Dignity Health - St. Rose Dominican Siena

Community Benefit 2022 Report and 2023 Plan

Adopted November 2022

Dignity Health.
St. Rose Dominican
Siena Campus

A message from

Jon Van Boening, Nevada Market Leader and President/CEO of Dignity Health St. Rose Dominican Siena Campus President, 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 2022 Report and 2023 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health hospitals in Arizona and Nevada voluntarily produce these reports and plans, as well. 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 2022 (FY22), Dignity Health – St. Rose Dominican Siena Campus provided $50,849,842 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $14,802,814 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 2022 Report and 2023 Plan at its November 17, 2022 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.

Jon Van Boening
Nevada Market Leader
President/CEO Siena Campus

Mark Wiley
Chairperson, Board of Directors

Table of Contents

At-a-Glance Summary **4**

Our Hospital and the Community Served **5**

About the Hospital 5
Our Mission 7
Financial Assistance for Medically Necessary Care 7
Description of the Community Served 8

Community Assessment and Significant Needs **9**

Community Health Needs Assessment 9
Significant Health Needs 9

2022 Report and 2023 Plan **11**

Creating the Community Benefit Plan 11
Community Health Strategic Objectives 12
Report and Plan by Health Need 12
Community Health Improvement Grants Program 17
Program Highlights 18
Other Programs and Non-Quantifiable Benefits 35

Economic Value of Community Benefit **37**

Hospital Board and Committee Rosters **39**

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 2,326,403.
Economic Value of Community Benefit	$50,849,842 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $14,802,814 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 • Funding
FY22 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, Patient Financial Assistance; Funding Grantees such as Catholic Charities, Lend a Hand of Boulder City, Roseman University Medicare Call Center, CSN Community Health Worker Students • Motor vehicle and pedestrian safety: Zero Fatalities Program Partnership, AARP Drivers Safety, Car Seat Safety Checks • Violence prevention: Human Trafficking Response Program, Mental Health First Aid, SafeTALK Suicide Prevention, Senior Peer Counseling; Grantees such as Rape Crisis Center • Substance use: Mental Health First Aid, Let's Talk Support Groups, AA & NA groups; • Mental health: Senior Peer Counseling, Perinatal Mood and Anxiety Disorders Program, Mental Health First Aid (Adult & Youth), Let's Talk Support Groups;
FY23 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, Parkinson's Program, CDSME, COPD Better Breathers, Breast Cancer, Pathways Community HUB, Mental & Behavioral Health, Chronic Disease Prevention Programs • Transportation: Helping Hands of Henderson, Golden Grocery, Pathways Community Hub, Community Health Improvement Grantees • Funding: Legislative Advocacy, Pathways Community HUB, Grant Writing, Collaborative Partnerships, Community Health Improvement Grantees

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

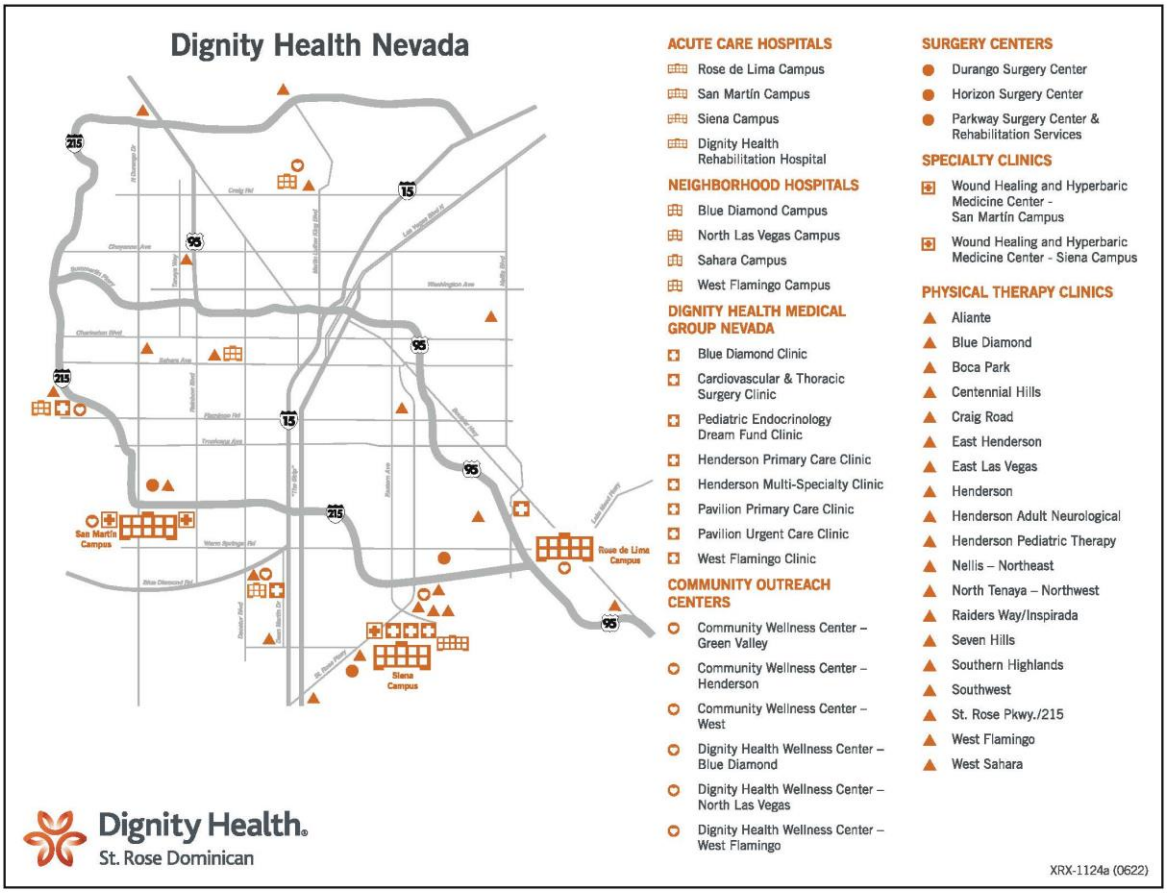
Written comments on this report can be submitted to Dignity Health – St. Rose Dominican Community Health Program at 2651 Paseo Verde Parkway, Suite 180, Henderson, NV 89074 or by e-mail to holly.lyman@dignityhealth.org.

Our Hospital and the Community Served

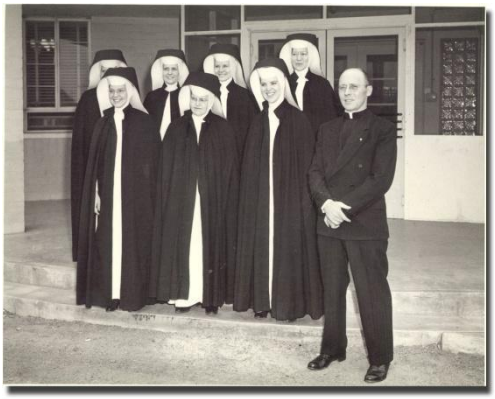
About Dignity Health – St. Rose Dominican

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 2022-2023 High Performing hospital for six different condition categories, more than any other southern Nevada hospital. 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 Martín prides itself as a safe and comfortable place for families to grow and is consistently ranked by the readers of the Las Vegas Review-Journal in the Best Place to Have a Baby category of the Best of Las Vegas Poll. San Martín is one of the only hospitals in southern Nevada with Laborists on duty 24/7, and Birthing Suites where mothers remain in the same room throughout Labor, Delivery, Recovery, and Post-partum.

In 2014, San Martín was the first hospital in southern Nevada to earn the prestigious Baby-Friendly designation, demonstrating adherence to the highest standards of care for breastfeeding mothers and their babies, based on evidence-based practices recommended by the World Health Organization and UNICEF.

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
- Six 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;	●

Significant Health Need	Description	Intend to Address?
	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	Having 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 health care 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.	●
Funding	Having appropriate public health funding will aid in grants that help reduce issues of Southern Nevada and aid in promoting programs and initiatives. 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.	●

2022 Report and 2023 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 FY22 and planned activities for FY23, 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
- GME Program
- Legislative Advocacy Committee & System 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
- 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 Strategic Objectives

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

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

Advance Community Health Alignment and Integration

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

Expand Clinical - Community Partnerships and Linkages

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

Build Capacity for More Equitable Communities

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

Inspire, Innovate and Scale High Impact Initiatives

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

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 FY22	Planned FY23
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 health care system; increased primary care visits among home-bound seniors;

Collaborators: The hospital will partner with Nevada Health Link, Catholic Charities, Lend a Hand of Boulder City, 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 FY22	Planned FY23
Diabetes	• National Diabetes Prevention Program (Available in Spanish) • ADCES Program • Diabetes Self-Management Program (Available in Spanish) • Diabetes Conversation Map • Medication Therapy Management • Nevada Quality Technical and Assistance Center	☒	☒
HIV	• Positive Self-Management for HIV • Medical Nutrition Therapy • Medication Therapy Management • Medical Case Management • Food Bank • Psychosocial Support Group	☒	☒
Innovative Heart Health	• Self-Measured Blood Pressure Program • Healthy Hearts Club • 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 • Rural Medical Nutrition Therapy	☒	☒
Cognitive Stimulation Therapy	Group intervention for individuals with mild to moderate dementia. Evidence-based program reduces the progression of dementia.	☒	☒
Prevention of Chronic Disease	• Enhance Fitness – 21 sessions per week • Stepping On Fall Prevention • Nutrition Education & Consultation • Freedom from Smoking • Meditation • Other Fitness: Tai Chi, Bingocize, Yoga (Chair, Gentle, TRY, Yin, Mixed-Level, Vinyasa Flow), Walking Club, High Fitness, UpBeat Barre, Surge Strength, Zumba	☒	☒
Parkinson's Disease	Tai Ji Quan Movement for Better Balance	☒	☒
CDSME	• Chronic Disease Self-Management Program • Cancer Thriving & Surviving • Chronic Pain Self-Management	☒	☒
COPD	Better Breathers	☒	☒
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 • PMAD	☒	☒

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, College of Southern Nevada, Roseman School of Pharmacy, University of Nevada Las Vegas, Remnant Ministries, Nevada Diabetes Association, Dignity Health Heart & Vascular, 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, OLLIE, 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 Heath Foundation, Southern Nevada Health District, Aid for AIDS of Nevada, The Center-LGBTQ, Huntridge Family Clinic, 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 FY22	Planned FY23
Helping Hands of Henderson	Provide 500 clients with over 9000 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	Deliver food to homebound seniors	☒	☒
Pathways	A sustainable evidence-based model that leverages community	☒	☒

Community Hub	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, Wells Fargo, Lend a Hand of Boulder City, Helping Hands of Vegas Valley, City of Henderson, HopeLink Family Resource Center.

Health Need: Funding

Strategy or Program	Summary Description	Active FY22	Planned FY23
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 FY22, the hospital awarded the grants below totaling $331,026. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Amount
Catholic Charities of Southern Nevada	Health, Hope, and Housing	$50,000
College of Southern Nevada	Community Health Worker Students Helping Vulnerable Elders	$96,311
Lend a Hand of Boulder City	Senior Transportation and Respite Care	$20,000
Signs of Hope/The Rape Crisis Center	Child Abuse Prevention and Services	$69,250
Roseman University of Health Sciences	Medicare Call Center	$22,000
Shade Tree	Emergency Shelter for Women	$73,465

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 twelve 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 30 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 2022 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 • 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 all 6 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 • Provide over 9,000 Medicare Assistance Program counseling sessions
Performance / Impact	NHL • Enrolled 1,133 Individuals • 920 Qualified Health Plan (NHL) & 213 Medicaid • Attended 270 Events • 12 Certified EEFs on staff MAP • 14,901 Medicare Beneficiary Contacts • 5,255 Counseling Sessions • Attended 165 Events • Recruited 35 Volunteers • Promoted NHL and MAP in the REACH Magazine and e-Newsletters
Hospital's Contribution / Program Expense	Total expense $1,038,749 less grant funding (MAP+NHL) of $672,976. 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 $22,000
FY 2023 Plan	
Program Goal / Anticipated Impact	NHL • Achieve NHL grant outcomes to secure ongoing funding • Enroll 1000 clients in a Qualified Health Plan (QHP) and 225 in Medicaid • Attend 300 community events MAP • Provide 15,000 Medicare beneficiary contacts and 5700 counseling sessions • Attend 180 community events • Staff & Volunteer Diversity 50% • SMP Message to 75% of Beneficiary Contacts
Planned Activities	• Train staff, maintain licenses and certification for 12 EEFs and 35 MAP Benefits Counselors • Identify and reach underserved populations who need healthcare and low-income assistance programs • Marketing in Class Catalog, 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 6 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 2022 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 7 ADA-adapted vans, plus 2 back-up vehicles • Hired and trained 2 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 • Provide emergency food deliveries within 24 hours of referral
Performance / Impact	• Enrolled/Reassessed 374 unduplicated transportation clients • Provided 6,257 round-trip rides • Recruited 5 new volunteers for a total of 33 volunteers • Provided 6,819 community referrals and 239 reassurance calls or well checks • Enrolled/Reassessed 177 unduplicated Golden Grocery Pantry clients • Provided 1,464 Golden Grocery and/or COVID Emergency Food Deliveries
Hospital's Contribution / Program Expense	Total expense $920,951 less grant funding of $522,925. Hospital provided required match for grant funding, overhead, leadership and some fringe benefits.
Program Goal / Anticipated Impact	• Reduce waiting list to 75 • Enroll/Reassess 410 unduplicated clients in Transportation • Enroll/Reassess 150 unduplicated clients in Golden Grocery Food Pantry • Provide 7,500 round trip rides • Provide 1,500 Golden Grocery deliveries • 6,000 Referrals • Recruit and maintain an active volunteer base of 50 • 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 • Purchase new vans • 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 (SNTC and JFSA) 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 2022 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 Program Manager and Community Health Worker • Developed a Breast Cancer Risk Screening tool to assess people's risk factors for Breast Cancer • Outreach efforts in the community through health fairs, events, and presentations
Performance / Impact	• Breast Cancer Risk Screening 311 • Eligibility Screenings: 209 • Clinical Breast Exams: 171 • Diagnostic Mammograms: 189 Screening Mammograms: 15 • Ultrasounds: 196 Biopsies: 24 Surgical Consultations: 23 • Cancer Diagnosis: 12 and Surgical Treatment: 14 • Temporary Financial Assistance: 22 Clients $73,691.73 TOTAL; Rent $40,640.00; Electricity $3,050.33; Gas $1,936.40; Water $985.10; Groceries $16,550.00; Transportation $10,250.00 • The RED Rose program continues to see 96% Spanish-speaking clients, and 100% of clients are uninsured • Attended 40 Community Events reaching 1102 people

Hospital's Contribution / Program Expense	The hospital contribution to this program totaled $667,944 less grant funding of $400,458. St. Rose provided space, staff, fringe, clinical services, IT, overhead and leadership.
FY 2023 Plan	
Program Goal / Anticipated Impact	• 300 Diagnostic mammograms • 300 Ultrasound • 3000 encounters at 100 Community events and presentations • 800 Breast Cancer Risk screenings • 12 monthly Breast Cancer Support Group • 4 Breast Cancer Survivor luncheons • 4500 call inquires • Provide 30 women financial assistance totaling $100,000
Planned Activities	• Engage the Hispanic community by collaborating with the Mexican and El Salvador Consulates • Increase social media outreach and presence • Continue working with EAC Public Relations firm for radio and television media features • 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	Expand access to evidence-based programs for people with diabetes and at risk for diabetes, including the use of distance learning modalities for remote access. Increase access to minority groups.
FY 2022 Report	
Activities Summary	• Continue to offer DPP to the Spanish-speaking community. • Target minority groups in underserved areas to promote access to diabetes education. • Provide support to an African American church in implementing DPP. • Continue to promote services to providers.
Performance / Impact	Due to COVID-19 restrictions to protect the most vulnerable and the community at large, program outcomes for FY22 have been impacted.

	Diabetes Prevention/National Diabetes Prevention Program (NDPP): • 2 lifestyle coach trainings conducted for 14 new facilitators • 1 DPP cohort planned focusing on the African American community • 2 Spanish DPP cohorts with 25 participants enrolled • 24 people attended Prediabetes classes in person and virtually • 496 participants completed Pre-diabetes risk test in the Spanish community • 83 participants completed Pre-diabetes risk test in the African American community • 21 people attended the virtual Diabetes Alert Day event • 16 participants completed the Diabetes Challenge to attend 5 classes promoting healthy lifestyle for Diabetes Month Association of Diabetes Care & Education Specialists (ADCES) Program: • 11 attendees for the Diabetes Conversation Maps offered for participants with financial limitations • 153 encounters for monthly diabetes support group held in-person a 42% increase from FY21 • 193 individuals received formal diabetes education in person and virtually • 254 encounters for formal diabetes education sessions offered in person and virtually • 24 individuals participated in advanced meal planning sessions for hands-on training/cooking demonstrations • 85% of formal diabetes program completers met their behavior change goal; average A1c dropped from 8.9% to 7.1% • 217 encounters for community nutrition classes held in-person and virtually Diabetes Self-Management Program (DSMP): • $220,215 received in state funding for continued work with QTAC on Diabetes education and prevention • 2 leader trainings in English with 15 completers • 1 Spanish DSMP workshop with 6 completers
Hospital's Contribution / Program Expense	Hospital expense $338,523 less $219,976 in grant funding includes overhead, space, and staff.
FY 2023 Plan	
Program Goal / Anticipated Impact	Diabetes Prevention: Host two NDPP Leader Trainings. Initiate 2 NDPP cohorts in community settings ADCES Program: Provide formal diabetes education/training to 200 individuals. Stanford DSMP: Expand the Diabetes Self- Management Program by delivering two 2-day leader trainings. Collaborate with organizations to host DSMP to underserved communities.
Planned Activities	Target minority groups in underserved areas to promote access to diabetes education. Provide support to lifestyle coaches providing DPP. Continue to promote services to providers.

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 2022 Report	
Activities Summary	CDSME: Continue working with community partners to host CDSME workshops, secure additional grant funding, and support partners in expanding and developing an infrastructure to offer CDSME programs statewide Innovative Heart Health: Continue implementation of MNT protocol and nutrition education services to patients with hypertension and/or high cholesterol and track evaluation indicators. Increase the implementation of MTM into the Dignity Health Medical Groups and community partners. Work with local clinics and community coalitions to develop workflow to receive referrals for the patients with hypertension and/or high cholesterol. Caregivers: Recruit potential PTC leaders for the training. Secure additional funding to expand program to other underserved areas Better Breathers: Returned in person to monthly meetings
Performance / Impact	CDSME • Total Participants: 119 (89 in English, 30 in Spanish) • Total Classes: 13 Workshops (10 in English, 3 in Spanish) • Total Chronic Pain Leaders: 15 Leaders (12 in English, 3 in Spanish) • Chronic Pain Leader Training: 1 Leader training and certified 8 new Chronic Pain Leaders • Delivered PSMP-HIV to 104 Ryan white Part A clients Innovative Heart Health • Enrolled 41 patients in the Community CHF Program. • Enrolled 27 patients in the Self-Measured Blood Pressure Program • Delivered the Healthy Heart Program to 113 participants • Enrolled 98 people into the Fruit and Vegetable Prescription Program • Delivered Heart Healthy kits to 124 participants • Delivered 9 Healthy Heart Programs in Spanish with 22 enrolled • Delivered 2 Healthy Heart Programs in the African American communities with 33 participants enrolled Caregivers • Total Participants: 124 enrolled and 73 Program Completers (68 in English, 5 in Spanish) • Total Classes: 12 Workshops (11 in English, 1 in Spanish)

	• Total Powerful Tools for Caregivers leaders: 50 in total (39 in English, 11 in Spanish) • Powerful Tools for Caregivers Leader Training: 4 Leader trainings and certified 26 new Leaders
Hospital's Contribution / Program Expense	Total hospital expense $468,659 less grant funding of $314,211. Hospital provided staff, classroom and consult space, overhead and fringe, IT, marketing and promotion.
FY 2023 Plan	
Program Goal / Anticipated Impact	CDSME: • Continue working with Community partners to host CPSMP workshops. Secure additional grant funding and support partners in expanding and developing an infrastructure to offer CPSMP programs statewide • Reach 113 program completers in CPSMP • Deliver 2 CDSMP/Tomando and 2 CPSMP Leader Trainings • Deliver 15 workshops; 13 in English and 2 in Spanish Innovative Heart Health: • Continue to deliver the Healthy Heart Program to patients with hypertension and/or high cholesterol and track evaluation indicators. Work with local clinics and community-based organizations to receive referrals for the Spanish and African American Healthy Heart Program. • Enroll 25 participants in the Community CHF Program • Enroll 50 participants in the Healthy Heart Program • Enroll 50 participants in the Fruit and Vegetable Prescription program • Deliver 2 Healthy Heart Programs in Spanish with 15 participants enrolled. • Deliver 2 Healthy Heart Programs in the African American communities with 15 participants enrolled • Provide 125 Heart Health Kits Caregivers: • Collaborate with new and existing partners to recruit leaders for the PTC leader training in Southern, Northern, and Rural Nevada. Secure additional funding to expand program to other underserved areas • Deliver 18 workshops (13 in English) (5 in Spanish) • Enroll 126 people in Powerful tools for Caregivers and have 90 completers • Conduct 2 leader trainings - certifying 16 new leaders • Provide 3 month support groups to 20 participants
Planned Activities	CDSME: Recruit CDSMP and CPSMP leaders for four trainings. Work with community partners to host CDSMP and CPSMP Workshops. Support Partners in expanding and developing infrastructure to offer CDSMP and CPSMP programs to prison populations, tribal organizations and throughout the state Innovative Heart Health: Continue to implement the Healthy Heart Program to patients with hypertension and/or high cholesterol and track evaluation indicators. Work with Spanish local clinics and community based organizations to receive referrals for the Spanish Healthy Heart Program Caregivers: Collaborate with new and existing partners to recruit leaders for the PTC leader training in Southern, Northern, and Rural Nevada. Secure additional funding to expand program to other underserved areas

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 five Stepping On Classes and two Tai Ji Quan classes. Train 15 leaders in Stepping On and Tai Ji Quan statewide Fitness: Provide Enhance Fitness and other fitness classes at all 6 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 4700 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 2022 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 two Stepping On classes with 27 registered participants and 19 completers (participants completing five of the seven sessions). Fitness Provided over 2600 fitness classes at six centers generating 27,139 fitness encounters Fruit and Vegetable Prescription Program Delivered fresh fruit and vegetable boxes to 200 participants WIC Provided 4783 clients with EBT cards, nutrition education and breastfeeding support Golden Grocery Deliveries 1464 MNT: 41 clients received Medical Nutrition Therapy Consults with an RD Nutrition Lectures & Cooking Demos: Hosted 16 community nutrition classes and cooking demos reaching 217 participants. Topics included: Hosting Vegans for the Holidays, Eating for a Healthy Holiday, Mastering the Art of Smoothie Making, Add Some Spice to your Life, Ancient Grains, All About Snacks

Hospital's Contribution / Program Expense	Total hospital expense $2,404,764 less grant funding of $1,394,722. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2023 Plan	
Program Goal / Anticipated Impact	Fall Prevention • Secure grant funding. Expand the Nevada Goes Falls Free Coalition, increase fall risk screenings • Enroll 72 people aged 60 and older into 6 Stepping On Workshops with 42 completers • 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 program to community partners. • Provide 2800 classes generating 30,000 fitness encounters Fruit and Vegetable Prescription Program Deliver fresh fruits and vegetables to 200 participants WIC: Reach 4800 clients Golden Groceries: 1500 deliveries MNT: Provide 45 consults Nutrition Lectures & Cooking Demos: Provide a new topic each quarter at all 6 Centers
Planned Activities	Fall Prevention: Secure grant funding. Expand the Nevada Goes Falls Free Coalition, increase fall risk screenings Fitness: Host an instructor training, and expand program to community partners. 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 to the program.

Pathways	
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 are: Adult Education, Developmental Referral, Employment, Family Planning, 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 2022 Report	
Activities Summary	• Recruit/train CHW's in Pathways Community HUB • Recruit at risk participants through Dignity Health Community Outreach programs • CHW's provide care coordination to Pathways participants
Performance / Impact	49 Total Participants 181 Total Visits by CHW to address risk and coordinate care 550 Total Pathways opened 228 Total Pathways successfully closed 17 CHWs/Staff trained in Pathways
Hospital's Contribution / Program Expense	Total hospital expense $8,662. Hospital provided Program Manager, staff, space, overhead and fringe, IT, marketing and promotion.
FY 2023 Plan	
Program Goal / Anticipated Impact	100 Total Participants 300 Total Visits by CHW to address risk and coordinate care 700 Total Pathways opened 400 Total Pathways successfully closed
Planned Activities	• Recruit/train CHW's in Pathways Community HUB • Recruit at risk participants through Dignity Health Community Outreach programs • CHW's provide care coordination to Pathways participants

Ryan White 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, nutrition counseling, and medication therapy management. Provides supplemental groceries and supplements to low-income/homebound clients, home delivered prepared meals, HIV management education, and peer support.

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 enrich their lives, and manage their health.
FY 2022 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 PSMP 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
Performance / Impact	Health Education Risk Reduction (HERR) • Delivered PSMP to 104 clients living with HIV • Total PSMP classes: 46; Total PSMP Leaders: 6 • Delivered SCRIPT Medication adherence program to 42 RWPA clients living with HIV • Delivered Health Benefits Take Charge classes and individual coaching to 42 RWPA clients living with HIV Medical Nutrition Therapy (MNT) • 200 referrals received from 10 partner agencies • Serviced 308 unduplicated clients living with HIV • 560 Nutrition Consultations completed • 232 Fruit and Vegetable bags delivered • 1,744 prepared meals delivered • 781 cases of Nutrition Supplements delivered
Hospital's Contribution / Program Expense	Total hospital expense $384,827 less grant funding of $274,333. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2023 Plan	
Program Goal / Anticipated Impact	Medical Nutrition Therapy (MNT): 200 unduplicated clients Medical Case Management (MCM): 60 unduplicated clients Food Bank/Home Delivered Meals: 90 unduplicated clients Health Education/Risk Reduction: 120 unduplicated clients Psychosocial Support Services: 80 unduplicated clients
Planned Activities	Medical Nutrition Therapy (MNT): • Continue collaboration with Case Managers at HIV clinics and RWPA agencies Medical Case Management (MCM): • Continue collaboration 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 Huntridge Family Clinic Rapid Start Team to engage newly diagnosed clients • Advocate for HIV testing in Dignity Health Neighborhood Hospitals, and set up referral system

	• Collaborate with Dignity Health Medical Group and set up referral system • Continue Partnership with Community Pharmacist Kaylynn Bowman PharmD. Food Bank/Home Delivered Meals: • Continue collaboration with vendors: Cluck it Farms and Diced Kitchen • 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

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 2022 Report	
Activities Summary	• Train CST Facilitators • Recruit CST participants to participate in 14 CST sessions • Perform pre and post assessments to measure improvement • Offer CST classes and Maintenance groups quarterly
Performance / Impact	14 Total Participants 58% Total Improvement in Mental Status with 77% of individual scores improving 100% Total Decrease in depression with 75% of individual scores improving 40% Total Improvement in Quality of Life
Hospital's Contribution / Program Expense	Total hospital expense $34,573 less grant funding of $18,429. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.

FY 2023 Plan	
Program Goal / Anticipated Impact	30 Total Participants 50% Total Improvement in Mental Status with 70% of individual scores improving 70% Total Decrease in depression with 70% of individuals scores improving 40% Total Improvement in Quality of Life
Planned Activities	• Train CST Facilitators • Recruit CST participants to participate in 14 CST sessions • Perform pre and post assessments to measure improvement • Offer CST classes and Maintenance groups quarterly

Senior Peer Counseling

Significant Health Needs Addressed	• Chronic Disease
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 2022 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	58 Total Clients 809 Total Counseling Sessions 81 Total Intakes 23 Active Counselors 44 Total Referrals to other programs or services 17 Total Clients who have completed counseling
Hospital's Contribution / Program Expense	Total hospital expense $230,638 less grant funding of $22,522. 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 2023 Plan	
Program Goal / Anticipated Impact	60 Total Clients 830 Total Counseling Sessions 80 Total Intakes 25 Active Counselors 50 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 and website. • Match clients with an appropriate counselor and monitor counseling through supervision. Expand counselors out to other Centers

Perinatal Mood & Anxiety Disorder

Significant Health Needs Addressed	• Chronic Disease
Program Description	The PMAD (Perinatal Mood and Anxiety 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 PMADs and available community resources for their clients/patients, and continue to provide support and care coordination to moms and families experiencing PMADs.
FY 2022 Report	
Activities Summary	Provided PMAD trainings to community and health professionals, support groups, mommy mixers and support with funding therapy. PMAD facilitators have trained over 600 community and health professionals and currently offer **6** support groups – 4 Mommy Care Clubs 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 173 community and health professionals on PMADs • Hosted 133 support group sessions (Mommy Care Club & Mommy Mixer) • Completed 155 health navigation • Completed 155 client intakes • Provided 84 counseling sessions • Distributed 884 New Mama Care Kits to moms in Southern NV • Hosted Virtual Fall Symposium with 60 attendees • Attended 43 Community meetings, educated and promoted PMAD program resources to 2078 community members

Hospital's Contribution / Program Expense	Total program expense $191,821 less grant funding of $126,260. Program includes personnel, therapy services, support groups, supplies and continuing education. Hospital provided classroom and office space, IT, marketing and promotion.
FY 2023 Plan	
Program Goal / Anticipated Impact	• Educate and train 100 community and health professionals on PMADs. • Reach 100 moms who attend 2 support groups across the valley (Mommy Mixer) • Provide health navigation for 150 clients • Provide counseling services for 150 clients • Reach 240 new followers for MCH social media pages • Attend 60 Community meetings to educate and promote PMAD program resources
Planned Activities	We will continue to offer PMAD training to community and health professionals, provide support groups and Mommy Mixers and fund therapy.

Mental Health First Aid (MHFA) & SafeTALK Suicide Prevention

Significant Health Needs Addressed	• Chronic Disease
Program Description	SafeTALK teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide. Mental Health First Aid gives participants the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand and respond to signs of mental illness.
Population Served	Community
Program Goal / Anticipated Impact	Provide training on Mental Health First Aid and suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
FY 2022 Report	
Activities Summary	<u>Safe Talk</u> • Train 4 staff as safeTALK instructors to provide program • Host safeTALK at all six centers across the valley • Reach 50 participants per year • Train all Community Health Staff and offer training to hospital staff <u>MHFA</u> • Advertise program in REACH magazine • Offer training to staff and volunteers of Dignity Health – St. Rose Dominican • Attend Nevada Coalition for Suicide Prevention meetings, PACT Coalition meetings, and NAMI meetings • Promote program at special events, health fairs, on social media, and in the community.

	• Partner with key groups to cross-promote program
Performance / Impact	Safe Talk 28 SafeTALK classes conducted with 495 participants MHFA 22 Adult MHFA Classes conducted with 316 participants 10 Youth MHFA Classes conducted with 115 participants
Hospital's Contribution / Program Expense	Total hospital expense $26,807 less funding of $10,043. Hospital provided staff, classroom and consult space at 6 wellness centers, overhead and fringe, IT, marketing and promotion.
FY 2023 Plan	
Program Goal / Anticipated Impact	Provide training on Mental Health First Aid and suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
Planned Activities	Safe Talk Teach 5 SafeTALK/Gatekeeper trainings reaching 60 participants per year MHFA Teach 20 MHFA classes per year reaching 200 participants per year

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.

OTHER PROGRAMS

Breastfeeding
St. Rose Dominican is committed to protecting new mothers milk supply and the nutrition of the baby. Outcomes: Maintained Baby-Friendly designations for both San Martin and Siena. Served 767 moms in outpatient program.

Community Coalitions
The Nevada Statewide Maternal and Child Health Coalition (NVMCH) provide leadership to improve the physical and mental health, safety and well-being of the maternal and child population across Nevada. Outcomes: 663 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 921 participants.

Infants, Children & Parenting
Provided programs to enhance baby safety, early bonding, baby development and parenting. Outcomes: 3,215 participants.

Neighborhood Hospital Wellness Centers
Three Wellness Centers provide classes, consults, support and resources.

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: 394 participants.

Support Groups
Provide support to individuals working through the healing process. Twenty-one groups started returning in person in April 2021 for a total of 2813 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 1,311 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 Susan G. Komen Race for the Cure and the American Lung Association Scale the Strat climb.
- Employees participated in the Rebuilding Together program in April 2022
- 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 family 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 and other means-tested programs 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.

521 St. Rose Dominican - Siena					
Complete Summary - Classified Including Non Community Benefit (Medicare)					
For period from 7/1/2021 through 6/30/2022					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits For Poor					
Financial Assistance	**3,800**	**9,723,383**	**0**	**9,723,383**	**2.0%**
Medicaid	**20,091**	**63,111,649**	**27,815,122**	**35,296,527**	**7.1%**
Means-Tested Programs	**28**	**31,631**	**24,165**	**7,466**	**0.0%**
Community Services					
A - Community Health Improvement Services	82,143	3,352,241	1,979,216	1,373,025	0.3%
E - Cash and In-Kind Contributions	4	225,118	0	225,118	0.0%
G - Community Benefit Operations	0	10,000	0	10,000	0.0%
Totals for Community Services	**82,147**	**3,587,359**	**1,979,216**	**1,608,143**	**0.3%**
Totals for Poor	**106,066**	**76,454,022**	**29,818,503**	**46,635,519**	**9.4%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	56,519	3,907,061	2,032,020	1,875,041	0.4%
B - Health Professions Education	27	3,784,958	1,903,906	1,881,052	0.4%
F - Community Building Activities	2,049	191,821	126,260	65,561	0.0%
G - Community Benefit Operations	0	392,669	0	392,669	0.1%
Totals for Community Services	**58,595**	**8,276,509**	**4,062,186**	**4,214,323**	**0.8%**
Totals for Broader Community	**58,595**	**8,276,509**	**4,062,186**	**4,214,323**	**0.8%**
Totals - Community Benefit	**164,661**	**84,730,531**	**33,880,689**	**50,849,842**	**10.2%**
Medicare	**15,318**	**114,978,861**	**100,176,047**	**14,802,814**	**3.0%**
Totals with Medicare	**179,979**	**199,709,392**	**134,056,736**	**65,652,656**	**13.2%**

Hospital Board and Committee Rosters

Community Board Members
July 1, 2022 – June 30, 2023

Mark Wiley, Board Chair
Mark Wiley Realty

Maggie Arias-Petrel
CEO, Cano Health

Jon Van Boening
Nevada Market Leader and President/CEO
Dignity Health –St. Rose Dominican Siena

Timothy Bricker
Interim 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

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
Chief of Staff, San Martin Campus

Kate Zhong
Physician/CEO, CNS Innovations

Community Health Advisory Committee (CHAC) Members
July 1, 2022 – June 30, 2023

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

Polly Bates
Grant Manager, Foundation

Nicole Bungum, MS, CHES
Supervisor, Office of Chronic Disease Prevention & Health Promotion, SNHD

Sr. Patricia Dulka
Holy Rosary Chapter Prioress, Adrian Dominican Sisters

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