Dignity Health - St. Rose Dominican San Martín

Community Benefit 2024 Report and 2025 Plan

Adopted November 2024

Dignity Health®
St. Rose Dominican
San Martín Campus

A message from

Thomas Burns, President/CEO of Dignity Health St. Rose Dominican Rose de Lima and San Martín Campuses, and Mark Wiley, Chair of the Dignity Health St. Rose Dominican Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social determinants of health.

Dignity Health – St. Rose Dominican shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2024 Report and 2025 Plan describes much of this work. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2024 (FY24), Dignity Health – St. Rose Dominican San Martín Campus provided $30,362,533 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $8,264,235 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2024 Report and 2025 Plan at its November 21, 2024 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to Holly Lyman, Market Director of Community Health (702) 616-4903.

Thomas Burns
President/CEO Rose de Lima & San Martín Campuses

Mark Wiley
Chairperson, Board of Directors

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At-a-Glance Summary

Community Served	Dignity Health – St. Rose Dominican provides health services throughout Clark County. Clark County is the most populous county in Nevada, accounting for nearly three-quarters of the state's residents with a total population of 2,333,185.
Economic Value of Community Benefit	$30,362,533 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $8,264,235 in unreimbursed costs of caring for patients covered by Medicare fee-for-service
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 Care ● Chronic Disease ● Transportation ● Public Health Funding
FY24 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: ● Access to care: Nevada Health Link & Medicaid Enrollment, Medicare Assistance Program, Helping Hands Program, Engelstad Foundation RED Rose Program Navigation, Pathways Community HUB, GME Family & Internal Medicine Resident Clinics, Patient Financial Assistance; Community Health Improvement Grantees ● Chronic Disease: Diabetes Lifestyle Center, HIV Program, Innovative Heart Health, Cognitive Stimulation Therapy, CDSME, Breast Cancer, Pathways Community HUB, Chronic Disease Prevention ● Transportation: Helping Hands of Henderson, Golden Grocery, Pathways Community Hub, Community Health Improvement Grantees ● Public Health Funding: Legislative Advocacy, Pathways Community HUB, Collaborative Partnerships, Community Health Improvement Grantees
FY25 Planned Programs and Services	The hospital intends to take several actions and dedicate resources to the following needs, including: ● Access to care: Nevada Health Link & Medicaid Enrollment, Medicare Assistance Program, Helping Hands Program, Engelstad Foundation RED Rose Program Navigation, Pathways Community HUB, GME Family & Internal Medicine Resident Clinics, Patient Financial Assistance; Community Health Improvement Grantees ● Chronic Disease: Diabetes Lifestyle Center, HIV Program, Innovative Heart Health, Cognitive Stimulation Therapy, CDSME, Breast Cancer, Pathways Community HUB, Chronic Disease Prevention ● Transportation: Helping Hands of Henderson, Golden Grocery, Pathways Community Hub, Community Health Improvement Grantees ● Public Health Funding: Legislative Advocacy, Pathways Community HUB, Collaborative Partnerships, Community Health Improvement Grantees

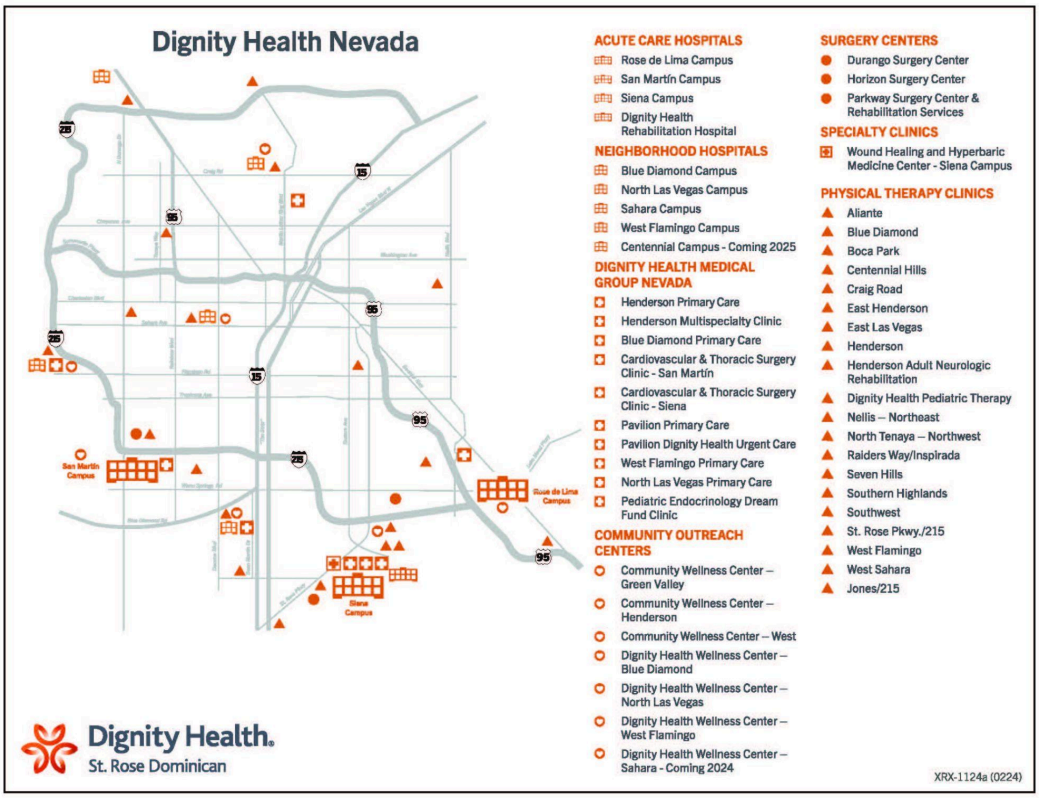
This document is publicly available online at
https://www.dignityhealth.org/las-vegas/about-us/serving-the-community

Written comments on this report can be submitted to Dignity Health – St. Rose Dominican Community Health Program at 2651 Paseo Verde Parkway, Suite 180, Henderson, NV 89074 or by e-mail to holly.lyman@dignityhealth.org.

Our Hospital and the Community Served

About Dignity Health – St. Rose Dominican

Dignity Health – St. Rose Dominican is a member of Dignity Health which is a part of CommonSpirit Health.
Dignity Health Nevada Locations



As the community's only nonprofit, faith-based hospital system, St. Rose Dominican hospitals are guided by the vision and core values of the Adrian Dominican Sisters and Dignity Health.

Rose de Lima Campus on opening day, 1947

The Adrian Dominican Sisters arrived in Henderson, Nevada, the summer of 1947 to run what was then a small community hospital. Over the last 75 years, this small hospital began what has become a large multi-faceted healthcare system. Dignity Health - St. Rose Dominican now has three hospital campuses in the Las Vegas valley, with a total of 473 beds, more than 1,300 physicians, 200 volunteers and more than 3,500 employees.

Dignity Health – St. Rose Dominican is part of CommonSpirit Health, a nonprofit, Catholic health system dedicated to advancing health for all people. It was created in February 2019 by Catholic Health Initiatives and Dignity Health. CommonSpirit is committed to creating healthier communities, delivering exceptional patient care, and ensuring every person has access to quality health care. With a team of approximately 150,000 employees and 25,000 physicians and advanced practice clinicians, CommonSpirit Health operates 140 hospitals and more than 1,000 care sites across 21 states.

The Rose de Lima Campus

More than 75 years after its founding, the Rose de Lima Campus remains a vital part of the Henderson community, providing 24/7 Emergency Room services, diagnostic imaging, and a limited number of inpatient beds. Originally built in 1943 and operated by the U.S. government during World War II, Basic Magnesium Hospital was renamed Rose de Lima Hospital in 1947, when the Dominican Sisters of Adrian agreed to assume operation of the hospital and care for the community. The hospital has remained in continuous operation in its original location providing compassionate care for the Henderson community. Following a multi-year transition into a small hospital, the downtown Henderson campus is now also home to:

- The Dignity Health Education Center for the Nevada Market, providing New Employee and New Leader orientation training, clinical staff training and ongoing education to maintain certifications.
- The Dignity Health Henderson Wellness Outreach Center, which provides life-long care for the local families through a variety of free and low-cost fitness and education classes and other services
- More than 100 Dignity Health Nevada support staff, who provide Compliance, Medical Records, Marketing & Communications and many other essential services.

The Siena Campus

The Siena Campus, the second and largest St. Rose Dominican Hospital in southern Nevada, opened its doors in a rapidly growing Henderson community in 2000. The 326-bed hospital is a Level 3 Trauma Center, operates a Level III Neonatal Intensive Care Unit, and is home to Henderson's only Pediatric Emergency Room and Pediatric Intensive Care Unit.

In June 2021, the hospital was the first in Nevada to achieve accreditation as a Center of Excellence in Robotic Surgery by Surgical Review Corporation, an independent, not-for-profit organization that administers best-in-class accreditation programs for medical facilities and professionals. Siena has also been accredited as a Comprehensive Center by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, a joint Quality Program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery.

Among many honors and awards over the past two decades, U.S. News & World Report, the global authority in hospital rankings and consumer advice, recently named the Siena Campus as a 2023-2024 High Performing hospital for five different condition categories: Heart Attack, Heart Failure, Kidney Failure, Knee Replacement, and Stroke. High Performing is the highest award a hospital can earn in the U.S. News' Best Hospitals Procedures & Conditions ratings.

The San Martín Campus

The 30-acre San Martin Campus began providing care amidst the expansive residential growth of the southwest Las Vegas valley in 2006. The 147-bed facility provides 24-hour Emergency Department services, Diagnostic Imaging, Robotic Surgical Suites, Cardiac Catheterization and Electrophysiology Lab, Orthopedics, Cardiovascular and Neurologic Services. The San Martin surgical staff recently achieved accreditation as a Center of Excellence in Robotic Surgery by Surgical Review Corporation.

San Martin Hospital was also named by U.S. News & World Report to its 2023-2024 Best Hospitals survey as a High Performing hospital, earning High Performing distinctions in two categories - Heart Failure and Kidney Failure. In January 2023 the San Martin Campus was also included as one of only 101 U.S. hospitals on Money.com's first-ever Best Hospitals for Bariatric Surgery list.

San Martin hospital is also home to Dignity Health Nevada's inaugural class Medical Residents. The first twelve Residents in the long history of St. Rose Dominican Hospitals received their white coats in a brief ceremony in June 2023. The event highlighted the beginning of their three-year journey in Internal Medicine clinical training in southern Nevada. It also marked the realization of St. Rose Dominican's long sought-after mission to establish a Graduate Medical Education program to improve health care in our community.

In addition to its acute-care hospitals, Dignity Health Nevada provides a variety of health care services, including,

- Primary and specialty care services from the Dignity Health Medical Group
- Four Dignity Health Neighborhood Hospitals offering Emergency Department services and in-patient facilities in underserved areas of our community
- Seven Dignity Health Wellness centers which provide free or low-cost classes, services, and activities for all ages across a wide range of health-related topics
- Nineteen Dignity Health Physical Therapy offering outpatient physical therapy and a wide range of rehabilitation services
- Dignity Health Rehabilitation Hospital, a 60-bed rehabilitation hospital providing highly specialized care, advanced treatment, and leading-edge technologies following severe injury or illness.

Our 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.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

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 – St. Rose Dominican serves Clark County. A summary description of the community is below. Additional details can be found in the hospital's community health needs assessment (CHNA) report online.

The geographic area for the CHNA is Clark County, the common community for all partners participating in the CHNA collaborative. Clark County is the nation's 14th largest county that serves more than 2.25 million citizens and more than 46 million visitors a year. Clark County serves a community living in rural or urban areas. A key component of the county's economy is tourism, and among its largest industries are accommodation and food service, retail trade and health care and social assistance.

All counties within Nevada have had tremendous population growth within the last decade. However, the majority of the population remains within Clark County, and it continues to grow. Between 2015 and 2021 Clark County's population grew from 2.11 million to 2.32 million. Clark County comprises only 7% (8,091 square miles) of Nevada's land mass (110,567 square miles) but contains 72% of the state's total population. Because of Clark County's contribution to the state population, caution should be exercised when comparing the county to the state.

Dignity Health - St. Rose Dominican also serves an increasingly diverse population. The largest racial group, White (non-Hispanic/Latino ethnicity), makes up 36.7% of the population, followed by the populations identifying as Black or African American (13.1%) and as Asian (11%). Notably, 32.4% of Clark County residents identify as Hispanic or Latino, a higher percentage than seen across Nevada and much higher than the rest of the U.S. (U.S. Census Bureau). Two-thirds of Clark County residents spoke only English at home as of 2014. Among the remaining third, the residents spoke Spanish or Spanish Creole at home.

Community Demographics – Clark County
Total Population 2,333,185

Race
Asian/Pacific Islander 11.0%
Black/African American - Non-Hispanic 13.1%
Hispanic or Latino 32.4%
White Non-Hispanic 36.7%
All Others 6.7%

% Below Poverty 9.7%
Unemployment 5.4%
No High School Diploma 13.9%
Medicaid 24.4%
Uninsured 10.9%

Source: Claritas Pop-Facts® 2022; SG2 Market Demographic Module

Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its 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, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in May 2022.

This document also reports on programs delivered during fiscal year 2022 that were responsive to needs prioritized in the hospital's previous CHNA report.

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 at strosehospitals.org or upon request at the hospital's Community Health office.

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 Care	Promoting health equity within access to care is important as everyone has the right to be healthy. Health should not depend on the ZIP code, economic status, or color of skin of an individual. Having access to care helps address disparities while it is the first step in creating a more equitable health system that improves the physical, social, and mental health for everyone in the community.	☑
Chronic Disease	Chronic diseases are long-lasting illnesses that persist over a long period of time and require on-going medical attention, limited activities of daily living, or both. Between 2016-2018, chronic diseases ranked consistently among the top ten causes of death in Clark County. Social determinants of health, such as safe housing; job opportunities; discrimination and violence; language and literacy skills have an impact on the prevalence of chronic diseases in the community. Having appropriate resources to decrease chronic disease in the community is important, as it will promote programs and interventions.	☑
Transportation	Transportation to and from health care services can improve health as well as health equity, which can reduce air pollution and increase physical activity. Reliable access to transportation can increase employment rates, access to healthy foods, access to healthcare providers and facilities, and access to parks and recreation for a healthy lifestyle. The assessment identified the high cost of transportation, accessibility to transportation and an insufficient utilization of transportation funding as areas to address.	☑
Public Health Funding	Having appropriate public health funding will aid in grants that help reduce health disparities of Southern Nevada. With improvement to transparency with public health funding for key stakeholders and the public, it provides knowledge for individuals in the decision-making process. A high unemployment rate, high health care and transportation costs, limited public health funding, and lack of education funding, have been identified as funding focus areas.	☑

2024 Report and 2025 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY24 and planned activities for FY25, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

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 Community Benefit Plan

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 included:

- Community Health Leadership Team
- Community Health Advisory Committee
- Community Boards – Dignity Health, Emerus, Select Medical
- Mission Integration
- Care Coordination Team
- Radiology & Lab
- GME Program
- Legislative Advocacy Committee & Director of Nevada Government Relations
- Dignity Health Foundation
- Community Health Improvement Grants Committee
- Dignity Health Medical Group

Community input or contributions to this implementation strategy included:

- Dignity Health Community Health Advisory Committee with Community Representatives
- Southern Nevada Health District CHIP Steering Committee
- Community Boards – Dignity Health, Emerus, Select Medical
- Ryan White
- Comagine Pathways HUB
- Aging and Disability Services Division (ADSD)
- Nevada Health Link and Medicare Assistance Program
- State of Nevada Division of Public and Behavioral Health

The programs and initiatives described here were selected on the basis of:

1. Existing Dignity Health – St. Rose Dominican programs with evidence of success/impact.
2. Researched effective interventions through meeting with key partners and began implementation of new programs.
3. Focused the Dignity Health Grants on the CHNA priorities to leverage the skills and capabilities of community partners.
4. Access to appropriate skills or resources.

Community Health Core Strategies

Driven by a commitment to equity and social justice, we envision a future where health and well-being are attainable by all regardless of background or circumstance.

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 three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Strengthen community capacity to achieve equitable health and well-being.
- Implement and sustain evidence-based health improvement program initiatives.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Access to Care

Strategy or Program	Summary Description	Active FY24	Planned FY25
Nevada Health Link & Medicaid Enrollment	Enrollment assistance for uninsured individuals and families in Nevada Health Link plans and Medicaid.	☒	☒
Helping Hands Program	Provide home-bound seniors with transportation to doctor appointments, pharmacy, grocery and other needs.	☒	☒
Medicare Assistance Program	Free, unbiased, local help with: Comparing Medicare health or drug plans and exploring options; finding and applying for programs that help with Medicare costs; protecting, detecting, and reporting healthcare fraud, errors, and abuse.	☒	☒
GME Family and Internal Medicine Resident Clinics	The residents will care for continuity patients in the outpatient setting. They will be the doctor of record for a panel of patients and provide all care for those patients under the supervision of an	☒	☒

	attending physician. They will provide prenatal, pediatric, adult, and geriatric care at this site. During their training, residents will increase access to care for an underserved population in North Las Vegas and Henderson. The IM Primary Care Track residents will provide person-centered care to underserved patients, connect patients to Wellness Center resources to address social determinants that complicate their care, and volunteer and advocate for systemic change to address disparities.		
Pathways Community HUB	A sustainable evidence-based model that leverages community health workers (CHWs) to orchestrate care for high-risk individuals and connect them to community resources to meet their health and social needs. The model provides a centralized system to track standardized services and tie payments to outcomes that improve the health of vulnerable and underserved populations.	☒	☒
Engelstad Foundation RED Rose	Breast cancer screening and navigation for uninsured and/or undocumented women	☒	☒
Patient Financial Assistance	Educate and inform patients and the community about our hospital's financial assistance policy	☒	☒

Goal and Impact: Gains in public or private health care coverage; increased knowledge about how to access and navigate the healthcare system; increased primary care visits among home-bound seniors;

Collaborators: The hospital will partner with Nevada Health Link, Catholic Charities, State of Nevada Department of Welfare and Social Services, Nevada WIC, Aging and Disability Services, Fund for a Healthy Nevada, Regional Transportation Commission, Southern Nevada Health District, Nye County, Public Libraries, Senior Centers, Local Churches, CARE Coalition, PACT Coalition, Hope for Prisoners

Health Need: Chronic Disease

Strategy or Program	Summary Description	Active FY24	Planned FY25
Diabetes	• National Diabetes Prevention Program (Available in Spanish) • ADCES Program • Diabetes Self-Management Program (Available in Spanish) • Diabetes Conversation Map • Medication Therapy Management	☒	☒
HIV	• Positive Self-Management for HIV • Medical Nutrition Therapy • Medication Therapy Management • Medical Case Management • Food Bank • Psychosocial Support Group • Universal Testing HIV and syphilis (launched 11/1/23)	☒	☒
Innovative Heart Health	• Self-Measured Blood Pressure Program • Eating for a Healthy Heart • Fruit and Vegetable Prescription Program • Healthy Heart Program • Buena Salud Para Un Corazon Sano	☒	☒

	• Viva Saludable • Pop-up Farmer's Stand		
Cognitive Stimulation Therapy	Group intervention for individuals with mild to moderate dementia. This evidence-based program reduces the progression of dementia.	☒	☒
Prevention of Chronic Disease	• Enhance Fitness – 16 sessions per week • Stepping On Fall Prevention • Nutrition Education & Consultation • Freedom from Smoking • Other Fitness: Tai Chi, Bingocize, Yoga, Walking Club, High Fitness, Zumba	☒	☒
Chronic Disease Self-Management Education (CDSME)	• Chronic Disease Self-Management Program • Cancer Thriving & Surviving • Chronic Pain Self-Management	☒	☒
Breast Cancer	Englestad RED Rose Program provides clinical breast exams, mammograms, ultrasounds and biopsies for uninsured women	☒	☒
Pathways Community Hub	A sustainable evidence-based model that leverages community health workers (CHWs) to orchestrate care for high-risk individuals and connect them to community resources to meet their health and social needs. The model provides a centralized system to track standardized services and tie payments to outcomes that improve the health of vulnerable and underserved populations	☒	☒
Mental & Behavioral Health	• Senior Peer Counseling • Powerful Tools for Caregivers • Mental Health First Aid & Safe Talk • Support Groups – AA, NA, SMART Recovery • Perinatal Mental Health Disorders (PMHD) Program	☒	☒

Goal and Impact: Expand access to evidence-based programs to prevent, educate and manage chronic disease. Increase access to minority groups.

Collaborators: The hospital will partner with Nevada Promise, State of Nevada, ADCES, CDC, QTAC, YMCA, Nevada Health Centers, Dignity Health Medical Group, Nevada Diabetes Stakeholder group, Comagine Health, Cardiac Rehab, Wound Care, University of Nevada Cooperative Extension, Holy Family Catholic Church, North Las Vegas Church of Christ, Mexican and El Salvadoran Consulate REACH Program, Navi Health, Inpatient Case Managers/Dietitians, Physician groups-cardiology, nephrology, internal medicine, and optometry, Roseman School of Pharmacy, University of Nevada Las Vegas, Remnant Ministries, Nevada Diabetes Association, UNR Sanford Center, Touro University, College of Southern Nevada CHW Program, State of Nevada Department of Public and Behavioral Health, Aging and Disabilities Service Division, Ryan White Part A Program, Cleveland Clinic Lou Ruvo Center for Brain Health, OLLI, City of Henderson Parks & Recreation, Nye County Communities Coalition, Nye County Health and Human Services, William N. Pennington Life Center, University of Nevada Reno, Access to Health Care Network, Nevada Health Centers, Volunteers in Medicine of Southern Nevada, Community Counseling Center, Aid Health Foundation, Southern Nevada Health District, Aid for AIDS of Nevada, The Center-LGBTQ, UMC Healthy Living Institute, UMC Wellness Center, Nevada AIDS Research and Education Society (NARES), Pacific AIDS Education and Training Center, Healthy Communities Coalition – Dayton and Lyon County, Nevada Cancer Coalition

Health Need: Transportation

Strategy or Program	Summary Description	Active FY24	Planned FY25
Helping Hands of Henderson	The hospital provides 400 clients with over 8000 round-trip rides per year to medical appointments, grocery store, pharmacy and other	☒	☒

	needed services		
Community Health Improvement Grants	Community Improvement Grant to expand transportation services	☒	☒
Golden Grocery	The hospital delivers food to homebound seniors	☒	☒
Pathways Community Hub	A sustainable evidence-based model that leverages community health workers (CHWs) to orchestrate care for high-risk individuals and connect them to community resources to meet their health and social needs. The model provides a centralized system to track standardized services and tie payments to outcomes that improve the health of vulnerable and underserved populations	☒	☒

Goal and Impact: The hospital will provide drivers, vans, community health workers, food pantry, Community Health Improvement Grants, grant writer and program management support for these initiatives.

Collaborators: The hospital will partner with Aging and Disability Services Division (ADSD), Regional Transportation Commission (RTC), Fund for a Healthy Nevada, Three Square Food Bank, MGM Grand Resorts Foundation, Caesars Entertainment, Lend a Hand of Boulder City, Helping Hands of Vegas Valley, City of Henderson, HopeLink Family Resource Center.

Health Need: Public Health Funding

Strategy or Program	Summary Description	Active FY24	Planned FY25
Community Health Improvement Grants	Provide over $300,000 in grant funding per year to local non-profit partners	☒	☒
Legislative Advocacy	• Support legislation to fund public health initiatives in coordination with the Nevada State Public Health Resource Office • Transparency with public health funding • Telehealth Parity • Medicaid Integrated Care Model	☒	☒
Grant Writing	Full-time grant writer will work to secure additional funding for priority programs in the community.	☒	☒
Collaborative Partnerships	Work with local coalitions and partners to secure additional funding for Nevada	☒	☒
Pathways Community Hub	A sustainable evidence-based model that leverages community health workers (CHWs) to orchestrate care for high-risk individuals and connect them to community resources to meet their health and social needs. The model provides a centralized system to track standardized services and tie payments to outcomes that improve the health of vulnerable and underserved populations.	☒	☒

Goal and Impact: The hospital will provide a full-time grant writer, legislative advocacy committee, Community Health Improvement Grants, attendance in statewide coalitions and support to partners.

Collaborators: The hospital will partner with Maternal Child Health Coalition, Nevada Cancer Coalition, PACT Coalition, CARE Coalition, Nevada Public Health Association, Nevada Minority Health & Equity Coalition, American Heart Association, Nevada Policy Council on Human Trafficking, Southern Nevada Task Force on Human Trafficking, Southern Nevada Regional Trauma Advisory Board, Southern Nevada Public Health Advisory Board, Nevada Hospital Association

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY24, the hospital awarded the grants below totaling $372,024. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Brooke's Good Deeds	Rural Pantry Services	Access to care	$38,400
CARE Chest	DME Services	Access to care	$22,553
Catholic Charities of Southern Nevada	Help, Hope, and Housing	Access to care	$50,000
Jewish Family Service Agency	Senior Transportation	Transportation	$88,000
Living Grace Homes	Increase Access & Transportation	Transportation	$83,304
NV Future of Nursing	Nayon Nevada: Filipino American Patient-Centered Outcomes	Chronic disease	20,000
Research, Education and Access for Community Health	R.E.A.C.H. Access to Care	Access to care	100,000
Roseman University of Health Sciences	Medicare Call Center	Access to care	$30,000

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

	Medicaid/Nevada Health Link Enrollment (NHL) & Medicare Assistance Program (MAP)
Significant Health Needs Addressed	Access to Care
Program Description	St. Rose has thirteen trained and licensed NHL Exchange Enrollment Facilitators (EEF) who assist the uninsured with enrollment in Medicaid, CHIP or a Qualified Health Plan. In addition we are funded as the Southern Nevada Medicare Assistance Program and have trained over 35 MAP Counselors who provide free, unbiased, local help navigating Medicare and applying for programs that assist with Medicare costs.
Population Served	Uninsured of all ages, Medicare Beneficiaries
Program Goal / Anticipated Impact	Reduce the number of uninsured adults and children and provide Medicare Assistance Program counseling, navigation and education to Southern Nevada Medicare beneficiaries.
FY 2024 Report	
Activities Summary	• Trained staff and volunteers, maintained licenses and certifications • Identified and outreached to underserved populations in need of healthcare. Focused on hard to reach populations.

	• Provided extensive outreach to educate the population on unwinding of Public Health Emergency and Medicaid auto-renewals. • Marketing in REACH, SRDH website, Vans and all programs • Staffed an Exchange Enrollment Facilitator at 4 of our Community Wellness Centers and MAP Counselors and volunteers at 4 centers. • Provided virtual enrollment assistance at all 6 Community Wellness Centers • Achieved NHL & MAP grant outcomes to secure ongoing funding • Enrolled clients in a QHP or Medicaid • Attended community events
Performance / Impact	NHL • 64,589 Nevada Health Link Contacts • 9,049 NHL & Medicaid Counseling Sessions • Enrolled 1,548 Individuals: 1279 Qualified Health Plan (NHL) & 269 Medicaid • Attended 875 Outreach Events • 13 Certified EEFs on staff MAP • 13,151 Medicare Beneficiary Contacts • 5,939 Counseling Sessions • Attended 218 Events • Promoted NHL and MAP in the REACH Magazine and e-Newsletters
Hospital's Contribution / Program Expense	Total expense $1,044,294 less grant funding (MAP+NHL) of $492,848. Hospital provided space at 6 locations, some fringe benefits, overhead, computers and tech support, marketing and some mileage. Funded the Roseman University of Health Sciences MAP Assistance program through the Community Health Improvement Grants at $30,000
FY 2025 Plan	
Program Goal / Anticipated Impact	NHL • Achieve NHL grant outcomes to secure ongoing funding • Enroll 1350 clients in a Qualified Health Plan (QHP) and 265 in Medicaid • Attend 900 community events MAP • Provide 15,000 Medicare beneficiary contacts and 5700 counseling sessions • Attend 225 community events • Staff & Volunteer Diversity 50% • SMP Message to 80% of Beneficiary Contacts
Planned Activities	• Train staff, maintain licenses and certification for 13 EEFs and 35 MAP Benefits Counselors • Identify and reach underserved populations who need healthcare and low-income assistance programs. Continue education of changes to Medicaid renewals. • Marketing in REACH, SRDH website and through all programs • Staff an EEF at 4 of our Community Wellness Centers and MAP Counselors and volunteers at all 6 centers • Provide virtual enrollment assistance to serve all 7 Community Health Centers • Provide education for Medicare beneficiaries, families and caregivers • Provide information and education on the Protect, Detect, Report SMP message

 **Helping Hands**	
Significant Health Needs Addressed	Access to Care Chronic Disease Transportation

Program Description	Helping Hands of Henderson assists homebound individuals 60 years of age and older who live in Henderson, with transportation to medical/dental/optical appointments, prescription drop off/pickup, grocery shopping, food pantry, congregate meals and social activities. Provides supplemental groceries to low-income/homebound seniors.
Population Served	Homebound individuals 60 years of age and older
Program Goal / Anticipated Impact	Provide transportation to improve access to medical, nutrition, and personal care for seniors age 60+ living in Henderson. Increase access to basic nutritional needs for homebound seniors age 60+ living in Henderson and surrounding areas with home-delivered food pantry.
FY 2024 Report	
Activities Summary	• Maintained and prioritized wait list of eligible clients for intake. • Provided intake and annual reassessment of clients for transportation and food pantry program services, provide community referrals, reassurance calls and well checks. • Scheduled and assigned client ride requests, prioritizing medical appointments and life-sustaining needs, provided transportation. • Maintained fleet of 9 ADA-adapted vans. • Hired and trained 3 new Drivers. • Secured 3 new ADA-adapted vans for transportation. • Collaborate with Southern Nevada Transit Coalition to expand transportation services. • Retained, recruited, trained and scheduled volunteers for transportation and food delivery services. • Participated in aging services and food pantry collaborative coalitions • Provide bi-annual client surveys, ongoing resource referrals, and transportation services. • Coordinate monthly food pantry orders and deliveries to homebound seniors. • Provided emergency food deliveries within 24 hours of referral. • Provided pop-up food pantries in low-income senior housing communities without pantry access.
Performance / Impact	• Waitlist reduced to 20 • Enrolled/Reassessed 496 unduplicated transportation clients • Provided 7,324 round-trip rides • Recruited 7 new volunteers for a total of 49 volunteers • Provided 16,980 community referrals and 661 reassurance calls or well checks • Enrolled/Reassessed 362 unduplicated Golden Grocery Pantry clients • Provided 3,371 Golden Grocery Food Deliveries
Hospital's Contribution / Program Expense	Transportation total expense $1,055,211 less grant funding of $565,689. Golden Groceries Food Pantry total expense $62,936 less grant funding of $33,041. Hospital provided required match for grant funding, overhead, leadership and some fringe benefits.
FY 2025 Plan	
Program Goal / Anticipated Impact	• Maintain waitlist below 15 • Enroll/Reassess 525 unduplicated clients in Transportation • Enroll/Reassess 400 unduplicated clients in Golden Grocery Food Pantry • Provide 8,000 round trip rides • Provide 4,200 Golden Grocery deliveries • 10,000 Referrals • Recruit and maintain an active volunteer base of 60 • 98% of clients will have access to food as a result of Helping Hands services. • 95% of clients will report they were able to maintain medical appointments because of Helping Hands. • 90% of clients will report an increase in feelings of independence since enrolling in Helping Hands.
Planned Activities	• Increase grant funding to hire additional drivers.

	• Launch modernized software and technology for scheduling, routing and reporting to enhance efficiency and accuracy. • Reduce Wait List for transportation services. • Attend community outreach events for volunteer recruitment. • Provide pop-up food pantries in low-income senior housing communities without pantry access. • Expand collaboration with community partners to expand transportation services.

 **Engelstad Foundation RED Rose Program**	
Significant Health Needs Addressed	Access to Care Chronic Disease Transportation
Program Description	The RED Rose program provides free mammography, ultrasound, biopsy, and surgical consultations for individuals 49 years and younger who are uninsured or underinsured. The bi-lingual Breast Health Navigator coordinates care from screening to treatment. Support services such as payment of monthly utilities, transportation, groceries and rent available for clients during breast cancer treatment. In addition, all Navigators are trained Nevada Health Link Enrollment Facilitators and can enroll clients into the appropriate plan.
Population Served	Individuals 49 years and younger who are uninsured or undocumented
Program Goal / Anticipated Impact	Increase breast cancer screening to diagnose breast cancer as early as possible for uninsured and/or undocumented clients.
FY 2024 Report	
Activities Summary	• Increased marketing efforts through Spanish radio advertisement and interviews with Telemundo and Univision • Increased in capacity by hiring additional bilingual staff including a Community Health Worker • Developed a Breast RED Rose Patient Survey to receive feedback that will help us improve our services. • Outreach efforts in the community through health fairs, events, and presentations
Performance / Impact	• Intake assessment: 7,626 • Eligibility Screenings: 420 • Clinical Breast Exams: 98 • Diagnostic Mammograms: 337 Screening Mammograms: 191 • Ultrasounds: 340 Biopsies: 29 Surgical Consultations: 61 • Cancer Diagnosis: 14 and Surgical Treatment: 22 • Temporary Financial Assistance: 59 Clients $285,512.40 TOTAL; Rent $153,588.85; Electricity $25,424.79; Gas $8,183; Water $3,991.64; Groceries $62,450; Transportation $28,910 • Support group participants 221 • The RED Rose program continues to see 96% Spanish-speaking clients, and 100% of clients are uninsured • Attended 89 Community Events reaching 4451 people
Hospital's Contribution / Program Expense	The hospital contribution to this program totaled $1,437,786 less grant funding of $1,050,611. St. Rose provided space, staff, fringe, clinical services, IT, overhead and leadership.
FY 2025 Plan	

Program Goal / Anticipated Impact	• 530 Diagnostic mammograms • 350 Ultrasound • 100 Community events and presentations • 500 attendees at Breast Cancer Support Groups • 6000 call inquires • Provide 50 women financial assistance
Planned Activities	• Engage the Hispanic community by collaborating with the Mexican and El Salvador Consulates • Promote Breast Cancer Risk Screening in the community by conducting presentations and attending health fairs • Increase capacity by hiring an additional bilingual Community Health Worker • Expand community reach and access by being available onsite at the Sahara Neighborhood Hospital Wellness Center

 **Diabetes Lifestyle Center**	
Significant Health Needs Addressed	Chronic Disease
Program Description	Provide evidence-based diabetes prevention, education and self-management programs
Population Served	People with diabetes and at risk for diabetes
Program Goal / Anticipated Impact	Diabetes Prevention: Host 2 CDC Recognized NDPP cohorts for a total of 25 participants. Initiate 2 NDPP cohorts for employer-based organizations. ADCES Accredited Program: Provide formal diabetes education to 250 individuals. SMRC's DSMP: Provide 2 DSMP leader training. Collaborate with community partners to host DSMP workshops. Enroll 170 participants to DSMP workshops.
FY 2024 Report	
Activities Summary	Targeted minority groups in underserved areas to promote access to diabetes education. Provided support to lifestyle coaches providing DPP. Continued to promote services to providers throughout the Valley.

Performance / Impact	Diabetes Prevention/National Diabetes Prevention Program (NDPP):
	• CDC Recognized NDPP
	  ○ Number of cohorts - 2
	  ○ Number of participants - 19
	• Hosted 2 NDPP Leader trainings- 1 in-person, 1 virtual; 19 new lifestyle coaches trained
	ADCES Accredited Program:
	• 401 referrals from providers for billable education services.
	• 299 individuals received diabetes education.
	• Provided quarterly diabetes and nutrition classes/cooking demos at the Moapa Paiute Indian Reservation.
	• 88% of participants who completed diabetes education met their behavior change goals.
	• A1c reduction from 8.0% to 6.8% among program completers.
	• 727 patient encounters for diabetes education and diabetes meal planning classes.
	• 140 encounters for diabetes support group.
	Diabetes Self-Management Program (DSMP):
	• DSMP classes - 10
	• DSMP participants enrolled - 115
	• Hosted 2 DSMP Leader Trainings

Hospital's Contribution / Program Expense	The hospital contribution to this program totaled $164,581 less grant funding of $109,860. St. Rose provided space, staff, fringe, clinical services, IT, overhead and leadership.
FY 2025 Plan	
Program Goal / Anticipated Impact	Diabetes Prevention: Host 2 CDC Recognized NDPP cohorts for a total of 25 participants. ADCES Accredited Program: Provide diabetes education to 330 individuals. Provide monthly diabetes and nutrition education at the Moapa Paiute Indian Reservation. SRMC's DSMP: Provide 1 DSMP leader training. Collaborate with community partners to host DSMP workshops. Enroll 120 participants to DSMP workshops.
Planned Activities	Promote access to diabetes education especially for minority populations. Promote services to more providers throughout the Valley.

Chronic Disease Management	
Significant Health Needs Addressed	Chronic Disease
Program Description	Provide access to evidence-based programs for prevention, education and self-management. Programs include: • Chronic Disease Self-Management Programs - Cancer Thriving & Surviving, Tomando Control de Su Salude, Positive Self-Management for HIV, Chronic Pain Self-Management, Diabetes Self-Management (English & Spanish) also reported in Diabetes. • Innovative Heart Health • Community CHF Program • Powerful Tools for Caregivers • Better Breathers COPD
Population Served	People with chronic disease and/or other risk factors
Program Goal / Anticipated Impact	Expand access to evidence-based programs for people with chronic disease and other risk factors. Increase access to minority groups
FY 2024 Report	
Activities Summary	CDSME: Hosted five leader trainings for CDSMP and CPSMP. Engaged with new community partners and increased in-person workshops. Certified community advocates in the rural communities to be able to deliver CDSMP and CPSMP workshops. Continued to support the expansion and development of infrastructure to our partners in Northern Nevada, Nevada Correctional facilities, and throughout the state of Nevada. Innovative Heart Health: Expanded our reach into the Spanish community through our partners in Volunteers in Medicine of Southern Nevada to provide services to patients living with hypertension and/or high cholesterol. Developed a new partnership with the Station Casinos to deliver the Healthy Heart program to their employees. Caregivers: Recruit potential PTC leaders for the training. Increase workshops and support groups offered to the underserved population. Better Breathers: Returned in person to monthly meetings
Performance / Impact	CDSME • Provided 40 CDSME workshops to 254 participants with 165 program completers • Hosted 1 CDSME Leader Training for 13 new leaders • Delivered 28 workshops; 23 in English and 5 in Spanish Innovative Heart Health • Enrolled 116 participants in the Healthy Heart Program • Enrolled 22 participants in the Fruit and Vegetable Prescription program

	• Delivered 2 Healthy Heart Programs in Spanish with 34 participants enrolled • Delivered 6 Healthy Heart Programs in the English with 82 participants enrolled • Provided 220 Heart Health Kits • Trained 13 facilitators for the Healthy Heart Ambassador- Blood Pressure Self Monitored Program <u>Caregivers</u> • Total Participants: 270 enrolled, 179 Program Completers (109 in English, 30 in Spanish), Total Classes: 17 Workshops (12 in English, 5 in Spanish) • Total Powerful Tools for Caregivers leaders: 31 active facilitators total (8 Spanish-Speaking) • Caregivers Leader Training: 1 Leader training and certified 9 new Leaders • Total Caregiver Support Group Meetings: 81 • Total Support Group attendees: 307
Hospital's Contribution / Program Expense	Total hospital expense $420,664 less grant funding of $273,384. Hospital provided staff, classroom and consult space, overhead and fringe, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	<u>CDSME:</u> • Deliver 20 CDSME workshops; 15 in English and 5 in Spanish • Host CDSME workshops in collaboration with community partners. Establish new partnerships in the community to bring CDSME programs to their facilities. • Conduct 1 CDSMP/Tomando and 1 CPSMP Leader Trainings • Enroll 140 participants in the CPSMP <u>Heart Health:</u> • Enroll 80 participants in the Healthy Heart Program • Deliver 4 Healthy Heart Programs in Spanish with 30 participants enrolled. • Train 2 health educators to deliver the Healthy Heart Program • Enroll 50 participants in the Fruit and Vegetable Prescription program • Collaborate with 2 educators to train their staff in the Healthy Heart Ambassador - Blood Pressure Self Monitored Program <u>Caregivers:</u> • Collaborate with new and existing partners to recruit leaders for the PTC leader training in Southern, Northern, and Rural Nevada. • Deliver 18 workshops - 13 in English (10 Southern NV, 1 Northern NV, 2 Rurals) and 5 in Spanish (4 Southern NV and 1 Northern NV) • Enroll 250 people in Powerful tools for Caregivers and have 175 completers • Conduct 1 leader training - certifying 12 new leaders • Provide 3 monthly support groups to 100 participants in English and Spanish
Planned Activities	<u>CDSME:</u> Recruit CDSMP and CPSMP leaders for four lay leader trainings. Engage with community partners to promote leader trainings. Foster new relationships with community organizations to host CDSMP and CPSMP workshops. Support partners in expanding infrastructure to offer CDSMP and CPSMP programs to prison populations, rural areas, and throughout the state. <u>Innovative Heart Health</u>: Improve the infrastructure for the Healthy Heart Program to promote the sustainability of the program. Develop a facilitator guide for a lay led Healthy Heart Program for community partners to facilitate within their organizations. Train community partners in the Healthy Heart Ambassador - Blood Pressure Self-Management Program to be able to offer these services to their patients living with hypertension. Continue working with local Spanish clinics and community based organizations to receive referrals for the Spanish Healthy Heart Program. <u>Caregivers:</u> Conduct more program outreach to rural and Northern Nevada. Facilitate additional 1-time PTC Managing Stress workshops throughout the state. Recruit new leaders from rural and Northern Nevada. Recruit more bilingual leaders to be trained. Collaborate with existing and new partners in the community.

Prevention of Chronic Disease	
Significant Health Needs Addressed	Chronic Disease
Program Description	Expand access to evidence-based programs for prevention including physical activity, nutrition, healthy food security and fall prevention
Population Served	Community
Program Goal / Anticipated Impact	Fall Prevention: Provide six Stepping On Classes and 2 TJQMBB classes. Train 15 leaders in Stepping On. Fitness: Provide Enhance Fitness and other fitness classes at all 7 centers Fruit and Vegetable Prescription Program: Deliver fresh fruit and vegetables to people who are food insecure and living with a chronic disease twice a month for 6 months. WIC: Provide 5000 Women Infants and Children with healthy food, nutrition education and breastfeeding support Golden Grocery Deliveries (also reported in Helping Hands) deliver home-bound seniors healthy food. Nutrition Lectures and Cooking Demos: Provide quarterly nutrition lectures and cooking demos at all 6 centers Medical Nutrition Therapy (MNT): Offer MNT with an RD for the community
FY 2024 Report	
Activities Summary	Fall Prevention: Partner with the Nevada Goes Falls Free Coalition, build capacity of fall prevention system Fruit and Vegetable Prescription Program Collaborate with Dignity Health Medical Group, Ryan White, Helping Hands, Southern Nevada Health District, and other community partners to recruit and enroll participants.
Performance / Impact	Fall Prevention • Trained 12 facilitators in a two-day TJQMBB Training • Completed 1 TJQMBB workshop generating 347 encounters and 7 completers (participants completing 75% of the workshop) • Completed 8 Stepping On: Fall Prevention workshops with 114 registered participants and 75 completers (participants completing five of the seven sessions). • Held 2 virtual Stepping On: Fall Prevention facilitator trainings - 15 new facilitators statewide Fitness Provided over 2700 fitness classes at six centers generating 28,387 fitness encounters Fruit and Vegetable Prescription Program Delivered 2,100 fresh fruit and vegetable boxes to 175 participants WIC Provided 5,477 clients with EBT cards, nutrition education and breastfeeding support Golden Grocery Deliveries 3,371 MNT: 50 clients received Medical Nutrition Therapy consults with an RD Nutrition Lectures & Cooking Demos: Hosted 10 community nutrition classes and cooking demos reaching 265 participants at 4 Centers. Topics included: Be Smart and Air Fry for Your Heart, Healthy Eating Beyond the Table, Healthy Habits for Weight Management, Snacking Your Way Through the Holidays, and The Plant-Based Diet- Starting from the Ground Up.
Hospital's Contribution / Program Expense	Total hospital expense $2,948,404 less grant funding of $1,615,164. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	Fall Prevention

	• Secure grant funding. Expand the Nevada Goes Falls Free Coalition, increase fall risk screenings • Enroll 150 people aged 60 and older into 8 Stepping On Workshops with 87 completers • Conduct 1 Stepping On: Facilitator Training to 16 community members • Provide five TJQMBB with 50 completers • Conduct one 2-day TJQMBB Facilitator Training • Develop 2 new partnerships Fitness • Host an Enhance Fitness instructor training, and expand the program to community partners. • Provide 2800 classes generating 30,000 fitness encounters Fruit and Vegetable Prescription Program Deliver fresh fruits and vegetables to 175 participants WIC: Reach 5800 clients Golden Groceries: 4200 deliveries MNT: Provide 55 consultations with an RD Nutrition Lectures & Cooking Demos: Provide a new topic each quarter at 5 Centers
Planned Activities	Fall Prevention: Secure grant funding. Expand the Nevada Goes Falls Free Coalition, increase fall risk screenings. Increase number of Stepping On: Fall Prevention facilitators throughout the state. Fitness: Host an instructor training, and expand the program. Fruit and Vegetable Prescription Program: Collaborate with Dignity Health Medical Group, Ryan White, Helping Hands, Southern Nevada Health District, and other community partners to identify patients who are food insecure and enroll into the program.

Pathways Community HUB	
Significant Health Needs Addressed	Access to Care Chronic Disease Transportation
Program Description	The Pathways Community HUB (PCH) program identifies individuals in the community who are at risk for poor outcomes, engaging them in the process to complete a comprehensive risk assessment, matching them with a Community Health Worker who is their Care Coordinator, assisting them in addressing all their risks through 21 Pathways. Pathways include: Adult Education, Developmental Referral, Employment, Food Security, Healthcare Coverage, Housing Pathway, Immunization Referral, Learning, Medical Home, Medical Referral, Medication Adherence, Medication Reconciliation, Medication Screening, Mental Health, Oral Health, Postpartum, Pregnancy, Social Service, Substance Use, Transportation.
Population Served	Underserved in the community at risk for poor outcomes
Program Goal / Anticipated Impact	Identify individually modifiable risk factors for those in the community who are at risk for poor outcomes and engage them in the process to identify and address these risks by matching them with a Pathways trained Community Health Worker (CHW). The CHW will assist participants to access services and overcome barriers to address their risks and track outcomes. When risks are addressed through completed Pathways, participants can have risk reduction, improved outcomes and communities reduce spending on healthcare.
FY 2024 Report	
Activities Summary	• Recruit/train CHWs in Pathways Community HUB • Recruit at risk participants through Dignity Health Community Outreach programs • CHW's provide care coordination to Pathways participants

Performance / Impact	181 Total Participants 1000 Total Visits by CHW to address risk and coordinate care 2113 Total Pathways opened 1404 Total Pathways successfully closed 12 CHWs/Staff trained in Pathways
Hospital's Contribution / Program Expense	Total hospital expense $259,893 less grant funding of $197.998. Hospital provided Program Manager, staff, space, overhead and fringe, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	250 Total Participants 1200 Total Visits by CHW to address risk and coordinate care 2200 Total Pathways opened 1500 Total Pathways successfully closed 15 CHWs/Staff trained in Pathways
Planned Activities	• Recruit/train CHWs in Pathways Community HUB • Recruit at risk participants through Dignity Health Community Outreach programs • CHW's provide care coordination to Pathways participants

HIV Program

Significant Health Needs Addressed	Access to Care Chronic Disease
Program Description	The Ryan White HIV program is designed to assist in meeting the needs of people, women, infants, children, and youth living with HIV. Our programs provide access and support for clinical care and support services including: medical case management, medical nutrition therapy, and medication therapy management. Provides supplemental groceries and nutrition supplements to low-income/homebound clients, home delivered prepared meals, HIV management education, and peer support. Clinical hospital inpatient implementation includes a universal HIV and syphilis screening for all patients 18 years old and older who need blood work. Patients who test positive for HIV will be connected to a patient/peer navigator for linkage to care. Comprehensive Prevention Services will be provided to those that test negative for HIV, but positive for syphilis.
Population Served	People living with HIV
Program Goal / Anticipated Impact	Provide support, evidence based education, and expand access to core support services for people living with HIV so that they can maintain care, enrich their lives, and manage their health.
FY 2024 Report	
Activities Summary	• Collaborated with multiple Ryan White Part A agencies to promote our services, obtain referrals, and delivered on site services to people living with HIV • Empowered clients to become CHW's and class facilitators • Offered program and services at community partner sites • Partnered with all Ryan White Funded HIV clinics in Southern Nevada • Participated in various community outreach events and provider planning committees • Established services at the Sahara Wellness Center, making it the Ryan White Hub and increasing food pantry services to 3 sites total in Las Vegas. • Expanded HIV testing to all 3 main hospital campuses

Performance / Impact	Medical Case Management (MCM) ● 152 referrals received from 4 HIV community health clinics ● 185 unduplicated clients serviced ● 385 Eligibility enrollments and renewals completed ● 77 Medication Therapy Management appointments Health Education Risk Reduction (HERR) ● Delivered to 220 clients living with HIV ● Total HERR classes: 105; Total PSMP Leaders: 6 ● A Better U classes: 75 newly diagnosed clients ● SCRIPT Medication adherence program to 40 RWPA clients living with HIV ● Delivered Health Benefits Take Charge classes and individual coaching to 116 participants Medical Nutrition Therapy (MNT) ● 225 referrals received from 8 partner agencies ● Serviced 378 unduplicated clients living with HIV ● 497 Nutrition Consultations completed ● 905 Fruit and Vegetable bags delivered ● 4,035 prepared meals delivered ● 660 cases of Nutrition Supplements delivered FOCUS HIV & Syphilis Screenings Launched screenings at all 3 campus ERs. Screened 4,789 patients
Hospital's Contribution / Program Expense	Total hospital expense $1,307,975 less grant funding of $968,020. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	Ryan White Part A total clients: 750 unduplicated clients Medical Nutrition Therapy (MNT): 400 unduplicated clients Medical Case Management (MCM): 250 unduplicated clients Food Bank/Home Delivered Meals: 250 unduplicated clients Health Education/Risk Reduction: 250 unduplicated clients Psychosocial Support Services: 150 unduplicated clients FOCUS HIV Screening: Screen 14,000 patients for HIV and syphilis. 75% of those that test positive for HIV will be linked to care. 75% of those that test HIV-/Sy+ will receive Comprehensive Prevention Services. Add Hep C screening.
Planned Activities	Medical Nutrition Therapy (MNT): ● Continue collaboration with Case Managers at HIV clinics and RWPA agencies ● Increase outreach in rural Nye County and Mohave, AZ Medical Case Management (MCM): ● Collaborate with HIV health clinics and RWPA support service agencies to obtain referrals ● Offer Case Management for eligibility renewal to already established clients ● Foster collaboration with Arlene Cooper Community Health Center's Rapid Start Team to engage newly diagnosed clients ● Collaborate with Dignity Health Medical Group and set up referral system Food Bank/Home Delivered Meals: ● Continue collaboration with vendors: Cluck it Farms and Diced Kitchen ● Continue collaborations with community partner sites to offer onsite services and distribution: Community Counseling Center ● Dietitians to screen and enroll participants during nutrition counseling ● Promote program to RWPA agencies Health Education/Risk Reduction ● Empower and train RWPA clients to become leaders and facilitators ● Foster collaboration with RWPA community health centers and agencies to offer workshops at their location ● Internal promotion to clients in care

	Psychosocial Support Services ● Empower RWPA clients to become peer navigators ● Foster collaboration with RWPA community health centers and agencies to offer sessions at their location ● Promotion to Las Vegas Advanced Practice Group Meetings ● Foster collaboration with RWPA health centers, resource centers, and case managers to obtain referrals Grow the FOCUS Program Universal Screening for HIV and syphilis ● Integrated EMR in all 3 EDs for HIV opt-out and Syphilis screenings ● Add Hep C Screening

 **Cognitive Stimulation Therapy**	
Significant Health Needs Addressed	Chronic Disease
Program Description	Cognitive Stimulation Therapy (CST) is an evidence-based group intervention for individuals with mild to moderate dementia that promotes cognitive function through integrating conversation, socialization, and physical activity. Proven benefits of CST are improved cognition, improved quality of life, cost-effective compared with medications.
Population Served	Individuals with mild to moderate dementia
Program Goal / Anticipated Impact	Improve cognition, quality of life, reduce depression and support caregivers for those with mild to moderate dementia.
FY 2024 Report	
Activities Summary	● Train CST Facilitators ● Recruit CST participants to participate ● Perform pre and post assessments to measure improvement ● Completed Train the Trainer Certification for 5 staff. We can now train our own facilitators ● Offer CST classes and Maintenance groups quarterly
Performance / Impact	47 Total Participants 77% Total Maintained or Improved cognition 78% Total Decrease in depression 84% Total Improvement in Quality of Life
Hospital's Contribution / Program Expense	Total hospital expense $63,266 less grant funding of $39,750. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	55 Total Participants 70% Total Improvement in Mental Status 80% Total Decrease in depression 80% Total Improvement in Quality of Life
Planned Activities	● Train 5 additional CST Facilitators ● Recruit CST participants to participate in 5 CST workshops and Maintenance Groups ● Launch CST in Spanish ● Complete pre and post assessments to measure improvement

Senior Peer Counseling	
Significant Health Needs Addressed	Chronic Disease Access to Care
Program Description	A nation-wide program designed by the Center for Healthy Aging, the Senior Peer Counseling program provides confidential, personal and supportive counseling to people facing the challenges and concerns of growing older, such as: loss and bereavement, retirement, health concerns, relationships, normal aging issues and loneliness. Dignity Health's counselors are a team of carefully trained volunteers who provide supportive counseling under the close supervision of mental health professionals.
Population Served	Seniors
Program Goal / Anticipated Impact	Discussing concerns with a trained and caring peer counselor can really make a difference in reducing loneliness and depression. Counseling offers an outlet to work through feelings, recognize strengths, consider alternatives, learn new coping skills and redirect your life toward greater meaning and purpose
FY 2024 Report	
Activities Summary	• Recruit, screen, train, and retain peer counselors annually. Provide bi-weekly supervision and ongoing training. • Recruit clients through physician referrals, self-referral, community partners, REACH Magazine and website. • Match clients with an appropriate counselor and monitor through supervision
Performance / Impact	41 Total Clients 520 Total Counseling Sessions 81 Total Intakes 22 Active Counselors 26 Total Referrals to other programs or services 27 Total Clients who have completed counseling
Hospital's Contribution / Program Expense	Total hospital expense $239,966 less grant funding of $41,821. Hospital provided staff including Clinical Psychologist and a Social Worker, classroom and consult space at 2 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	50 Total Clients 550 Total Counseling Sessions 40 Total Intakes 25 Active Counselors 30 Total Referrals to other programs or services 20 Total Clients who have completed counseling
Planned Activities	• Recruit, screen, train, and retain peer counselors. Provide monthly supervision and ongoing training. • Recruit clients through physician referrals, self-referral, community partners, REACH Magazine, mailings and website. • Match clients with an appropriate counselor and monitor counseling through supervision. Expand counselors out to other Centers

Perinatal Mental Health Disorders	
Significant Health Needs Addressed	Chronic Disease Access to Care
Program Description	The PMHD (Perinatal Mental Health Disorders) Program is a Statewide program that offers community training, education, support groups and care coordination for all families.
Population Served	Families
Program Goal / Anticipated Impact	Reduce mental health stigma, promote and educate health professionals on PMHDs and available community resources for their clients/patients, and continue to provide support and care coordination to moms and families experiencing PMHDs.
FY 2024 Report	
Activities Summary	Provided PMHD training to community and health professionals, support groups, mommy mixers and support with funding therapy. PMAD facilitators have trained over 820 community and health professionals and currently offer **5** support groups – 3 Mommy Care Club and 2 Mommy Mixers. The coordinator currently assists moms and families in need of clinical therapy. We help coordinate the family's insurance mental health provider and assist with funding the therapy if the provider is unable to see the patient within a two-week period.
Performance / Impact	• Trained 290 community and health professionals on PMHDs • Hosted 117 support group sessions with 510 participants (Mommy Care Club & Mommy Mixer) • Completed 190 health navigation • Completed 190 client intakes • Provided 185 counseling sessions • Distributed 556 New Mama Care Kits to moms in Southern NV • Hosted Virtual Fall Symposium with 76 attendees • Reached 1,000 followers on MCH social media pages • Attended 58 Community meetings, events, educated and promoted PMHD program resources to 16,800 community members
Hospital's Contribution / Program Expense	Total program expense $509,831 less grant funding of $282,424. Program includes personnel, therapy services, support groups, supplies and continuing education. Hospital provided classroom and office space, IT, marketing and promotion.
FY 2025 Plan	
Program Goal / Anticipated Impact	• Educate and train 350 community and health professionals on PMHDs. • Host 175 support group sessions with 600 participants across the valley (Mommy Mixer, Mommy Care Club) • Provide health navigation & client intakes for 275 clients • Provide 250 counseling sessions • Establish 10 new partners to provide safe sleep education • Provide 155 car seats to Indian Health Service Clinics for parents and caregivers • Distribute 600 safe sleep bundles to parents and caregivers • Expand New Mama Care Kit Initiative to Northern Nevada and Rural Nevada and distribute 1,000 New Mama Care Kits statewide • Reach 1,500 followers on MCH social media pages • Host hybrid Fall Symposium with 150 community members registered • Attend 75 Community meetings to educate and promote PMAD program resources
Planned Activities	Expand the PMHD program to Spanish-Speaking families by training bilingual community members and translating training and materials to Spanish. Continue PMHD training to community and health professionals, provide support groups and Mommy Mixers and fund therapy.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services 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 INVESTMENT PROGRAM PROJECTS IN NEVADA

Accessible Space, Inc. - Coronado & Bonnie Lane (ASI)
Accessible Space, Inc. (ASI), provides accessible, affordable housing; assisted/supportive living; and rehabilitation services to income-qualifying adults with physical disabilities and brain injuries and to seniors. Dignity Health has supported: the development of Bonnie Lane Apartments for $350,000, a 66-unit senior supportive housing development in Las Vegas, Nevada; and, the Coronado project for $1,125,000. The Coronado project loan was renewed in 2022. Dignity Health provided financing of a 60-unit affordable senior rental development known as Coronado Drive Senior Apartments in Henderson, Nevada.

NewWest Community Capital
NewWest Community Capital, has been a partner with Dignity Health since 2012, providing financing for affordable housing for seniors and the disabled, especially around Henderson, Reno, and Las Vegas, Nevada. To date, NewWest Community Capital has used Dignity Health funds to leverage over $400 million from other sources to build over 2500 affordable housing units. In June 2021, CommonSpirit approved another $1,000,000 loan to the organization maturing in 2028.

OTHER PROGRAMS

Breastfeeding
St. Rose Dominican is committed to protecting new mothers' milk supply and the nutrition of the baby. Outcomes: Served 875 moms in outpatient program.

Community Coalitions
The Nevada Statewide Maternal and Child Health Coalition (NVMCH) provides leadership to improve the physical and mental health, safety and well-being of the maternal and child population across Nevada. Outcomes: 505 active members statewide.

Health and Wellness Programs
Enhance quality of life by providing programs that reduce stress, provide education and psychosocial support. People who move to Las Vegas often leave their support systems behind and suffer from isolation and loneliness, which can have a negative impact on physical and mental health. Outcomes: Reached 712 participants.

Infants, Children & Parenting
Provided programs to enhance baby safety, early bonding, baby development and parenting. Outcomes: 8,432 participants.

Neighborhood Hospital Wellness Centers
Three Wellness Centers provide classes, consults, support and resources reaching 10,345 attendees.

Safety/Injury Prevention
Based on community mortality reports, provide education, skills and services to the community on safety for the prevention of injury and death. Target specific groups and needs – teens, new parents, work sites, adults and seniors. Outcome: 535 participants.

Support Groups
Provide support to individuals working through the healing process. Twenty-three groups meet regularly for a total of 4,025 encounters.

Transportation Assistance
Transportation program for patients and families to enhance patient access to care including bus passes with a specific focus on vulnerable populations. Outcomes: Assisted 900 individuals with 24-hour bus passes.

NON-QUANTIFIABLE BENEFITS

Community Building Activities: Dignity Health - St. Rose Dominican engages in a variety of activities to further the mission of advocacy, partnership and collaboration.

- Kindness Kloset. Employees donate new sweatpants, sweatshirts, t-shirts, socks and slippers for patients who are being discharged with no clothing to wear home. These patients are discharged from one of the units or from the Emergency Departments at all three campuses.
- Smoke-Free Campus Initiative. All three St. Rose Dominican campuses are smoke free and have been recognized by the American Lung Association and the Nevada Cancer Coalition.
- Healthy Rose Employee Wellness Program. St. Rose Dominican was recognized as a Silver Level recipient of the American Heart Association's Fit Friendly Worksites Recognition Program for taking steps to create a culture of wellness for our employees.
- Sister Robert Joseph Bailey Elementary School - Back-to school supplies and Christmas gifts were donated by employees for over 150 low-income children.
- Prayer Shawls were distributed to over 600 patients at all three campuses, local hospice and partner convalescent rehab centers. These shawls are knitted with love and prayers to help patients heal.
- Bus Passes and Boxed Lunches are distributed to walk-ins in need at all three campuses.
- Community Events. Many of our employees volunteer their time and money by participating in community events with local charities such as the American Lung Association Scale the Strat climb.
- ECHO (Employees Can Help Others) allows employees to donate spare change and other funds to help fellow employees who need financial assistance with rent/mortgage, utilities and other payments while going through a financial crisis. These funds are distributed through the ECHO committee which handles all requests.

Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. The economic value of community benefit for patient financial assistance (charity care), Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

524 St. Rose Dominican San Martín

Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)

For period from 07/01/2023 through 06/30/2024

	Persons	Expense	Offsetting Revenue	Net Benefit	% of Expenses
Benefits for Poor					
Financial Assistance	**1,744**	**$7,033,495**	**$0**	**$7,033,495**	**3.20**
Medicaid	**7,306**	**$42,197,987**	**$20,989,690**	**$21,208,297**	**9.65**
Other Means Tested Programs	**4**	**$19,474**	**$3,918**	**$15,556**	**0.01**
Community Services					
E - Cash and In-Kind Contributions	2	$109,647	$0	$109,647	0.05
Totals for Community Services	**2**	**$109,647**	**$0**	**$109,647**	**0.05**
Totals for Benefits for Poor	**9,056**	**$49,360,603**	**$20,993,608**	**$28,366,995**	**12.91**
Benefits for Broader Community					
Community Services					
B - Health Professions Education	19	$1,989,970	$0	$1,989,970	0.91
E - Cash and In-Kind Contributions	300	$5,568	$0	$5,568	0.00
Totals for Community Services	**319**	**$1,995,538**	**0**	**$1,995,538**	**0.91**
Totals for Broader Community	**319**	**$1,995,538**	**$0**	**$1,995,538**	**0.91**
Totals - Community Benefit	**9,375**	**$51,356,141**	**$20,993,608**	**$30,362,533**	**13.82**
Medicare	**4,985**	**$41,028,106**	**$32,763,871**	**$8,264,235**	**3.76**
Totals Including Medicare	**14,360**	**$92,384,247**	**$53,757,479**	**$38,626,768**	**17.58**

Hospital Board and Committee Rosters

Community Board Members
July 1, 2023 – June 30, 2024

Mark Wiley, Board Chair
Mark Wiley Realty Group

Maggie Arias-Petrel
CEO, Cano Health

Katherine Vergos
Nevada Market Leader and President/CEO
Dignity Health –St. Rose Dominican Siena

Timothy Bricker
Southwest Division President
CommonSpirit Health

Cynthia Cammack, O.P.
Nursing Services Specialist, Hospice By The Bay, Dominican Sisters of San Rafael

Rod Davis
Retired

Patricia Dulka, O.P
Holy Rosary Chapter Prioress
Adrian Dominican Sisters

Patrick Hays
Retired

Brian Glicklich
Crisis and Strategic Advisor
Digital Strategy, Ltd

Saville Kellner
Founder
Lake Industries

Sean McBurney
Senior Vice President and General Manager
Caesars Entertainment

Shaundell Newsom
Founder and Visionary
SUMNU Marketing

Timothy Sauter, MD
Chief of Staff, Siena/Rose de Lima Campuses

Irena Vitkovitsky, MD
System Medical Director
Vituity

Kate Zhong, MD
Physician/CEO, CNS Innovations

Community Health Advisory Committee (CHAC) Members
July 1, 2023 – June 30, 2024

Tyler Whipkey., Chairperson
Service Area Vice President of Mission Integration & Spiritual Care

Polly Bates
Grant Manager, Foundation

Rayleen Earney, M Ed., CHES
Health Educator II/Diabetes Program
Southern Nevada Health District

Jennifer Trinkle
Helping Hands Manager

Mark Domingo
Community Health Manager

Dr. Shawn Gerstenberger
Dean, UNLV School of Community Health Sciences

Patricia Lindberg
Retired, Community Member

Holly Lyman, MPH, CLC
Director Community Health

Deacon Thomas A. Roberts
President and CEO
Catholic Charities of Southern Nevada

Shelley Williams, RN, CDE
Lead Diabetes Educator