Dignity Health - St. Rose Dominican Rose de Lima Campus

Community Benefit 2025 Report and 2026 Plan

Adopted November 2025

Dignity Health®

A member of CommonSpirit

A message from

Katherine Vergos, Las Vegas Market President and CEO 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 2025 Report and 2026 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 2025 (FY25), Dignity Health – St. Rose Dominican Rose de Lima Campus provided $3,588,152 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $1,388,309 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 2025 Report and 2026 Plan at its November 20, 2025 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.

Katherine Vergos
Las Vegas Market President and CEO

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 2,293,764
Economic Value of Community Benefit	$3,588,152 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $1,388,309 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 • Social Determinants of Health (Transportation, Housing, Food Security)
FY25 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
FY26 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 Transportation 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 Programs • Social Determinants of Health: Helping Hands of Henderson, Golden Grocery, Fruit & Vegetable Prescription Program, Pathways Community Hub, WIC Program, Emergency Housing Project, Roundtrip Transportation Program, Community Health Improvement Grantees

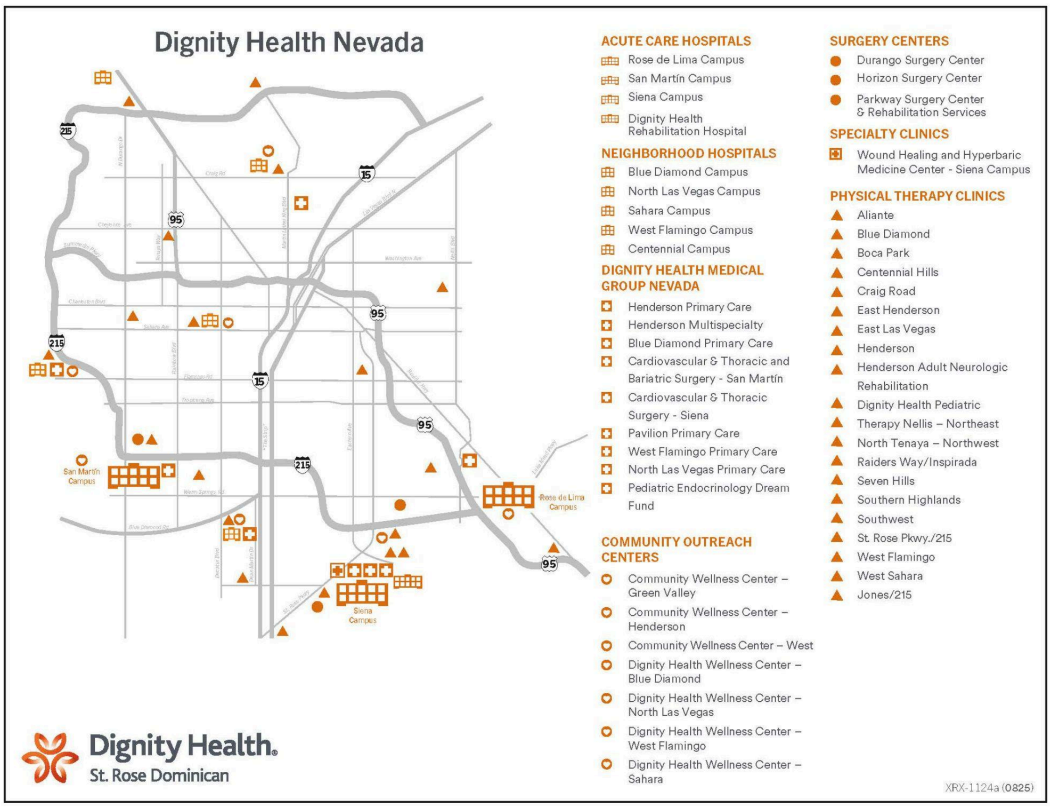
This document is publicly available online at
https://www.dignityhealth.org/las-vegas/about-us/serving-the-community

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 chna-strose@commonspirit.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 366-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.

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 2025-2026 High Performing hospital for ten different condition categories: Abdominal aortic aneurysm repair, Aortic valve surgery, back surgery (spinal fusion), Diabetes, Hip Fracture, Hip Replacement, Kidney Failure, Knee Replacement, Leukemia, lymphoma, & Myeloma, and Pacemaker implantation. High Performing is the highest award a hospital can earn in the U.S. News' Best Hospitals Procedures & Conditions ratings.

In 2025 the Siena Campus was recognized by Healthgrades as a Five-Star Recipient for the following: Heart Attack, Heart Failure, Cranial Neurosurgery, Sepsis, Pulmonary Embolism and Respiratory Failure.

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 118-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 and Metabolic and Bariatric Surgery by Surgical Review Corporation.

San Martin Hospital was also recognized by Healthgrades as a five-Star recipient for the Treatment of Sepsis and Heart 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
- Five 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 programs 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 39.39% of the population, followed by the populations identifying as Black or African American (11.66%) and as Asian (10.99%). Notably, 31.45% 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 2,293,764

Race/Ethnicity

Asian/Pacific Islander 10.99%
Black/African American - Non-Hispanic 11.66%
Hispanic or Latino 31.45%
White Non-Hispanic 39.39%
All Others 6.5%

Median Household Income $73,845
% Below Poverty 9.87%
Unemployment 7.42%
No High School Diploma 13.19%
Medicaid 20.72%
Uninsured 12.07%

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 2025.

This document also reports on programs delivered during fiscal year 2025 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.	☑
Social Determinants of Health	Social determinants of health are the conditions where we grow, live, work, and play. They include factors like income, education, housing, transportation and food security. Addressing these determinants is key to reducing inequities and improving health outcomes across populations	☑

Significant Health Need	Description	Intend to Address?
Environmental Factors	The impacts of heat, based on the Heat Health Index are higher for Clark County. Extreme heat can lead to heat stroke, heat cramps, heat exhaustion, dehydration, and death. Anyone can be at risk, but some are more vulnerable, including pregnant women, people with heart or lung conditions, young children, older adults, athletes and outdoor workers.	☐
Public Health Funding	Increased public health funding is essential for addressing health challenges in Southern Nevada. Greater transparency in how these funds are allocated will empower key stakeholders and the public to make informed decisions.	☐
Mental Health	Connections with those around us have a profound impact on our resilience and how we manage stress. A lack of healthy social interactions can lead to adverse mental health, unhealthy coping mechanisms, such as substance use, and can lead to negative effects on physical well-being	☐
Substance Use (drugs, alcohol)	Drug overdose mortality is a critical public health issue that affects families, communities, and health care systems, with long-term social and economic impacts.	☐

2025 Report and 2026 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 FY25 and planned activities for FY26, 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 Work Group
- Community Boards – Dignity Health, Emerus, Select Medical
- Mission Integration
- Care Coordination Team
- 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 Work Group
- Southern Nevada Health District CHIP Steering Committee
- Community Boards – Dignity Health, Emerus, Select Medical
- Ryan White, and Ending the HIV Epidemic programs
- 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 FY25	Planned FY26
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, Roseman University of Health Sciences

Health Need: Chronic Disease

Strategy or Program	Summary Description	Active FY25	Planned FY26
Diabetes	• National Diabetes Prevention Program (Available in Spanish) • ADCES Program • Diabetes Self-Management Program (Available in Spanish) • Diabetes Conversation Map • Medication Therapy Management	☒	☒
HIV	• Health Education classes for HIV Risk Reduction • 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 • Pop-up Farmer's Stand	☒	☒
Cognitive	Group intervention for individuals with mild to moderate dementia. This	☒	☒

Stimulation Therapy	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	☒	☒
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, 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, 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: Social Determinants of Health (Transportation, Housing, Food Security)

Strategy or Program	Summary Description	Active FY25	Planned FY26
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	☒	☒
WIC	Three St. Rose WIC Clinics provide nutrition services to over 5,200 Women, Infants and Children	☒	☒
Community Health Improvement Grants	Community Improvement Grant to expand transportation services	☒	☒

Golden Grocery	Increase access to basic nutritional needs for 400 homebound seniors age 60+ living in Henderson and surrounding areas with home-delivered food pantry.	☒	☒
Fruit & Vegetable RX Program	Provide monthly free fresh produce and prepared meals to food-insecure people with a chronic disease and link them to nutrition education and Community Health programs to address social determinants of health and improve overall well-being.	☒	☒
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 including housing, food security, transportation, education, access to care, and chronic disease management.	☒	☒
Roundtrip	Provide 1,750 round-trip rides annually, including medical transportation, to clients and patients who require transportation at hospital discharge, to medical appointments, and to community health services.	☒	☒
Emergency Housing Program	Navigate 100 at-risk community members annually with the housing application process, making referrals to appropriate housing programs, and following up to ensure success. Provide rental assistance for 50 clients who don't qualify or have exhausted community housing programs.		☒
RED Rose Financial Assistance	Provide underserved clients who are undergoing breast cancer treatment with housing/rent, utility, grocery and transportation assistance.	☒	☒
Goal and Impact: The hospital will provide drivers, vans, community health workers, food pantry, housing navigator and emergency housing funds, 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.			

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 FY25, the hospital awarded the grants below totaling $379,500. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
CARE Chest	DME Services	Access to care	$150,000
Catholic Charities of Southern Nevada	Renewing Hope Program	Access to care	$50,000
Living Grace Homes	Increase Access & Transportation	Transportation	$25,000
Brooke's Good Deeds	Moapa Senior Food Pantry & Transportation	Chronic disease, Transportation	$29,500
Lend A Hand of Boulder City	Senior Independent Living and Respite Care	Access to care	$30,000
Candlelighters Childhood Cancer Foundation	Emotional Wellness Program	Chronic Disease	$25,000
Desert Spring Community Resource Center	Expanding Food Pantry	Access to Care	$25,000
Serving Our Kids	Feeding their Dreams Program	Access to Care	$25,000
HELP of Southern Nevada	Homeless 55+	Access to Care	$20,000

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 ☐ Chronic Disease ☐ Social Determinants of Health
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 2025 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 enrollment assistance, virtually and by appointment, at all 7 Wellness Centers • Achieved NHL & MAP grant outcomes to secure ongoing funding

	• Enrolled clients in a QHP or Medicaid • Attended community events
Performance / Impact	NHL • 81,582 Nevada Health Link Contacts • 12,052 NHL & Medicaid Counseling Sessions • Enrolled 1,758 Individuals: 1,471 Qualified Health Plan (NHL) & 287 Medicaid • Attended 1,107 Outreach Events • 12 Certified EEFs on staff MAP • 14,444 Medicare Beneficiary Contacts • 5,172 Counseling Sessions • Attended 267 Events • Promoted NHL and MAP in the REACH Magazine and e-Newsletters • $1,919,508.37 million in pharmacy savings for beneficiaries
Hospital's Contribution / Program Expense	Total expense **$1,291,553** less grant funding (MAP+NHL) of $716,438. The hospital provided space at 7 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.
FY 2026 Plan	
Program Goal / Anticipated Impact	NHL • Achieve NHL grant outcomes to secure ongoing funding • Enroll 1,500 clients in a Qualified Health Plan (QHP) and 250 in Medicaid • Attend 1,600 community events MAP • Provide 15,000 Medicare beneficiary contacts and 5200 counseling sessions • Attend 250 community events • Staff & Volunteer Diversity 50% • SMP Message to 80% of Beneficiary Contacts
Planned Activities	• Train staff, maintain licenses and certification for 12 EEFs and 35 MAP Benefits Counselors • Expand NHL from 4 FTEs to 6 FTEs • 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 and in-person by appointment enrollment assistance to serve all 7 Community Health Centers, plus El Mercado outreach site • 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 ☑ Social Determinants of Health
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 2025 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. Secured 3 new ADA-adapted vans. • Hired and trained 3 new Drivers. • 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 maintained at less than 30 (25 at year end) • Enrolled/Reassessed 581 unduplicated transportation clients • Provided 8,282 round-trip rides • Recruited 8 new volunteers for a total of 50 active volunteers • Provided 16,980 community referrals and 661 reassurance calls or well checks • Enrolled/Reassessed 690 unduplicated Golden Grocery Pantry clients • Provided 4,306 Golden Grocery Food Distributions
Hospital's Contribution / Program Expense	Transportation total expense $1,455,266 less grant funding of $698,780. Golden Groceries Food Pantry total expense $115,880 less grant funding of $66,646. The Hospital provided a required match for grant funding, overhead, leadership and some fringe benefits.
FY 2026 Plan	
Program Goal / Anticipated Impact	• Maintain waitlist below 15 • Enroll/Reassess 550 unduplicated clients in Transportation • Enroll/Reassess 400 unduplicated clients in Golden Grocery Food Pantry • Provide 9,000 round trip rides • Provide 5,000 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 ☑ Social Determinants of Health
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 underinsured
Program Goal / Anticipated Impact	Increase breast cancer screening to diagnose breast cancer as early as possible for uninsured and/or undocumented clients.
FY 2025 Report	
Activities Summary	• Incorporated new services that include Chemo Port Placements and Genetic Testing. • Collaborating with DHMG to provide Screening and Diagnostic Mammogram orders. • Developed a new in-person eligibility and financial assistance application process. • Cross trained all R.E.D. Rose staff to elevate our customer service. • Increased outreach efforts in the community through health fairs, events, and presentations
Performance / Impact	• Intake assessment: 8,090 • Eligibility Screenings: 648 • Clinical Breast Exams: 137 • Diagnostic Mammograms: 313 Screening Mammograms: 295 • Ultrasounds: 300 Biopsies: 65 Surgical Consultations: 89 • Cancer Diagnosis: 29 and Surgical Treatment: 22, Port placement: 9 • Temporary Financial Assistance: 69 Clients $226,144.44 TOTAL; Rent $120,103.30; Electricity $19,297.08; Gas $9,500.00; Water $6,900.14; Groceries $52,464.00; Transportation $15,370.00 • Support group participants 309 • The RED Rose program continues to see 96% Spanish-speaking clients, and 100% of clients are uninsured • Attended 86 Community Events reaching 4712 people
Hospital's Contribution / Program Expense	The hospital contribution to this program totaled $1,844,663 less grant funding of $1,227,755. St. Rose provided space, staff, fringe, clinical services, IT, overhead and leadership.
FY 2026 Plan	
Program Goal / Anticipated Impact	• 600 Mammograms • 300 Ultrasound • 50 Community events and presentations • 325 attendees at Breast Cancer Support Groups • 8200 intake assessment • Provide 40 women financial assistance or chemotherapy
Planned Activities	• Promote Breast Cancer Risk Screening in the community by conducting presentations and attending health fairs • Increase capacity by hiring an additional Community Health Worker

Diabetes Lifestyle Center	
Significant Health Needs Addressed	☐ Access to Care ☑ Chronic Disease ☐ Social Determinants of Health
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. ADCES Accredited Program: Provide diabetes education to 330 individuals.
FY 2025 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 - 4 ● Number of participants - 49 ● Per the CDC's 6-month evaluation of our program, overall 83% of our completers reduced their diabetes risk compared to the national average of 55% and surpassed the national averages in all outcomes. ● Hosted 2 NDPP Leader trainings- 1 in-person, 1 virtual; 19 new lifestyle coaches trained ADCES Accredited Program: ● 390 individuals received diabetes education. ● Provided 3 quarterly diabetes and nutrition classes/cooking demos at the Moapa Paiute Indian Reservation. They identified an internal diabetes educator for ongoing services. ● 90% of participants who completed diabetes education met their behavior change goals. ● A1c reduction from 8.0% to 6.6% among program completers. ● 739 patient encounters for diabetes education and diabetes meal planning classes. ● 166 encounters for diabetes support group.
Hospital's Contribution / Program Expense	The hospital contribution to this program totaled $163,769 less grant funding of $93,748. St. Rose provided space, staff, fringe, clinical services, IT, overhead and leadership.
FY 2026 Plan	
Program Goal / Anticipated Impact	Diabetes Prevention: Host 2 CDC Recognized NDPP cohorts for a total of 20 participants. ADCES Accredited Program: Provide diabetes education to 330 individuals.
Planned Activities	Promote access to diabetes education and services to more providers and potential participants throughout the Valley. Expand the number of billable classes for diabetes self management.

Chronic Disease Management	
Significant Health Needs Addressed	☐ Access to Care ☑ Chronic Disease ☐ Social Determinants of Health

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). • Innovative Heart Health • Powerful Tools for Caregivers
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 SRMC's DSMP: Provide 1 DSMP leader training. Collaborate with community partners to host DSMP workshops. Enroll 120 participants to DSMP workshops.
FY 2025 Report	
Activities Summary	CDSME: Hosted two leader trainings for CDSMP, DSMP, 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, DSMP, and CPSMP workshops. Continued to support the expansion and development of infrastructure to our partners throughout the state of Nevada. Innovative Heart Health: Expanded our reach into the African-American community through our partners in Doolittle Community Center to provide services to seniors living with hypertension and/or high cholesterol. Provided a leader training for lay-leaders to provide the program in the community. Caregivers: Recruit potential PTC leaders for the training. Increase workshops and support groups offered to the underserved population.
Performance / Impact	CDSME (Chronic Disease Self-Management, Chronic Pain Self-management, and Diabetes Self-Management Programs) • Delivered 29 CDSME workshops to 283 participants with 143 program completers; 19 in English and 10 in Spanish. • Hosted 2 CDSME Leader Training for 11 new leaders Innovative Heart Health • Enrolled 98 participants in the Healthy Heart Program • Enrolled 54 participants in the Fruit and Vegetable Prescription program • Delivered 2 Healthy Heart Programs in Spanish with 38 participants enrolled • Delivered 4 Healthy Heart Programs in the English with 60 participants enrolled • Provided 162 Heart Health Kits • Trained 2 facilitators for the Healthy Heart Ambassador- Blood Pressure Self Monitored Program Caregivers • Total Participants: 200 enrolled, 132 Program Completers (97 in English, 35 in Spanish), Total Classes: 20 Workshops (15 in English, 5 in Spanish) • Total Powerful Tools for Caregivers leaders: 22 active facilitators total (6 Spanish-Speaking) • Caregivers Leader Training: 1 Leader training and certified 7 new Leaders • Total Caregiver Support Group Meetings: 94 • Total Support Group attendees: 347
Hospital's Contribution / Program Expense	Total hospital expense $417,127 less grant funding of $259,737. Hospital provided staff, classroom and consult space, overhead and fringe, IT, marketing and promotion.
FY 2026 Plan	
Program Goal / Anticipated Impact	CDSME: • Deliver 20 CDSME workshops. • Host CDSME workshops in collaboration with community partners. Establish new partnerships in the community to bring CDSME programs to their facilities.

	• Conduct 1 CDSME Leader Training • Enroll 100 participants in the CPSMP • Enroll at least 50 participants in the DSMP Heart Health: • Enroll 80 participants in the Healthy Heart Program • Deliver 4 Healthy Heart Programs in Spanish with at least 30 participants enrolled. • Train 2 health educators to deliver the Healthy Heart Program • Enroll 80 participants in the Fruit and Vegetable Prescription program • Collaborate with an organization to provide the Healthy Heart Ambassador - Blood Pressure Self Monitored Program to 15 individuals in the community Caregivers: • Participate in 32 community meetings, health fairs, and outreach events, reaching 2,400 people to increase enrollments into PTC workshops by 20%. • Deliver 18 workshops - 13 in English (10 Southern NV, 2 Northern NV, 1 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 virtual leader training - certifying 12 new leaders • Provide 3 monthly support groups to 400 participants in English and Spanish
Planned Activities	CDSME: Recruit CDSMP and CPSMP leaders for one lay leader training. Engage with community partners to promote leader training. 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. Innovative Heart Health: Improve the infrastructure for the Healthy Heart Program to promote the sustainability of the program. Recruit HHP leaders for one lay leader training. Foster new relationships with community organizations to host Healthy Heart Ambassador - Blood Pressure Self-Management Program. Continue working with local Spanish clinics and community based organizations to receive referrals for the Spanish Healthy Heart Program. Caregivers: 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	☐ Access to Care ☑ Chronic Disease ☐ Social Determinants of Health
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 8 Stepping On Classes and 2 TJQMBB classes. Train 10 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 2025 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, Pathways, Southern Nevada Health District, Volunteers in Medicine of Southern Nevada 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 107 registered participants and 75 completers (participants completing five of the seven sessions). • Held 1 virtual Stepping On: Fall Prevention facilitator trainings - 5 new facilitators statewide • Conducted 300 fall risk screenings statewide during National Fall Prevention Awareness Week. • Participated in 37 community meetings, health fairs and outreach events, reaching 4,664 community members; provided 147 professionals with fall prevention resources. Fitness Provided over 2700 fitness classes at six centers generating 28,387 fitness encounters Fruit and Vegetable Prescription Program Delivered 1,740 fresh fruit and vegetable boxes to 175 food insecure participants. Provided 360 $30 vouchers for food-insecure participants to redeem seasonal fresh produce at various Las Vegas Farmers Markets locations. A combined total of 14,895.3 lbs of produce were distributed via deliveries and farmers market vouchers. 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 $3,032,856 less grant funding of $1,724,880. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2026 Plan	
Program Goal / Anticipated Impact	Fall Prevention • Expand the Nevada Goes Falls Free Coalition, increase fall risk screenings statewide to 400; collaborating with the Dignity Health Medical Group and Residents. • Enroll 120 people aged 60 and older into 8 Stepping On Workshops with 72 completers • Provide a 3-day statewide virtual Stepping On: Facilitator Training to 10 community members • Provide at least 200 professionals with fall prevention resources. • Establish 2 new partnerships within the community. • Increase fall prevention awareness and education by participating in 40 community meetings, health fairs, and outreach events throughout the year; have a 10% increase in registration from outreach efforts. • Provide five TJQMBB with 50 completers • Conduct one 2-day TJQMBB Facilitator Training Fitness • Host an Enhance Fitness instructor training, and expand program to community partners. • Provide 2800 classes generating 30,000 fitness encounters Fruit and Vegetable Prescription Program

	Provide bi-monthly locally grown, organic produce box deliveries, produce vouchers for local Farmers Markets and prepared meal delivery to individuals living with chronic health conditions • Enroll 295 unduplicated individuals in fresh produce delivery program • Deliver 3,400 produce bags • Provide 80 individuals with 950 produce vouchers for Farmer's Markets • Enroll 50 unduplicated clients in the Diced Kitchen Prepared Meal Delivery Program • Deliver 2,000 meals WIC: Reach 5300 clients Golden Groceries: 5000 deliveries MNT: Provide 55 consultations with an RD Nutrition Lectures & Cooking Demos: Provide a new topic each quarter
Planned Activities	Fall Prevention: 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 internal partners such as Dignity Health Medical Group, Ryan White, Helping Hands, Pathways, Red Rose for referrals. Continue ongoing partnerships with the Southern Nevada Health District, Volunteers in Medicine of Southern Nevada, 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 ☑ Social Determinants of Health
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 2025 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	340 Total Participants 1909 Total Visits by CHW to address risk and coordinate care 4988 Total Pathways opened 3642 Total Pathways successfully closed

	15 CHWs/Staff trained in Pathways
Hospital's Contribution / Program Expense	Total hospital expense $408,677 less grant funding of $380,519. Hospital provided Program Manager, staff, space, overhead and fringe, IT, marketing and promotion.
FY 2026 Plan	
Program Goal / Anticipated Impact	400 Total Participants 2100 Total Visits by CHW to address risk and coordinate care 5100 Total Pathways opened 3800 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 ☑ Social Determinants of Health
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 meals, HIV management education, and peer support. Clinical hospital inpatient implementation includes a universal HIV, syphilis, and Hepatitis C 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 or at risk for acquiring 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. Provide Ryan White Referral for individuals screened and diagnosed reactive living with HIV for wrap around services.
FY 2025 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. • Integrated opt-out HIV, and automated Syphilis and Hep C screenings at all 3 ED's.
Performance / Impact	713 unduplicated people living with HIV served Medical Case Management (MCM) • 167 referrals received from 12 HIV community health clinics

	● 357 unduplicated clients ● 483 Eligibility enrollments and renewals completed Health Education Risk Reduction (HERR) ● Delivered to 180 clients living with HIV ● Total HERR classes: 79; Total PSMP Leaders: 4 ● A Better U classes: 70 newly diagnosed clients ● SCRIPT Medication adherence program to 51 clients ● Delivered Health Benefits Take Charge classes and individual coaching to 173 participants Medical Nutrition Therapy (MNT) ● 401 referrals received from 4 partner agencies ● Serviced 384 unduplicated clients living with HIV ● 589 Nutrition Consultations completed ● 474 Fruit and Vegetable bags delivered ● 8,078 prepared meals delivered to clients ● 660 cases of Nutrition Supplements delivered Food Bank & Food Bank Home Delivery (FB) ● Serviced 307 unduplicated clients living with HIV ● Provided 1,560 Food Pantry Bags ● Provided 554 Smith Food Vouchers ● 1,533 prepared meals provided FOCUS HIV, Syphilis and Hepatitis C Screenings in Emergency Departments Cerner automatic screening integration for Syphilis, Hepatitis C along with HIV as an "opt-out" screening went into effect on February 18, 2025 at all 3 campus ERs. ● 13,959 HIV Screens conducted; ● 30,267 Syphilis Screens conducted ● 22,155 Hepatitis C Screens conducted
Hospital's Contribution / Program Expense	Total hospital expense $1,433,464 less grant funding of $1,100,195. Hospital provided staff, classroom and consultation space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2026 Plan	
Program Goal / Anticipated Impact	Ryan White Part A total clients: 1,500 Medical Nutrition Therapy (MNT): 400 unduplicated clients Medical Case Management (MCM): 400 unduplicated clients Food Bank/Home Delivered Meals: 600 unduplicated clients Health Education/Risk Reduction: 200 unduplicated clients Psychosocial Support Services: 100 unduplicated clients Medical Transportation (MT): 300 unduplicated clients Eligibility Referral for Healthcare & Support Services: 900 unduplicated clients Outpatient Ambulatory Health Services: 80 unduplicated clients FOCUS HIV Screening to help support ending the HIV epidemic: ● Screen 14,000 patients for HIV. 75% of those that test positive for HIV will be linked to care. ● Screen 24,000 patients for Hepatitis C. 75% of those that test positive for Hepatitis C will be linked to care. ● Screen 33,000 patients for Syphilis. 75% of those that test HIV-/Sy+ will receive Comprehensive Prevention Services.
Planned Activities	Medical Nutrition Therapy (MNT): ● Continue collaboration with provider referrals at HIV clinics and RWPA agencies ● Continue medically tailored supplements, meals, and food deliveries Medical Case Management (MCM): ● Collaborate with non-RW health facilities and RWPA support service agencies for referrals ● Collaborate with Dignity Health Medical Group and set up referral system ● Continue receiving referrals from Ryan White Centralized Eligibility team

	Food Bank/Home Delivered Meals: ● Continue collaboration with vendors: Farm Fresh 2 You and Diced Kitchen ● Continue collaborations with community partner sites to offer onsite services and distribution: Community Counseling Center and CAN Community Health ● Medical Case Managers and Dietitians screen and enroll participants during counseling ● Promote program to RWPA agencies Health Education/Risk Reduction ● Empower and train RWPA clients to become leaders and facilitators ● Collaborate with RWPA agencies to offer workshops at their location ● Internal promotion to clients in care Psychosocial Support Services ● Empower RWPA clients to become peer navigators and facilitators ● Promotion to Las Vegas Advanced Practice Group Meetings ● Collaborate with RWPA health centers, resource centers, and case managers for referrals ● Offer virtual support groups in rural communities Minority AIDS Initiative ● Collaborate with Arlene Cooper Community Health Center's Rapid Start Team to engage newly diagnosed clients ● Increase rural outreach in: Boulder City, Mesquite, Moapa, Nye County and Mohave, AZ ● Collaborate with the FOCUS team on linkage to care for newly diagnosed clients Outpatient Ambulatory Health Services ● Partner with Dignity Health Medical Group to provide services ● Community Pharmacist provides Medication reviews and management ● Establish a comprehensive medication adherence program Grow the FOCUS Program Universal Screening for HIV, Hepatitis C and Syphilis ● Continue on-going provider support to increase screening at all 3 campus ERs. ● Continue collaboration with the American Medical Association on best practices utilizing universal screenings in the Emergency Departments ● Develop referral process for Ryan White to integrate internal wrap-around services ● Establish collaboration with 5 new community partnerships ● Submit at least 2 abstract presentations for 2026

Cognitive Stimulation Therapy	
Significant Health Needs Addressed	☐ Access to Care ☑ Chronic Disease ☐ Social Determinants of Health
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 2025 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 $160,372 less grant funding of $89,543. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, and marketing.
FY 2026 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	☑ Access to Care ☑ Chronic Disease ☐ Social Determinants of Health
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 2025 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	62 Total Clients 480 Total Counseling Sessions 58 Total Intakes 27 Active Counselors 30 Total Referrals to other programs or services 23 Total Clients who have completed counseling

Hospital's Contribution / Program Expense	Total hospital expense $222,280 less grant funding of $37,132. Hospital provided staff, a Social Worker, Senior Peer Counseling Facilitator and Health Educator, classroom and consult space at 3 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2026 Plan	
Program Goal / Anticipated Impact	65 Total Clients 500 Total Counseling Sessions 60 Total Intakes 30 Active Counselors 30 Total Referrals to other programs or services 25 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, Safe Sleep & MCH Coalition

Significant Health Needs Addressed	☑ Access to Care ☑ Chronic Disease ☐ Social Determinants of Health
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 2025 Report	
Activities Summary	Provided PMHD training to community and health professionals, support groups, mommy mixers and support with funding therapy. PMHD 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 client intakes and health navigation • Provided 185 counseling sessions • Distributed 1,241 Safe Sleep bundles statewide • Provide 63 Car seats to Indian Health Services • 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 $1,683,064 less grant funding of $1,087,133. Program includes personnel, therapy services, support groups, supplies and continuing education. Hospital provided classroom and office space, IT, marketing and promotion.
FY 2026 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 788 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: 539 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 1,590 participants.

Infants, Children & Parenting
Provided programs to enhance baby safety, early bonding, child development and parenting. Outcomes: 13,028 participants.

Neighborhood Hospital Wellness Centers
Four Wellness Centers provide classes, consults, support and resources reaching 15,248 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: 506 participants.

Support Groups

Provide support to individuals working through the healing process. Twenty-three groups meet regularly for a total of 3,992 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 2,123 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.

520 St. Rose Dominican Rose de Lima		
Complete Summary - Classified (Programs) - Including Non Community Benefit (Medicare)		
For period from 07/01/2024 through 06/30/2025		
	Persons	Net Benefit
Benefits for Poor		
Financial Assistance	1,542	$1,644,823
Medicaid	7,651	$1,827,390
Other Means Tested Programs	4	$5,836
Community Services		
E - Cash and In-Kind Contributions	1	$16,000
Totals for Community Services	1	$16,000
Totals for Benefits for Poor	9,198	$3,494,049
Benefits for Broader Community		
Community Services		
E - Cash and In-Kind Contributions	-	$94,103
Totals for Community Services	0	$94,103
Totals for Broader Community		$94,103
Totals - Community Benefit	9,198	$3,588,152
Medicare	1,417	$1,388,309
Totals Including Medicare	10,615	$4,976,461

Hospital Board and Committee Rosters

Community Board Members
July 1, 2024 – June 30, 2025

Mark Wiley, Board Chair
Mark Wiley Realty Group

Rod Davis, Vice Chair
Retired

Tim Bricker
President, CommonSpirit Health Central Region

Katherine Vergos, RN, MHA, FACHE
Las Vegas Market President and CEO

Maggie Arias-Petrel
CEO, Global Professional Medical Consulting, Inc.

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

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

Brian Glicklich
Crisis and Strategic Advisor, Digital Strategy

Patrick Hays
Retired

Saville Kellner
Founder, Lake Industries

Aldo Madrigrano
Philanthropist

Sean McBurney
Senior Vice President and General Manager
Caesars Entertainment

Shaundell Newsom
Founder, SUMNU Marketing

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

Irena Vitkovitsky, MD
Medical Director, Vituity

Kate Zhong, MD
President and CEO, CNS Innovations

Community Health Work Group (CHWG) Members
July 1, 2024 – June 30, 2025

Coy Raiford, Chairperson
Mission Leader, Nevada Market

Polly Bates, Director of Philanthropy

Luz Castro, RED Rose Program Manager

Tori Diego, MCH Program Manager

Angel Garcia Saavedra, Chronic Disease Program Manager

Wilma Herrera, RD, HIV Manager

Holly Lyman, MPH, Market Director Community Health

Julie Tousa, LSW, MA, Pathways Program Manager

Jennifer Trinkle, Helping Hands Market Manager

Rogena Watkins, WomensCare Program Manager

Shelley Williams, RN, CDE, Lead Diabetes Educator