners to address the chronic health conditions: obesity, diabetes, and cardiovascular disease (CVDs) strategy. Planned collaborators include SJHMC Cardiovascular Clinic, Chicanos por la Causa/Keogh, Foundation for Senior Living, and GetWell Network.
Addressing Health Equity	In 2019, Black/African Americans followed by American Indians had the highest inpatient hospitalization rates. **Cardiovascular disease** was ranked second for inpatient hospitalization visits, and third for emergency department visits in Maricopa County, with Black/African Americans had the highest rate for emergency department visits. • **Gender disparity:** males had a higher inpatient stay at 14%, death rate at 5% while females had a higher emergency department visit at 1%. • **Age disparity:** patients aged 75 years and older had the highest inpatient stay at 502%, emergency department visits at 322%, and a death rate of 910%. • **Racial disparity:** Black/African American patients had the highest inpatient stays at 44% and emergency department visits at 104%, while White/Caucasian patients had the highest death rate at 47%. **Diabetes** affects an estimated 29.1 million people in the United States and is the 7th leading cause of death. In 2019, diabetes was ranked sixth for inpatient hospitalization visits, and seventh for emergency department visits in Maricopa County, with Black/African Americans and American Indians having the highest rates for emergency department visits. • **Gender disparity:** males had a higher inpatient stay at 21%, females at 20%, and emergency department visits 1%. • **Age disparity:** patients aged 75 and older had the highest inpatient stays at 91% and death rate at 508%, while patients aged 55 – 64 had the highest emergency department visits at 104%. • **Racial disparity:** Black/African American patients had the highest inpatient stays at 107%, emergency department visits at 155%, and death rate at 113%. **Obesity** is associated with the leading causes of death in the United States and worldwide, including diabetes, heart disease, stroke and some types of cancer. In 2019, 34.4% of Arizona residents were considered

Health Need: Chronic Health Conditions

	overweight (BMI 25.0 – 29.9) and 31.4% were considered obese (BMI 30.0 - 99.8). In Maricopa County, 34% of residents were considered overweight and 30.1% were considered obese in 2019. At SJHMC, we are committed to addressing health inequities through internal and external partnerships, including local community-based organizations to provide continuity of care for patients living with chronic health conditions. These partnerships help to improve health care delivery, quality of health care, address health inequities, and eliminate health disparities. An enhanced health and social needs screening, implementation of a closed loop referral system, and Community Health Worker Program, significantly enables us to expand our reach to serve and support diverse populations, increase knowledge and education, navigation, disease prevention, improve health outcomes and promote health equity for all.

Health Need: Cancer

Anticipated Impact (Goal)	To increase access to care, social and medical supports, and to ensure patients are screened within the care guidelines. These projects also increase the patient's ability to continue to receive the care they need within their community. Improve access to care and promote health equity for all across all priorities significant health needs.

Strategy or Program	**Summary Description**	**Strategic Objectives**			
		Alignment & Integration	Clinical - Community Linkage	Capacity for Equitable Community	Innovation & Impact

Health Need: Cancer					
Cancer Support Navigation & Screening	● Collaboration with Cancer Support Community of Arizona and the American Cancer Society to provide onsite community education and navigation for cancer patients and their caregivers ● Cancer support navigators are bilingual and meet the cultural and linguistic needs of patients and community members		●	●	
Lifestyle Management	● Lifestyle management workshops, support groups, transportation support and other classes that support physical, mental, and spiritual wellbeing.	●	●		
Medication Assistance	● Cancer center will assist in completing applications for cancer medications for uninsured and underinsured.		●		
Planned Resources	The hospital will provide care navigation, community health educators, community health improvement grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	Collaborative partnerships with Cancer Support Community of Arizona and the American Cancer Society to enhance navigation and bridge the gaps in care, linking patients to appropriate resources that address their social and health needs.				
Addressing Health Equity	From 2014-2018, the rate for all types of cancer was greatest among White/Caucasians. Lung cancer is the 5th leading cause of death, and breast cancer is the 8th leading cause of death for Maricopa County residents. Rates of death due to cancer increase with age, except for cervical cancer which typically occurs in women 64 and younger. In 2019, lung cancer was the leading type of cancer-related death for individuals 64-75. • **Lung Cancer Gender Disparity:** females had a higher inpatient rate at 11%, males and females had the same emergency department rate, and males had a higher death rate at 2%. • **Lung Cancer Age Disparity:** patients aged 75 years and older had the highest inpatient stay at 426%, emergency room visits at 374%, and death rate at 640%.				

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Lung Cancer Racial Disparity: White/Caucasian patients had the highest inpatient stay at 49% and a death rate of 55%, while Black/African American patients had the highest emergency department rate at 76%.
Breast Cancer Age Disparity: patients aged 65 – 74 years had the highest inpatient rate at 174%, patients aged 55-64 had the highest emergency room visit rate at 157%, and patients aged 75 years and older had the highest death rate at 388%.
Breast Cancer Racial Disparity: White/Caucasian patients had the highest inpatient rate at 31% while Black/African American patients had the highest emergency department visits at 219% and death rate at 46%.

At SJHMC, we are committed to addressing health inequities through internal and external partnerships, including local community-based organizations to provide continuity of care for patients living with cancer. These partnerships help to improve health care delivery, quality of health care, address health inequities, and eliminate health disparities. An enhanced health and social needs screening, implementation of a closed loop referral system, and Community Health Worker Program, significantly enables us to expand our reach to serve and support diverse populations, increase knowledge and education, navigation, disease prevention, improve health outcomes and promote health equity for all.
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Strategies and Programs for Health Equity

	Health Equity	
Anticipated Impact (Goal)	Initiate and support systems change (internally and externally) that proactively promote the elimination of health disparities and the achievement of health equity for all. To develop and implement programs and system change initiatives that address identified significant community health needs, health inequities, proactively promote the elimination of health disparities, and achieve health equity for all.	
		Strategic Objectives

	Health Equity				
Strategy or Program	**Summary Description**	Alignment & Integration	Clinical - Community Linkage	Capacity for Equitable Community	Innovation & Impact
Health Equity Initiative	● Hospital Board subcommittee focused on health equity ● Health Equity Alliance will provide education and collaboration opportunities to community partners with the shared goal of improving health equity. ● Internal review and transition of current demographic/ collection methods ● Development of the health equity dashboard to support the tracking and measurement of health equity advancements and improved health outcomes ● Internal Implicit bias, Anti-racism, and ● cultural competency training ● Implementation of a 5 year Health Equity Strategy for St. Joseph's Hospital and Medical Center	●			
Social Needs Screening	● Get Well Network - Virtual patient navigation and social needs screening	●			●
CommunityCares (Connected Community Network)	● Social needs screening and closed loop referral system for community-based resources	●	●		●
Health Equity Alliance	● Health Equity Alliance will engage cross sector collaborations to address social determinants of health, reduce health disparities, and improve health equity for all			●	
Community Health Worker Program	● Build and strengthen community capacity through development of the Pathways Community Hub model for the Community Health Worker program that includes social needs screening and navigation for 21 social needs pathways.		●		●

Health Equity	
Planned Resources	The hospital will provide the program management support for these initiatives.
Planned Collaborators	The hospital will partner with local community-based organizations, Get Well Network, CommunityCares - Arizona's Connection for Whole Person Care, Pathways Community Hub Institute, and the National Training Institute on Race & Equity / Morehouse College.