Dignity Health™
St. Rose Dominican
San Martín Campus

St. Rose Dominican San Martín Campus

Community Benefit Report 2013
Community Benefit Plan 2014

Dignity Health
St. Rose Dominican
San Martín Campus

A Message from the Chief Executive Officer and Board Chair

When we talk about health care today, the words *budget, cut*, and *restraint* get used a lot. It is impersonal and it is a way to look at health care by the numbers rather than by the patient. One word that has somehow lost its meaning is also the word we believe in most of all – the word *care.* At St. Rose Dominican hospitals we strive to reintroduce humankindness to an industry focused on finance.

The Affordable Care Act created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention for the health of all Americans. The overarching goals of the plan are to empower people, ensure healthy and safe community environments, promote clinical and community preventive services, and eliminate health disparities.

The Dignity Health system goals reflect those of health reform, namely expanding access, redesigning the delivery system, and utilizing limited resources in better, more coordinated ways so that quality can be continuously improved and patients and communities are healthier. These goals will be achieved through thoughtful *care*, whether it is demonstrated in the hospital or through the programs and services we offer in the community.

At St. Rose Dominican hospitals we share a commitment to optimize the health of our community. In fiscal year 2013, the San Martín Campus provided **$25,845,222** in financial assistance, community benefit and unreimbursed patient care. Because we care, how we contribute to the quality of life and the environment in our communities has always been and will continue to be a key measure of our success.

In accordance with policy, the St. Rose Dominican hospitals Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their September meeting.

Sincerely,

Vicky VanMeetren
President/CEO
San Martín Campus

James Barrett, Jr.
Board Chair

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Executive Summary

As the community's only not-for-profit, religiously sponsored hospital system, the 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 the summer of 1947 to run what was then a small community hospital. St. Rose Dominican now has three hospital campuses in the southern part of the Las Vegas valley, with a total of 496 beds, more than 1,300 physicians, 540 volunteers and more than 3,500 employees. St. Rose is part of Dignity Health, a network of more than 300 care centers, including hospitals, urgent and occupational care, imaging centers, home health and primary care clinics. As the community grows, the three St. Rose hospitals continue the Sisters' mission of serving people in need.

The Rose de Lima campus was founded in 1947, currently has 119 beds and was the only hospital in southern Nevada to receive an "A" in hospital safety scores from the Leapfrog Group in both 2012 and 2013. It also earned the 2013 Bariatric Surgery Excellence Award™ from Healthgrades, the leading online resource that helps consumers search, compare and connect with physicians and hospitals.

The Siena Campus, founded in 2000, has 230 beds and recently received the Gold Seal of Approval™ from the Joint Commission for its Joint Replacement Unit as well as the American Heart Association/ American Stroke Association's "Get with the Guidelines® - Stroke" Bronze Quality Achievement Award. Siena's Level III Trauma Center was also recently re-verified by the Committee on Trauma (COT) of the American College of Surgeons.

The San Martín Campus opened in 2006 and houses 147 beds. The hospital was awarded the American Heart Association/American Stroke Association's "Get with the Guidelines®–Stroke" Bronze Quality Achievement Award and received five stars from Healthgrades for the quality of its heart failure care. The San Martín Campus also earned the Gold Seal of Approval™ from The Joint Commission for Primary Stroke Centers.

The St. Rose Dominican hospitals system has a variety of community benefit programs designed to meet the health care needs of the residents of southern Nevada. Key programs this fiscal year include:

Disease Management – Stanford Chronic Disease Self Management Program (CDSMP) in English & Spanish, Stanford Diabetes Self Management Program (DSMP) in English & Spanish American Diabetes Association Certified Diabetes Management Program, Congestive Heart Active Management Program (CHAMP®), Stroke Sharegivers and the Asthma Kids Club.

Diabetes – Certified Diabetes Educators provide evidenced-based education, consultations, support, screening, and prevention programs for children and adults with diabetes. These programs include the ADA Approved Adult Outpatient Education Clinic and the Stanford DSMP Program.

Heart Disease & Stroke – Provide a core group of evidenced-based heart and stroke prevention, education, screening, support and disease management programs. These programs include CHAMP (Congestive Heart Active Management Program), Stroke Sharegivers, Cardiac Nutrition including DASH, Smoking Cessation, Screenings (Lipid Panel, Blood Pressure, PVD), Fitness, Meditation/Relaxation and Heartsaver CPR.

RED Rose – A bilingual Breast Health Navigator facilitates clinical breast exams, mammograms, ultrasounds, surgical consultations, biopsies and financial and emotional support services for women who lack adequate health care coverage or the financial means to obtain these services.

Childhood Asthma – In an effort to address the prevalence of asthma and reduce subsequent ER visits, the Asthma Kids Club was designed to help families effectively manage childhood asthma. This program offers an opportunity to partner with asthma and allergy-focused organizations to conveniently bring targeted resources and education together for quarterly interventions which include pulmonary function screening, no cost immunizations, medication screening by a pharmacist, asthma equipment testing and education activities with a pediatric allergist and pulmonologist.

Helping Hands – Transportation services are provided to those 60 and older for medical appointments and grocery shopping to help them maintain their independence and live in their homes unassisted.

The St. Rose Dominican hospitals continues to meet the community's health needs in a variety of ways based on a commitment to promote wholeness of body, mind and spirit in an atmosphere of collaboration. This past fiscal year, that mission has been prominent as St. Rose Dominican hospitals (all 3 campuses) provided over $51,901,776 in community benefits (not including the unpaid cost of Medicare). Including the unpaid cost of Medicare, the net community benefit was $95,463,498.

The San Martín Campus provided over $12,109,004 in community benefits (not including the unpaid cost of Medicare). Including the unpaid cost of Medicare, the net community benefit was $25,845,222.

Mission Statement

St. Rose Dominican hospitals is part of Dignity Health, a network of more than 300 care centers including hospitals, urgent and occupational care, imaging centers, home health and primary care clinics.

Dignity Health Mission Statement

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Organizational Commitment

Community Commitment

The 66 year journey of St. Rose Dominican hospitals – from its inception in 1947 to its remarkable growth in the new millennium – is inspired by timeless values. These values are firmly rooted in the hospital's sponsors, the Dominican Sisters of Adrian, whose even more remarkable legacy of service to the poor, sick and oppressed is a tradition dating back to 12th century France. Today, St. Rose Dominican is the only not-for-profit, religiously sponsored hospital system in southern Nevada.

As St. Rose Dominican has grown as an organization so has its commitment to the communities it serves. St. Rose has remained dedicated to establishing long-term relationships with community organizations that provide frontline services to the area's under-served and vulnerable populations. The various departments that administer the community benefit programs have sought to enhance organizational value, acknowledge and respect the contributions of the various programs and staff and create a strong foundation and support system to fulfill not only the current needs of the community but also prepare for the future.

Community Board

St. Rose Dominican is governed by a Hospital Advisory Board, which is comprised of prominent citizens, physicians, religious sponsors and administrative staff. The Hospital Advisory Board reviews and approves the overall focus of community benefit programs and content as presented by the employees and managers directly involved with the programs. In addition, the annual Community Benefit Report and Plan and the triennial Community Health Needs Assessment is reviewed and approved by the Board. A roster of the Hospital Advisory Board members is included in Appendix B.

Community Health Advisory Committee

The St. Rose Dominican Community Health Advisory Committee launched in December 2009, and includes all three Mission Vice Presidents, the Chief Strategy Officer, board member representation, community stakeholders and key staff from the community outreach programs. This committee focuses on how St. Rose can best minister to the health needs of our community through the integration of existing programs, creation of new programs throughout our communities and greater collaboration with others. These stakeholders help review the community's needs, establish priorities and develop goals in line with our strategic plan.

Dignity Health Community Grants

The Dignity Health Community Grants program is funded by contributions from its member hospitals. This program is one way in which Dignity Health realizes its mission and enhances the advocacy, social

justice and healthier community efforts of its hospitals and religious and community sponsors. Each year we seek to partner with other nonprofit organizations who are working to improve the health status and quality of life of the communities we serve and whose efforts embody our core values and key areas identified in our Community Health Needs Assessment. In 2012, the St. Rose Dominican hospitals Dignity Health Community Grants Committee awarded $316,843 in grants to the following community partners:

- Lend a Hand of Boulder City
- Bower School-Based Health Center
- Boys & Girls Club of Southern NV
- Easter Seals
- Helping Kids Clinic
- Nevada Diabetes Association
- Poverello House
- Saint Therese Center
- The Shade Tree
- Volunteers in Medicine of SNV

Ecology Initiatives

All three St. Rose campuses received the Practice Green Health Award, which recognizes facilities that have virtually eliminated mercury from their facilities and have made a commitment to continue to be "mercury free." In addition, St. Rose has a market-wide Go Green committee to share best practices between the three campuses.

The hospitals have also joined with Dignity Health in supporting the Healthier Hospitals Initiative (HHI)—an organization created by Dignity Health and five other health care systems with the goal of speeding the health care sector toward environmental sustainability. Specifically, HHI has goals to provide health benefits for patients, staff and the community by reducing emissions and pollutants that are increasingly linked to chronic disease by:

- Engaging in environmentally preferred purchasing and building practices;
- reducing health care's use of natural resources and generation of waste; and
- encouraging/incorporating sustainability and safety as essential elements in the organization's culture

The hospitals, with the support of Dignity Health, have advocated for reform of the Toxic Substances Control Act of 1976. The updated legislation would take immediate action on the most dangerous chemicals, hold industry responsible for the safety of their chemicals and products and use the best science to protect all people - especially vulnerable groups.

Additionally, the hospitals collaborate with the Nevada Healthy Homes Partnership through the Asthma Kids Club program. Participants can schedule a healthy home check-up to reduce asthma triggers, prevent unintentional injuries, eliminate poisoning hazards, and leverage resources to fix problems in the home environment and improve quality of life and overall health.

Non-Quantifiable Benefit

St. Rose Dominican provides many types of assistance to our community that, while difficult or impossible to measure, are important contributions to the community, including:

- **Rebuilding Together Project.** St. Rose employees partnered with Rebuilding Together to make critical repairs to two homes in the Las Vegas Valley for low-income, disabled and/or aging residents. This project strives to preserve affordable home ownership and revitalize communities.
- **Smoke-Free Campus Initiative.** All three St. Rose campuses are smoke free and have been recognized by the American Lung Association and the Nevada Cancer Coalition for these efforts.
- **Healthy Rose Employee Wellness Program.** St. Rose was recognized as a 2013 Gold 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.
- **80 Back-to-School Backpacks & 80 Angel Tree Gifts** were donated by employees for low-income children.
- **Summer Bottled Water Collection for the Homeless** with Broken Chains Ministry and Catholic Charities. Employee donations of 350 cases of water or 8,400 bottles provided enough water for Pastor Huff to hand out to each homeless person for the whole summer.
- **Prayer Shawls** were distributed to over 700 patients at all three campuses. These shawls are knitted with love and prayers to help our patients heal.
- **Employee Canned Food Drive for Giving Life Ministries** in November and December.
- **100 pairs of Socks and 15 boxes of Toiletries** were collected last year for the homeless and the local S.A.F.E. House women's shelter.
- **Community Events.** Many of our employees volunteer their time and money by participating in community events with local charities. 75 employees volunteered at the Opportunity Village Magical Forest event during the Christmas holidays for two nights to raise funds for women and men with disabilities. The hospital coordinates three teams (60 employees) for the Rose Regatta Dragon Boat Festival, Susan G. Komen Race for the Cure, American Heart Association Heart Walk and the American Lung Association Scale the Strat climb.
- **Catholic Charities Donations.** Donation containers for Catholic Charities are located at each campus and employees are encouraged to donate.
- **Ecology Initiatives.** All three St. Rose campuses have a "Go Green" committee.
- **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 they are going through family crisis. These funds are distributed through the ECHO committee which handles all requests.
- **Maternity Tours.** St. Rose offers hospital maternity tours three times per month for new parents so they can become familiar with the maternal child centers before they are in labor.
- **Breastfeeding Boutiques** at the Barbara Greenspun Womens*Care* Centers of Excellence offer new moms specialty breastfeeding products, nursing bras and pumps.
- **My Healthy News.** This electronic newsletter provides current information on a variety of personalized, health-related topics and is distributed to its nearly 3,700 subscribers each month.

Community

Definition of Community

Dignity Health hospitals define the community as the geographic area served by the hospital, considered its primary service area. This is based on a percentage of hospital discharges and is also used in various other departments of the system and hospital, including strategy and planning.

St. Rose Dominican serves the areas surrounding the three acute care hospitals in the southern portion of the Las Vegas Valley. This area includes the City of Henderson and the southwest area of Clark County/Las Vegas, which are urban and suburban areas with diverse socio-economic conditions.

Description of Community

The structure of the southern Nevada economy is a major contributing factor to a modest economic recovery. In any economy, dependence on a single industry can lead to vulnerability, downturns and, in the long term, increased competition from other regions. The local economy is primarily service based – one of the largest sections of our economy is tourism. Approximately 60 percent of all workers are employed in the services or retail sector. For many of these workers, their income does not meet their basic needs without government assistance despite a higher median income due to a higher cost of living. In other words, many are not earning a livable wage. As a result, many cannot afford housing, health care, childcare or health insurance. This puts greater pressure on the social service agencies and health care providers to make up the difference when workers and their families cannot make ends meet or are in crisis.

Despite a past reputation for having an abundance of jobs, the current economic conditions have changed the outlook to some degree and a majority of valley residents are concerned about being able to find or keep jobs. However, in 2012 there was modest job growth in southern Nevada driven by improvements in tourism, gaming, construction and real estate. Nevada's unemployment rate stands at 9.5 percent, with Las Vegas at 9.8 percent (June 2013) and Nevada remains the state with the highest rate of unemployment in the nation. Unfortunately for the unemployed, Nevada still ranks near the bottom of all states in combined federal and state spending on cash assistance to welfare recipients and nearly three-quarters of all welfare recipients are children.

According to the 2012 Census estimate, Clark County, Nevada, had a population of 2,000,759 making it the most populous county in Nevada. It contains the city of Las Vegas, the state's most populous city, and several outlying areas which have experienced extensive population growth in the last 10 years such as the cities of Henderson and North Las Vegas, the second and fourth most populated cities in Nevada.

Community Demographics

Population: 363,611
Diversity: 48.7% Caucasian, 20.2% Hispanic, 17.7% Asian, 8.3% African American, 5.1% Other
Average Income: $73,155
Uninsured: 16.1%
Unemployment: 6.7%
No HS Diploma: 4.8%
Renters: 18.5%
CNI Score: 3.3

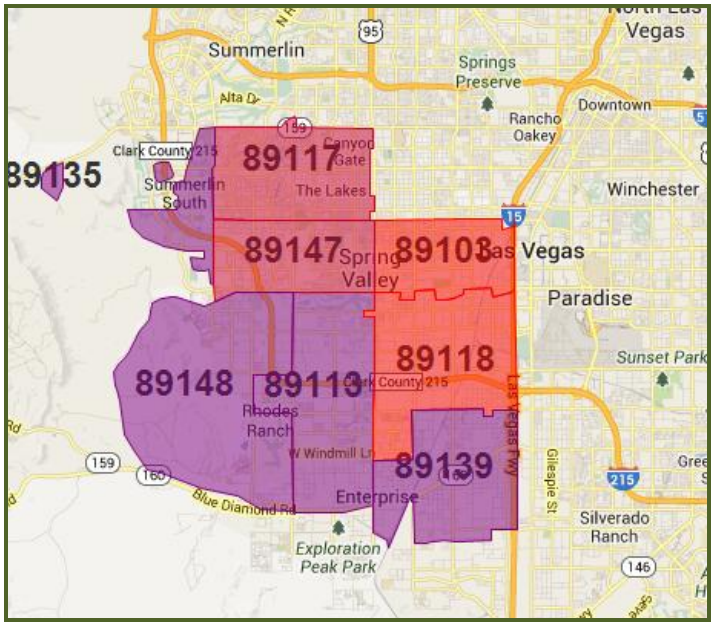
Medicaid Patients: 7.5%
Other Area Hospitals: Spring Valley Hospital, Southern Hills Hospital, Summerlin Hospital

Community Need Index

Dignity Health and Thomson Reuters, formerly Solucient, jointly developed a Community Need Index (CNI) to assist in the process of gathering vital socio-economic factors in the community. The CNI is strongly linked to variations in community healthcare needs and is a strong indicator of a community's potential demand for various healthcare services.

Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. The CNI score is an average of five different barrier scores that include income, language/culture, education, insurance and housing.

San Martin Campus CNI Score Median: 3.3



Lowest Need **Highest Need**

1 - 1.7 Lowest | **1.8 - 2.5 2nd Lowest** | **2.6 - 3.3 Mid** | **3.4 - 4.1 2nd Highest** | **4.2 - 5 Highest**

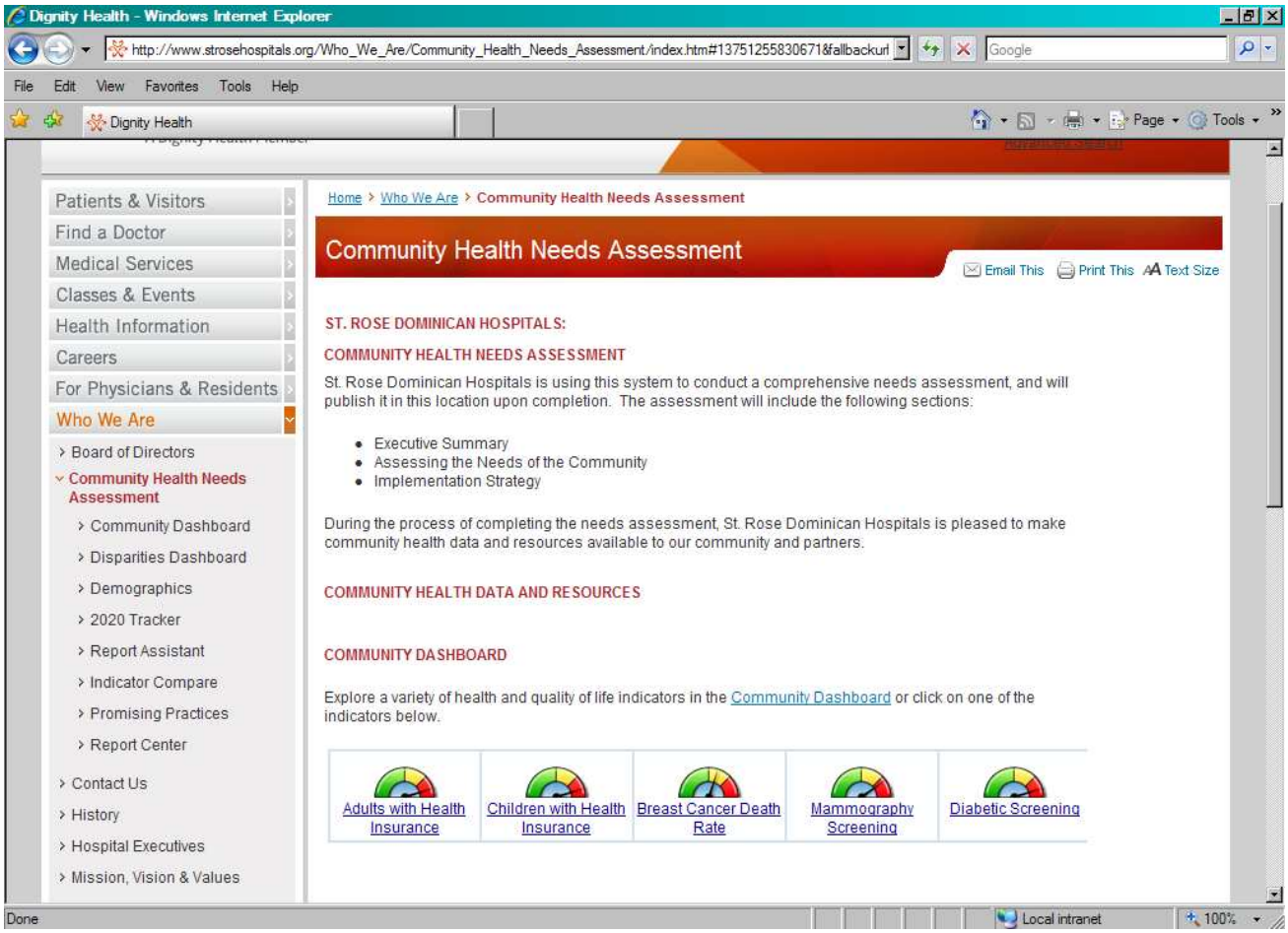
	Zip Code	CNI Score	Population	City	County	State
	89103	4.2	46,423	Spring Valley	Clark	Nevada
	89113	3.2	21,170	Spring Valley	Clark	Nevada
	89117	3.4	58,260	Las Vegas	Clark	Nevada
	89118	4.2	19,789	Spring Valley	Clark	Nevada
	89135	2.6	15,689	Summerlin South	Clark	Nevada
	89139	2.8	26,958	Enterprise	Clark	Nevada
	89147	3.4	51,927	Spring Valley	Clark	Nevada
	89148	3	35,068	Las Vegas	Clark	Nevada

Community Needs and Assets Assessment Process

Conducted every three years, most recently in 2013, the Community Health Needs Assessment identifies the health needs of Las Vegas Valley residents by recognizing ongoing health concerns and gaps in health related services offered to the community. St. Rose Dominican is able to focus outreach efforts and expand resources both unilaterally and in collaboration with other community service providers in an effort to continually improve the health status of the community we serve.

The Healthy Communities Institute (HCI) of Berkeley, California, in partnership with St. Rose Dominican, conducted a Community Health Needs Assessment of Clark County, Nevada. The purpose of the project was to gauge the health and well-being of community members, as well as their level of access to health care.

St. Rose Dominican recognized that access to this data could prove valuable for others, and be useful well beyond the completion of the hospitals' community health needs assessment process to build community capacity for partnering organizations and ultimately improve the quality of life and outcomes for those we serve. This information is available to the community at www.strosehospitals.org



Methodology

Both quantitative and qualitative research methodologies were used to ensure an accurate profile of the St. Rose service areas. This report combines both primary and secondary data from a variety of sources, including paper and electronic surveys; data from existing literature and databases; and information from community stakeholders. Taken as a whole, the information collected and analyzed illustrates the health care status and needs of the community.

Primary Data Collection

Several tools were created for primary data collection, and many methodologies were utilized, including the following:

1) 221 individuals completed a survey ranking the top health issues for their family and the community. The survey provided the list of 15 health issues that were selected after an analysis of the HCI and PQI data. A convenience sample of those utilizing the range of services offered through the St. Rose Community Outreach programs completed the surveys.

2) More than 50 key community stakeholders were invited to complete a survey ranking the priority areas within Clark County, identifying ways St. Rose can address these health issues, and providing suggestions for enhanced collaboration with partner organizations. Twenty-eight partners responded.

Secondary Data Collection

HCI has created a core indicator list that includes health and quality of life data for Clark County selected and vetted based on:

- Publicly available/accessible data from state and national sources, with data available at the county level.
- Likelihood that the indicator will be replicated again in the future.
- Validity of data sources (appropriate methodology).
- Corresponding Healthy People 2020 goals.

This data is updated annually as new data becomes available and provides a core list of indicators as a "community dashboard" available on the St. Rose website. Each indicator includes information about the public health importance of the data, comparisons and targets, breakout charts, data source information with URLs, and contextually related content.

Assets Assessment

In response to the 2013 Community Needs Assessment, the Community Health Advisory Committee, the Dignity Health Community Grants Committee and the Community Outreach Department identified the following key community partner assets for collaboration in 2013 and 2014:

Access to HealthCare Network
Acelero Learning
Alcoholics Anonymous
Allergy Partners of Nevada
Alzheimer's Association
American Cancer Society
American Diabetes Association
American Heart & Stroke Association
American Lung Association
American Stroke Association
Amerigroup
Arthritis Foundation
Bower School-Based Health Center
Breastfeeding Task Force of SNV
CareMore
Carol's Post Mastectomy Specialists
Catholic Charities of Southern Nevada
Children's Lung Specialists
Clark County Fire Department
Clark County School District
Easter Seals
El Salvadorian Consulate
Embrace 2 Empower
Family TIES of Nevada
Family to Family West
Food Allergy Parent Education Group
Future Smiles
Helping Hands Coalition
Henderson Library District
Heritage Park Senior Center
Hopelink
Improving Diabetes & Obesity Outcomes (iDO)
Immunize Nevada
Junior League of Las Vegas
Juvenile Diabetes Research Foundation
La Leche League
Latin Chamber of Commerce
Lend a Hand of Boulder City
Living Grace Home for Pregnant Teens
March of Dimes
Maternal Child Health Coalition
Mexican Consulate
Narcotics Anonymous
Neb Partners
Nevada Cancer Coalition
Nevada Colon Cancer Partnership
Nevada Co-Op
Nevada COPD Action Coalition
Nevada Diabetes Association
Nevada Diabetes Council
Nevada Early Intervention Services
Nevada Health Centers
Nevada Healthy Homes Partnership
Nevada Public Health Association
Nevada State Health Division
Nevada Tobacco Prevention Coalition
Nevada Tobacco Users Helpline
Nevada WebIZ
Nevada Youth Alliance
Partners for a Healthy Nevada
Poverello House
Roseman University
Rosie's Wish
SafeKids Coalition
Saint Therese Center for HIV
Southern NV Immunization & Health Coalition
Southern Nevada Affiliate of Susan G. Komen
Southern Nevada Health District
Southern Nevada Injury Prevention Partnership
Southern Nevada Suicide Prevention Coalition
Southwest Medical Associates
Springs Preserve
St. Jude's Ranch Shelter for Teen Mothers
State of NV Aging & Disabilities Services
Sunrise Children's Foundation
The Boulevard Mall
The Eyecare Center
The Shade Tree
Three Square SNAP
University of Nevada Cooperative Extension
United Healthcare & HPN
UNLV Nutrition Department
UNLV School of Dental Medicine
UNR Nutrition Department
Ventanas de Salud
Volunteers in Medicine

Developing the Hospitals' Implementation Plan

The Community Benefit Plan (CBP) reports on the previous fiscal year's community outreach efforts and the planned direction for the next year as they relate to the needs identified in the 2013 Community Health Assessment. As hospital employees, it is our unique responsibility and privilege to interact with community-based organizations, committees, advisory councils, religious congregations, schools and families.

The goals of community benefits are clear and planning is essential, but the nature of outreach is often charted day by day, person by person. We are reminded of this when we follow the example of unwavering spirit set by the Adrian Dominican Sisters yesterday and today. We are ever hopeful and inspired when we witness it in our employees who serve and in those we are fortunate enough to help in the community.

Definition of Community Benefit

Community benefits are programs or activities that provide treatment or promote health and healing in response to identified community needs and that meet at least one of these objectives:

- Improve access to health care services.
- Enhance the health of the community.
- Advance medical or health care knowledge.
- Relieve or reduce the burden of government or other community efforts.

Process of Community Benefit

The St. Rose Dominican hospitals strive to integrate community benefit into ongoing processes of planning, budgeting and reporting. At both system-wide and local levels, Dignity Health explicitly uses its resources to benefit our brothers and sisters who are poor and to promote health and healing in the community. The community benefit process addresses:

- Organizational Infrastructure
- Community Health Assessment
- Community-based Partnerships
- Resource Allocation
- Program Development
- Performance Measurement
- Program Evaluation
- Reporting

Priority Areas for Community Benefit Planning

Based on the data from the 2013 St. Rose Dominican hospitals Community Health Assessment, the following "health priorities" represent recommended areas of intervention. Priority areas were identified both because of high overall prevalence rates (indicating room for improvement), morbidity and mortality. The Community Health Advisory Committee made recommendations for priority areas which were presented to the Board of Directors for approval.

1. Diabetes Management
2. Adults & Children without Health Insurance
3. Heart Disease & Stroke
4. Breast Cancer Screening
5. Childhood Asthma

It is important to recognize two important facts in determining the areas of focus for St. Rose Dominican's Community Benefit programs: 1) many local efforts are currently active in addressing aspects of several of the outlined issues; and 2) no individual or organization acting alone can remedy all of the implications of a given issue or problem.

In evaluating current community benefit programs, identifying priorities for community action and designing strategies for implementation, a variety of criteria will be applied to the consideration process, including:

Impact – The degree to which the issue affects or exacerbates other quality of life and health-related issues.

Magnitude – The number of persons affected, also taking into account variance from benchmark data and Year 2010 targets.

Seriousness – The degree to which the problem leads to death, disability or impairs one's quality of life.

Feasibility – The ability of organizations to reasonably impact the issue, given available resources.

Consequences of Inaction – The risk of exacerbating the problem by not addressing it at the earliest opportunity.

Planning for the Uninsured/Underinsured Patient Population

Dignity Health is committed to providing financial assistance to persons who have health care needs and are uninsured, under-insured, and ineligible for a government program and are otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered a substitute for personal responsibility and patients are expected to cooperate with Dignity Health's procedures for obtaining financial assistance and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services for their overall personal health and protection of their individual assets (see Financial Assistance Policy -Appendix C).

At the time of admission, hospital personnel inquire about financial payment and explain the various options for financial assistance for those that qualify. The staff of the various community benefit programs also refers clients in need to the hospitals' finance offices for assistance. Information about the hospitals' payment assistance policy is posted in visible places throughout the hospital and is available on the hospital website.

Plan Report and Update including Measurable Objectives and Timeframes

Summary of Key Programs and Initiatives – FY2013 and FY2014

Below are the major initiatives and key community-based programs operated or substantially supported by St. Rose in FY2013. Programs were developed in response to the current Community Health Needs Assessment and are guided by the following five core principles:

- Disproportionate Unmet Health-related Needs – Seek to accommodate the needs of communities with disproportionate unmet health-related needs.
- Primary Prevention – Address the underlying causes of persistent health problems.
- Seamless Continuum of Care – Emphasize evidence-based approaches by establishing operations between clinical services and community health improvement activities.
- Build Community Capacity – Target charitable resources to mobilize and build the capacity of existing community assets.
- Collaborative Governance – Engage diverse community stakeholders in the selection, design, implementation and evaluation of program activities.

Initiative 1: Diabetes Management

- Stanford Diabetes Self Management Program (English & Spanish)
- Stanford Chronic Disease Self Management Program (English & Spanish)
- ADA Certified Diabetes Management Program
- Monthly Diabetes Support Group
- Pediatric Endocrinology Clinic
- Pediatric Diabetes Outreach Programs – Tykes & Tweens, Caregivers…Connecting the Dots, T2D Kids
- Clark County School District Ketone Test Strip Program
- Annual DiaBEATes Day Health Fair and Fun Walk
- Womens*Care* Pre-Diabetes Education Workshops
- Womens*Care* Nutrition Classes, Weight Management Club and one-on-one consultations
- Womens*Care* Monthly glucose and HbA1c Screenings
- Womens*Care* Medication Checks with Pharmacist
- Womens*Care* Happy Feet Diabetic Foot Screenings
- Womens*Care* Flu & Pneumonia Immunization Clinics
- Womens*Care* Peripheral Artery Disease (PAD) Screenings
- Womens*Care* Fitness Programs

Initiative 2: Adults & Children without Health Insurance

- Nevada Health Link Collaboration includes 15 Outreach Staff will become Certified Application Counselors and 4 Kiosks in community outreach locations
- Certified Application Counselor Program
- WIC Prenatal Programs
- RED Rose Mammography Program for the Uninsured

- Nevada Check-up and Medicaid Enrollment Assistance
- Volunteers in Medicine (Dignity Health Grantee)
- The Shade Tree Stallman Touro Medical Clinic (Dignity Health Grantee)
- Bower School-Based Medical Center (Dignity Health Grantee)
- Childhood & Adult Immunization Programs – WIC, NIIW, Back to School, Flu & Pneumonia
- Free & Low Cost Screenings – Fecal Immunochemical Testing (FIT), PVD, Lipid Panel, Liver Panel, Glucose, HbA1c, Thyroid Panel, Eye Screenings, Skin Cancer Screenings, Blood Pressure
- Statewide Nevada Maternal Child Health Coalition

Initiative 3: Heart Disease & Stroke

- Stroke Club
- Stroke Sharegivers Program at all 3 Campuses
- Annual Stroke Conference for patients
- Aphasia Lunch Bunch
- Congestive Heart Active Management Program (CHAMP®)
- Womens*Care* Cardiac Nutrition Class
- Womens*Care* Blood Pressure Screenings & DASH Class
- Womens*Care* Cholesterol Screenings & Cholesterol Control Class
- Womens*Care* Medication Checks with a Pharmacist
- Womens*Care* Peripheral Artery Disease (PAD) Screenings
- Womens*Care* Nutrition Classes, Weight Management Club and one-on-one consultations
- Womens*Care* Smoking Cessation Programs & Smoke Free Campuses
- Womens*Care* Fitness Programs
- Womens*Care* Stress Management and Meditation Classes

Initiative 4: Breast Cancer Screening - Mammogram

- RED Rose Program provides uninsured women with clinical breast exams, screening and diagnostic mammograms, ultrasounds, biopsies, surgeries.
- Rose Regatta Dragon Boat Festival for RED Rose
- Nevada Cancer Coalition

Initiative 5: Childhood Asthma

- Asthma Kids Club quarterly intervention includes asthma screenings, lung tests, free spacers and peak flow meters, no-cost flu shots for the family, medication checks and education, education with pediatric allergist and pulmonologist.
- Bower School-Based Health Center Asthma Program (Dignity Health Grantee)
- Childhood Immunizations & Flu Shots
- Southern Nevada Immunization & Health Coalition

This section reports on both the last fiscal year's community benefit efforts and the plans for the next fiscal year. We have also assessed the current demand for health care services to complement our more formal needs assessment process. Our community benefit plan includes programming to address community needs that have been identified through our community needs analysis as well as hospital utilization data. Five key programs are highlighted in the following section and are priority focus programs for St. Rose as they directly address some of the needs identified in the areas of access and modifiable health risks previously outlined.

Key Programs

- Stanford Chronic Disease Self Management Programs
- Diabetes Management Program
- Heart Disease & Stroke
- R.E.D. Rose Program
- Asthma Kids Club
- Helping Hands

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2015, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

Stanford Chronic Disease Self-Management Program	
Hospital CB Priority Areas	Priority Areas identified in the 2013 St. Rose Community Needs Assessment ✓ Diabetes ☐ Adults & Children without Health Insurance ✓ Heart Disease & Stroke ☐ Breast Cancer Screening ☐ Childhood Asthma
Program Emphasis	Please select the emphasis of this program from the options below: ❑ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ❑ Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	Chronic Health Conditions and healthy behaviors
Program Description	A six-week comprehensive, outcomes-based program developed by Stanford University which includes education and action planning for participants to improve management of their chronic condition in the following areas: Taking action to manage symptoms such as pain and difficult emotions; improving nutrition, physical activity, health literacy and communication with physicians; managing medications and making appropriate plans that work with their lifestyle. Chronic Disease Self-Management Program is available in English & Spanish; Positive Self-Management in English.
FY 2013	
Goal	Expand the Stanford Chronic Disease Self-Management Program and Diabetes Self-Management program in English & Spanish. Secure additional funding, staff, leaders, sites and partnerships. Replicate the program throughout our community.
Baseline FY12	• Reached 307 participants. 206 in English CDSMP, 84 in English Diabetes, 17 in Spanish CDSMP Program. • English Completion rate 80%, Spanish Completion Rate 94% • 20 English Classes, 1 Spanish Class • Trained 21 English CDSMP and DSMP Leaders. Trained 10 Spanish CDSMP leaders
2013 Objective Measure/Indicator of Success	1. Reach 210 participants by providing 8 programs in Spanish and 15 programs in English 2. Train 10 lay leaders for Spanish program, train 10 additional lay leaders for English program, train 10 lay leaders in the Diabetes CDSMP program 3. Reduce admissions, ER visits and unscheduled physician office visits 4. Improve participant self-management skills 5. Expand program to HIV program 6. Add four new community partners to replicate the program in their service areas
Intervention Strategy for Achieving Goal	Collaborate with local partners, recruit and retain leaders, secure additional funding, expand program into other areas
Result FY 2013	• Reached 544 participants: 319 in English CDSMP with 208 completers, 99 English Diabetes with 60 completers, 12 Spanish CDSMP with 9 completers, 105 Spanish Diabetes with 73 completers, and 9 PSMP HIV with 8 completers. • Provided 31 English workshops and 12 Spanish workshops. • Trained 26 new lay leaders in English CDSMP, 11 new leaders in Spanish CDSMP, 16 new lay leaders in Spanish Diabetes. Provided an Update Training to 2012 revised CDSMP curriculum for 18 lay leaders. Secured 6 Master Trainers of which 6 are certified in CDSMP, 2 in English Diabetes, 2 in Spanish CDSMP, 2 in Spanish Diabetes, 2 in PSMP HIV. • Implemented PSMP HIV for the first time in the state in April 2013. • Added 11 additional community partners including Saint Therese Center, Volunteers in Medicine, Heritage Park Senior Facility, Nevada Co-Op, Care More, Nevada Health Centers, The Boulevard Mall, and the Latin Chamber of Commerce. • Completed and exceeded all deliverables for two state grants: Nevada State Health Division and State of Nevada Aging and Disabilities Services Division. • Hospitalization utilization decreased 84.2%, ER visits decreased 84.4%, and unscheduled doctor's visits decreased 60% • Average self-rate health score improved from 2.97% pre-program to 2.60% post-program (5 point scale 1=excellent, 5=poor). • 17% Overall improvement in 6 aspects of self management. Includes increased confidence in managing fatigue, pain, discomfort, emotional distress, ability to do things other than take medication, and reducing the need to see a doctor. • The program was awarded the first State of Nevada Annual Silver ACE Award for outstanding clinical health promotion. • Secured two state grants for FY 2014, totaling $38,727 to continue expanding program in the community and statewide.
Hospitals' Contribution/ Program Expense	St. Rose's contribution to this totaled $157,229 in FY2013.
FY 2014	
Goal FY 2014	Continue expanding the Stanford CDSMP and DSMP Programs in English and Spanish as well as the HIV Positive Self-Management Program throughout our service area while contributing to the expansion of these programs in the State.
2014 Objective Measure/Indicator of Success	1. Reach 381 participants by providing 24 workshops in English and 8 in Spanish 3. Provide 2 English and1Spanish CDSMP lay leader trainings. Provide 1English Diabetes lay leader training and 1 Spanish Diabetes crossover training. 4. Continue to reduce admissions, ER visits, and unscheduled physician office visits 5. Improve participant self-efficacy in managing their chronic conditions 6. Continue working with our community partners to strengthen relationships and provide the programs on a reoccurring basis at their host sites. Establish further partnerships to reach the community.
Intervention and Strategy	Collaborate with local partners, recruit and retain leaders, secure additional funding, expand program into other areas

Diabetes Management Program – Adult & Pediatric	
Hospital CB Priority Areas	Priority Areas identified in the 2013 St. Rose Community Needs Assessment ✓ Diabetes ☐ Adults & Children without Health Insurance ☐ Heart Disease & Stroke ☐ Breast Cancer Screening ☐ Childhood Asthma
Program Emphasis	Please select the emphasis of this program from the options below: ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	Adult & Pediatric Diabetes Management, Education, Screening and Prevention Services.
Program Description	Provide opportunities for people with diabetes to improve lifestyle through education; participation and screenings
FY 2013	
2013 Objectiveeasure /Indicator of Success	Launch the Pediatric Endocrinology Clinic and Outreach Program. Expand the ADA approved adult outpatient education including medical nutrition therapy. Expand the Stanford Diabetes Self Management Program in English and Spanish.
Baseline	New measure
Intervention Strategy for Achieving Goal	UCLA Dream Fund Grant, State CDSMP Grants and key collaborations with community partners. Strengthen continuity of care from inpatient to outpatient clinic and education setting.
Result FY 2013	Pediatric Pediatric Endocrinology Clinic opened July 1. Established pediatric outreach programs Reached 26 participants-Tykes and Tweens diabetes support group Reached 25 participants-Connecting the Dots: Caregivers of T1D Kids workshop Provided 350 ketone strip boxes to Clark County School District Nurses, which is one for each school Adult **PREVENTION:** Foot checks: 35, A1c Testing: 333, Glucose: 360 Pre-diabetes Class: 17 Weight Management Club: 372, Fitness Class Encounters: 16,150 **ADA PROGRAM:** 479 Individual and Group Education (12% increase from last year). Each participant reports back on 3 goals. The following goals were met by participants: healthy eating 87%, being active 81%, taking medication 93%, monitoring 91%, problem solving 90%, reducing risks 89%, healthy coping 92% **STANFORD DSMP PROGRAM:** Reached 204 total participants in DSMP - 99 English Diabetes of which 60 completed, 105 Spanish Diabetes of which 73 completed. Provided 7 English DSMP workshops and 11 Spanish DSMP workshops. Trained 16 new lay leaders in Spanish Diabetes. Secured 6 Master Trainers of which 6 are certified in CDSMP, 2 in English Diabetes, 2 in Spanish CDSMP, 2 in Spanish Diabetes.
Hospitals' Contribution Program Expense	St. Rose's contribution to this program totaled $22,448 in FY2013.
FY 2014	
Goal 2014	Provide diabetes outreach, screenings, education and collaboration throughout the community.
2014 Objective Measure/Indicator of Success	Pediatric: 75 Inpatient Diabetes Referrals, 250 endocrinology visits and education sessions Reach 120 participants in Tykes and Tweens Support Group, 50 in Caregivers Group, 30 in T2D Kids, 15 in insulin pump group. Adult: **PREVENTION:** Reach 75 participants: diabetes health fair in November in correlation with national diabetes month Reach 75 participants: "Talk with the Doc" diabetes topic each quarter Reach 75 participants: diabetes awareness health fair in March in correlation with ADA diabetes awareness day Provide influenza vaccine to 25 uninsured participants **ADA PROGRAM:** Reach 500 participants for group and individual education; reach 200 participants for monthly support group **STANFORD DSMP PROGRAM:** Reach 150 DSMP participants by providing 7 workshops in English and 7 in Spanish Provide 1 English DSMP lay leader training and 1 Spanish Diabetes crossover training Continue to reduce readmissions, ER visits, and unscheduled physician office visits, and improve participant self-efficacy in managing their diabetes by focusing on DSMP program Continue working with our community partners to strengthen relationships and provide DSMP in English and Spanish on a reoccurring basis at their host sites. Establish further partnerships to reach those touched by diabetes.
Intervention Strategy for Achieving Goal	Increased room space at new WCC Center Henderson for greater number of participants in programs Collaborate with community partners and new St. Rose doctors for increased awareness of all diabetes programs Highlight one diabetes related story in WomensCare magazine. Recruit and retain DSMP leaders in English and Spanish, secure additional funding, expand DSMP program into other community areas and statewide.

RED Rose Program	
Hospital CB Priority Areas	Priority Areas identified in the 2013 St. Rose Community Needs Assessment ☐ Diabetes ☐ Adults & Children without Health Insurance ☐ Heart Disease & Stroke ✓ Breast Cancer Screening ☐ Childhood Asthma
Program Emphasis	Please select the emphasis of this program from the options below: ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	Among the uninsured and underinsured age 49 and under, these services are not available in our community. RED Rose provides uninsured, underinsured and undocumented women with access to screening and diagnostic breast health services.
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 are also available, such as payment of monthly utilities, transportation costs, groceries, rent and other incidentals while fighting breast cancer.
FY 2013	
2013 Objective Measure/ Indicator of Success	Number of mammograms, clinical breast exams, ultrasounds and biopsies provided as well as malignancies detected. Types of support services and dollar value.
Baseline	FY 2012 Results Eligibility Screenings: 668 Clinical Breast Exams: 201 Diagnostic Mammograms: 303 Screening Mammograms: 222 Ultrasounds: 357 Biopsies: 68 Surgical Consultations: 49 Cancer Diagnosis: 10 and Surgical Treatment: 7 Temporary Assistance: $64,756; Rent: $31,244; Electricity: $4,693; Gas: $1,123; Water: $370; Phone: $460; Groceries: $19,165; Transportation: $7,720.
Intervention Strategy for Achieving Goal	Funds were received through grants and fundraising events throughout the year. Increased marketing through Womens*Care* Magazine, English and Spanish versions, hired a part-time bi-lingual clerk to help with increases in phone volume.
Result FY 2013	FY 2013 Results: Program Volume increased 9% Eligibility Screenings: 728 Clinical Breast Exams: 220 Diagnostic Mammograms: 344 Screening Mammograms: 282 Ultrasounds:374 Biopsies: 61 Surgical Consultations: 56 Cancer Diagnosis: 8 and Surgical Treatment: 7 Temporary Financial Assistance: 34 Clients $66,779 TOTAL; Rent $23,511; Electricity $6,680; Gas $1,381; Water $862; Groceries $22,705; Transportation $11,640.
Hospitals' Contribution/ Program Expense	St. Rose's contribution to this program totaled $595,897 in FY2013.
FY 2014	
Goal 2014	Provide medical services to assist in diagnosing breast cancer for those individuals who are uninsured and underinsured and/or those who do not have the financial means to seek diagnostic care. Provide financial assistance to low-income women undergoing breast cancer treatment
2014 Objective Measure/ Indicator of Success	Provide: 150 clinical breast exams 200 mammograms 150 ultrasounds 60 surgical consultations 60 biopsies. Assist 36-48 women with financial support during chemotherapy. Assist 120 women in enrolling in Nevada Health Link or Medicaid.
Intervention Strategy for Achieving Goal	1. Secure additional funding through grants, the Rose Regatta Dragon Boat Festival and other fundraising so we can help more women. 2. Promote program to underserved/uninsured women and men through our Hispanic outreach efforts, the Womens*Care* Magazine and referrals from other agencies. 3. All RED Rose staff will become Certified Application Counselor for Nevada Health Link to assist uninsured women in enrolling in a health plan.

Heart Disease & Stroke	
Hospital CB Priority Areas	Priority Areas identified in the 2013 St. Rose Community Needs Assessment ☐ Diabetes Management ☐ Adults & Children without Health Insurance ✓ Heart Disease & Stroke ☐ Breast Cancer Screening ☐ Childhood Asthma
Program Emphasis	Please select the emphasis of this program from the options below: ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	Heart Disease & Stroke
Program Description	Implement evidenced-based heart and stroke prevention, education, screening, support and disease management programs.
FY 2013	
2013 Objective Measure /Indicator of Success	1. Launch CHAMP program 2. Expand Sharegivers program to all three campus 3. Host annual Stroke and Aphasia patient conference
Baseline 2012	Prevention Programs: Nutrition: 630 Fitness: 17,370 Stroke: 340 Sharegivers visits provided in 2012 at Siena. Trained 6 new Sharegivers and now have 18 total.
Intervention Strategy for Achieving Goal	Partner with stroke coordinator sat all three campuses to implement Sharegivers. Include all prevention programs for free or low-cost in WomensCare magazine. Target cardiac patients with Cardiac Nutrition class. Partner with American Heart Association on the Mended Hearts program.
Result FY 2013	Prevention Programs: Cardiac Nutrition Class: 75 DASH: 22 Cholesterol Control:10 Weight Management Club: 372 Nutrition Classes: 92 Blood Pressure Screenings: 493 Lipid Panel Screenings: 477 PVD Screenings: 68 Smoking Cessation: 53 Fitness: 16,150 Meditation/Relaxation: 776 Mended Hearts: 552 Heartsaver CPR: 72 CHAMP (Congestive Heart Active Management Program) Patients: 49 Stroke: Stroke Sharegiver Visits: 339 Stroke Club: 248 Aphasia Lunch Bunch: 571 Stroke Patient Conference & Lectures: 587
Hospitals' Contribution /Program Expense	St. Rose's contribution to this program totaled $20,000 in FY2013.
FY 2014	
Goal 2014	Reduce readmits for CHF population at all three campuses. Increase support for stroke survivors and increase prevention activities throughout the market.
2014 Objective Measure/Indicator of Success	Prevention: 650 Nutrition Education Encounters, 600 Blood Pressure Screenings, 500 Lipid Panel Screenings, 70 PVD Screenings 60 Smoking Cessation, 16,500 Fitness , 800 Meditation CHF: 75 CHAMP Enrollment, Reduce readmissions in enrolled population. Stroke: 400 Sharegiver Visits 300 Stroke Club 600 Aphasia Lunch Bunch
Intervention Strategy for Achieving Goal	1. Secure a Sharegivers coordinator 2. Meet with case management and cardiac rehab to increase referrals to CHAMP 3. Plan annual stroke and aphasia conference for patients and families.

Asthma Kids Club	
Hospital CB Priority Areas	Priority Areas identified in the 2013 St. Rose Community Needs Assessment ☐ Diabetes Management ☐ Adults & Children without Health Insurance ☐ Heart Disease & Stroke ☐ Breast Cancer Screening ✓ Childhood Asthma
Program Emphasis	Please select the emphasis of this program from the options below: ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ✓ Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	Childhood Asthma
Program Description	Childhood asthma is a growing problem nationwide with an estimated 47,000 children currently living with this chronic condition in Nevada alone. In an effort to address the prevalence of asthma and reduce subsequent ER visits, Asthma Kids Club has been designed to help families effectively manage childhood asthma. This program offers an opportunity for St. Rose Dominican to partner with asthma and allergy-focused organizations to conveniently bring targeted resources together at four events yearly. These quarterly interventions include pulmonary function screening for asthma, conversations with physicians, no cost immunizations, medication screening by a pharmacist, asthma equipment testing, asthma and allergy educational activities, and interaction with local lung health organizations. Emergency room visits and subsequent hospitalizations are a strong indicatorsof poorly-controlled asthma and preventable exacerbations, which can be life threatening. Asthma Kids Club targets the approximately 900 children ages 5-11 that have had an asthma-related emergency room visit at St. Rose in the past 12 months.
FY 2012/FY 2013	
Goal FY 2012	Reduce asthma-related hospital utilization and E.R. visits among the children participating in Asthma Kids Club events.
2013 Objective Measure/Indicator of Success	1. Provide three Asthma Kids Club educational interventions with a minimum of 200 unduplicated children with asthma and their families participating in at least one event in FY 2013. 2. Collaborate with St. Rose pediatric allergists/pulmonologists/immunologists to participate in and refer to the program. 3. Provide staff development through attendance at Association of Asthma Educators (AAE) Annual Conference, annual AAE membership, and testing fees for Certified Asthma Educator (AE-C) examination. 4. Create Asthma Kids Club marketing materials for inclusion in the Womens*Care* Magazine, distribution within the Clark County School District, and allocation throughout the St. Rose system. 5. Partner with at least five asthma/allergy-related community organizations to have an educational presence at the events. 6. Identify at least two new asthma-related partners to collaborate on Asthma Kids Club for FY 2012.
Baseline	FY 2012 Results • Of 1,827 families in our database (pediatric patients with an ER visit in the past year), 424 have a second visit within the year. (23% return to St. Rose for another asthma exacerbation.) • During the first year of Asthma Kids Club events, we reached 218 children and 138 parents/guardians during these events – a total of 122 families. • 34 of the 122 families have had emergency room visits for asthma exacerbations at our hospitals within the past year. Of these, only 2 returned to the ER since attending an AKC event. (6% return to St. Rose for another asthma exacerbation.) • Overall, the Asthma Kids Club program is demonstrating a significant reduction in repeat E.R. visits.
Intervention Strategy for Achieving Goal	Target children who have had an asthma-related E.R. visit or hospital admission in the past 12 months with an invitation to the program
Result FY 2013	FY 2013 Results: **Sep 22, 2012, Flu-Free Superheros** 228 participants. 28 Pulmonary Function Tests, 14 pharmacy consults, 12 pulmonologist consultations, 18 Allergist consultations, 148 Flu Shots, 14 Medicaid application assistance **Dec 9, 2012, Cough Control Winterfest** 241 participants. Provided 172 flu, 79 TDAP and 39 pneumonia immunizations, 21 Pulmonary Function Testing, 30 application assistance and referrals, 12 allergist and pulmonologist consultations. **March 9, 2013, Breathe Easy Luau** 103 participants.
Hospitals' Contribution /Program Expense	St. Rose's contribution to this program totaled $12,330 in FY2013.
FY 2014	
Goal 2014	Reduce asthma-related hospital utilization and E.R. visits among the children participating in Asthma Kids Club events.
2014 Objective Measure/Indicator of Success	Reach 300 families through Asthma Kids Club. Reduce ER visits by 5% for this population. Provide 100 flu shots for kids with Asthma and their families Provide 20 healthy homes visits through partnerships with existing programs.
Intervention Strategy for Achieving Goal	1. Partner with Dignity Health on the Innovation Grant to implement the Asthmapolis Project. 2. Increase funding and resources for this project

Helping Hands	
Hospital CB Priority Areas	Priority Areas identified in the 2013 St. Rose Community Needs Assessment ☐ Diabetes Management ☐ Adults & Children without Health Insurance ☐ Heart Disease & Stroke ☐ Breast Cancer Screening ☐ Childhood Asthma
Program Emphasis	Please select the emphasis of this program from the options below: ✓ Disproportionate Unmet Health-Related Needs ✓ Primary Prevention ❑ Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment Vulnerable Population	Persons with disabilities, uninsured/underinsured., and Seniors
Program Description	Helping Hands of Henderson assists individuals 60 years of age and older who live in a Henderson, NV Zip Code with transportation needs to medical/dental appointment, prescription pickup and grocery shopping. The program allows for easy access to physicians, grocery shopping, pharmacy pick up, and other needed services to allow the senior to maintain an independent and healthy lifestyle. By providing this service we are attempting to help seniors remain independent in their own homes by providing accessible transportation to meet daily needs.
FY 2013	
Goal FY 2013	Assist in meeting the needs of seniors living in Henderson city limits so they can remain independent in their home. The program allows for easy access to physicians, grocery shopping, pharmacy pick up, and other needed services to allow the senior to maintain an independent and healthy life. By providing this service we are attempting to help seniors to remain independent in their own homes. This is accomplished by allowing them access to transportation to meet daily needs.
2013 Objective Measure/Indicator of Success	Provide services to 350 unduplicated clients Provide 6,000 round trip rides Provide 1,000 reassurance calls Clients will report a 96% improvement in independence because of these services 0% of clients will go without food due to transportation issues
Baseline – FY 2013 Results	Unduplicated clients: 344 Round trip rides: 5,762 Reassurance Calls: 608 Referrals to other resources: 1427
Intervention Strategy for Achieving Goal	Distribute health information and supportive health service referrals, bi-annual surveys from clients, and the provision of transportation services that the program provides for the client base, which is the heart of the program.
Result FY 2013	Unduplicated clients: 368 Round trip rides: 6380 Reassurance Calls: 317 Referrals: 1087 During fiscal year 2013, the program provided 6,380 round trip rides to 368 unduplicated Henderson senior and disabled residents. Of the 284 seniors surveyed, 94% experienced an improvement in their ability to be independent, 13% reduction in visits to the ER or Urgent care within the last year, 8% improvement in our clients' ability to maintain doctor's appointments with the assistance of Helping Hands, and 3% reduction in seniors having to go without food due to not having transportation or access to Meals on Wheels. This year volunteers donated 2,682 hours, recruited 12 new volunteers, 317 reassurance calls completed and 1087 community referrals given out.
Hospital's Contribution / Program Expense	St. Rose's contribution to this totaled $557,876 in 2013.
FY 2014	
Goal 2014	Assist in meeting the needs of seniors living in Henderson city limits so they can remain independent in their homes. The program allows for easy access to physicians, grocery shopping, pharmacy pick up, and other needed services to allow the senior to maintain independent and healthy life. By providing this service we are attempting to help seniors to remain independent in their own homes. This is accomplished by allowing them access to transportation to meet daily needs.
2014 Objective Measure/Indicator of Success	Provide services to 400 unduplicated clients, provide 7,000 round trip rides, provide 1,000 reassurance calls Clients will report a 96% improvement in independence because of these services, reduce waitlist to three months, and retain volunteer level to 42.
Intervention Strategy for Achieving Goal	1. Recruit and maintain 8 new volunteers to the program for a total of 42 volunteers. 2. Reduce waiting list by three months with new fifth driver 3. Enroll 100 new patients into program.

524 St. Rose-San Martín Campus
Complete Summary - Classified Including Non Community Benefit
For period from 7/1/2012 through 6/30/2013
Utilized Cost Accounting Method for Calculating Community Benefit Expense

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Living in Poverty						
Financial Assistance	**1,455**	**2,569,986**	**0**	**2,569,986**	**1.6**	**1.8**
Medicaid	**3,700**	**9,096,051**	**1,708,870**	**7,387,181**	**4.6**	**5.1**
Means-Tested Programs	**70**	**830,404**	**1,832**	**828,572**	**0.5**	**0.6**
Community Services						
Community Benefit Operations	16	209,942	0	209,942	0.1	0.1
Community Building Activities	3	1,593	0	1,593	0.0	0
Community Health Improvement Services	1,049	387,116	0	387,116	0.2	0.3
Financial and In-Kind Contributions	57	114,270	0	114,270	0.1	0.1
Health Professions Education	4	7,261	0	7,261	0.0	0
Totals for Community Services	**1,129**	**720,182**	**0**	**720,182**	**0.4**	**0.5**
Totals for Living in Poverty	**6,354**	**13,216,623**	**1,710,702**	**11,505,921**	**7.1**	**8.0**
Benefits for Broader Community						
Community Services						
Community Benefit Operations	1	900	0	900	0	0
Community Building Activities	5	37,258	0	37,258	0	0
Community Health Improvement Services	35	81,194	0	81,194	0.1	0.1
Financial and In-Kind Contributions	6	51,177	0	51,177	0	0
Health Professions Education	15	315,053	0	315,053	0.2	0.2
Research	4	117,501	0	117,501	0.1	0.1
Totals for Community Services	**66**	**603,083**	**0**	**603,083**	**0.4**	**0.4**
Totals for Broader Community	**66**	**603,083**	**0**	**603,083**	**0.4**	**0.4**
Totals - Community Benefit	**6,420**	**13,819,706**	**1,710,702**	**12,109,004**	**7.5**	**8.4**
Unpaid Cost of Medicare	**7,114**	**43,760,504**	**30,024,286**	**13,736,218**	**8.5**	**9.5**
Totals with Medicare	**13,534**	**57,580,210**	**31,734,988**	**25,845,222**	**16.0**	**17.9**
Grand Totals	**13,534**	**57,580,210**	**31,734,988**	**25,845,222**	**16.0**	**17.9**

Region: Nevada Market
Multi Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2012 through 6/30/2013
Utilized Cost Accounting Method for Calculating Community Benefit Expense

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Living in Poverty						
Financial Assistance	**6,524**	**12,030,437**	**0**	**12,030,437**	**2**	**2**
Medicaid	**21,415**	**40,620,564**	**7,869,503**	**32,751,061**	**5.4**	**5.5**
Means-Tested Programs	**312**	**3,322,743**	**57,645**	**3,265,098**	**0.5**	**0.5**
Community Services						
Community Benefit Operations	38	526,440	0	526,440	0.1	0.1
Community Building Activities	3	1,593	0	1,593	0	0
Community Health Improvement Services	44,290	2,737,925	0	2,737,925	0.5	0.5
Financial and In-Kind Contributions	288	563,054	0	563,054	0.1	0.1
Health Professions Education	12	26,168	0	26,168	0	0
Totals for Community Services	**44,631**	**3,855,180**	**0**	**3,855,180**	**0.6**	**0.6**
Totals for Living in Poverty	**72,882**	**59,828,924**	**7,927,148**	**51,901,776**	**8.6**	**8.7**
Benefits for Broader Community						
Community Services						
Community Benefit Operations	14	362,295	0	362,295	0.1	0.1
Community Building Activities	14	141,661	0	141,661	0	0
Community Health Improvement Services	81,354	2,123,282	189,932	1,933,350	0.3	0.3
Financial and In-Kind Contributions	20	414,585	0	414,585	0.1	0.1
Health Professions Education	95	2,951,006	0	2,951,006	0.5	0.5
Research	11	346,625	0	346,625	0.1	0.1
Totals for Community Services	**81,508**	**6,339,454**	**189,932**	**6,149,522**	**1.0**	**1.0**
Totals for Broader Community	**81,508**	**6,339,454**	**189,932**	**6,149,522**	**1.0**	**1.0**
Totals - Community Benefit	**154,390**	**66,168,378**	**8,117,080**	**58,051,298**	**9.7**	**9.7**
Unpaid Cost of Medicare	**31,968**	**174,891,664**	**137,479,464**	**37,412,200**	**6.2**	**6.3**
Totals with Medicare	**186,358**	**241,060,042**	**145,596,544**	**95,463,498**	**15.9**	**16.0**
Grand Totals	**186,358**	**241,060,042**	**145,596,544**	**95,463,498**	**15.9**	**16.0**

Telling the Story

St. Rose Dominican promotes its Community Benefit programs in a variety of ways, including:

1. **strosehospitals.org** – The St. Rose Dominican website (www.strosehospitals.org) offers the Annual Community Benefit Report and Community Needs Assessment as well as health information for the Henderson and Las Vegas communities, including an extensive list of Community Programs. Visitors to the website can learn about services and programs ranging from Baby Rose, Family to Family and WIC to Chronic Conditions, Diabetes Education and R.E.D. Rose.
2. **Womens*Care* Magazine** – This quarterly publication is distributed at no cost to nearly 400,000 homes (more than any other publication in southern Nevada) and contains health-related articles and information along with a six-page calendar listing of programs and classes offered through St. Rose, the Barbara Greenspun Womens*Care* Centers of Excellence, Family to Family, etc. The Spanish Womens*Care* magazine is distributed to 25,000 Spanish-speaking homes annually. Womens*Care* magazine is also posted to the St. Rose Dominican hospitals external website, promoted through the St. Rose facebook page (with a link to a pdf of the newsletter) and distributed to the nearly 3,700 subscribers of My Healthy News (an electronic newsletter).
3. ***My Healthy News*** – A subscriber list of nearly 3,700 receives this free monthly eNewsletter via email. The newsletter contains health articles from over 350 of the country's leading health publications and journals – on the topics subscribers choose when they sign up, such as arthritis, diabetes, cancer, men's health, seniors' health, women's health, stroke and more. It also provides specific information on St. Rose services, community benefit programs and class offerings.
4. **GetWellNetwork®** – This interactive system is available in all patient rooms and is designed to inform and empower patients during their hospital stay. Through interactive education via in-room television monitors, patients can actively participate in their health care by learning about health conditions, procedures, medications, etc.
5. **Press Kit** – The St. Rose Dominican hospitals press kit is distributed to media and other interested parties on a regular basis. The Community Benefit Programs offered through the hospitals are listed as an integral piece of the press kit. The press kit is also available in its entirety on the "Who We Are" section of the St. Rose Dominican hospitals website.
6. **'StRoseHospitals' Facebook Page** – St. Rose began posting health-related information to its facebook page in mid-2010 which now has more than 1,700 followers. Posts include information on community benefit class schedules, health and wellness programs, exercise and fitness classes, nutrition, screenings, health conditions, community events, etc.
7. **St. Rose Blog –** The St. Rose blog was introduced in June 2010. To date, more than 120 posts have been made, and the blog has more than 22,000 unique page views. The blog features news stories relative to St. Rose, the Barbara Greenspun Womens*Care* Centers and the system's various community benefit offerings.
8. **Twitter –** twitter.com@StRoseHospitals – The St. Rose twitter page is used on a daily basis to promote information on St. Rose Dominican hospitals, the Barbara Greenspun Womens*Care* Centers and community benefit programs. St. Rose currently has more than 450 followers and more than 1,925 "tweets" have been posted.
9. ***The Rose Garden*** – This newsletter, produced by the St. Rose Dominican Health Foundation, reaches 6,300 donors both electronically and by mail. It highlights new technology and services offered at the hospitals along with community benefit program spotlights and fundraising events.
10. Foundation Board Meeting & Community Health Advisory Committee
11. Dignity Health Grantee Award Luncheon distribution
12. Distribution to key community partners

Appendix A
Community Need Index

Community Need Index

Dignity Health has developed the Community Need Index (CNI) in partnership with Thompson Reuters, to help health care organizations, non-profits, and policy makers identify and address barriers to health care access in their communities.

The CNI aggregates five socioeconomic indicators long known to contribute to health disparity and applies them to every zip code in the United States. Communities with the highest CNI scores were shown to be twice as likely to experience hospitalization for a preventable condition – such as ear infections, pneumonia and congestive heart failure – as communities with the lowest CNI scores.

Dignity Health's CNI index is a tool used to measure community need in a specific geographic area through analyzing the degree to which a community has the following health care access barriers:

- Income Barriers
- Educational Barriers
- Cultural Barriers
- Insurance Barriers
- Housing Barriers

Analysis has indicated a significant correlation (96 percent) between the CNI and preventable hospital admissions.

Communities with scores of "5" are more than twice as likely to need inpatient care for preventable conditions (ear infections, etc.) than communities with a score of "1".

The CNI provides compelling evidence for addressing socioeconomic barriers when considering health policy and local health planning. The tool clearly highlights health care disparities between geographic regions and illustrates the acute needs of several notable geographies, including inner city and rural areas. Further, it should enable health care providers, policy makers and others to allocate resources where they are most needed using a standardized, quantitative tool.

The CNI provides Dignity Health with an important means to strategically allocate resources where they will be the most effective in maintaining a healthy community.

The CNI integrates five factors long known to contribute to health need. Specifically, Dignity Health compiled data related to income, culture/language, education, housing status, and insurance coverage for every zip code in the United States. Each zip code is then given a score from 1.0 (low need) to 5.0 (high need).

"Accurate measurement of community need is challenging but crucial for ensuring that patients have appropriate access to quality health care," said Rich Roth, director of strategy and business development for Dignity Health and the principle investigator for the CNI. "We developed this tool to help us demonstrate and quantify the link between community need, access to care, and hospitalization."

Total admissions per 1,000 population for communities in the 23 states that publicly report discharge data showed that hospitalization rates for the most highly needy communities (CNI=5.0) were 60 percent higher than communities with the lowest need (CNI=1.0).

When admission rates for conditions that could have been treated in an outpatient setting (such as, ear infections, pneumonia or asthma) were compared to CNI scores, the correlation was even stronger, with the most highly needy communities experiencing admission rates that were almost twice as high (97 percent) as rates for the lowest need communities.

"Accurate assessment of community need is the first step in addressing disparities in health care access," said Paul Presken, Solucient's vice president of product development. "Objective measurement of at-risk communities should lead to better allocation at a local level." Healthcare resources frame successful health policy discussions at the state and national levels.

Appendix B

St. Rose Dominican hospitals' Community Board Members

Community Board Members

July 1, 2012 – June 30, 2013

James A. Barrett, Jr.
CFO, Marnell Corrao Associates

Arthur M. Cambeiro, MD
Cosmetic and Plastic Surgeon
SurgiSpa Cosmetic and Plastic Surgery

MaryKaye Cashman
Chief Executive Officer
Cashman Equipment Company

Radha Chanderraj, MBA, JD
Attorney

Rod A. Davis
President/CEO, Southern Nevada Market Area
Dignity Health

Derek Duke, MD, FACS
Neurosurgeon
Western Regional Center for Brain and Spine Surgery

Herb Hunter
Public Sector & General Business Sales Manager
Sprint/Nextel

Maureen McGrath, OP
Adrian Dominican Sister

Donna M. Miller, MD, FACOG
OB/GYN Physician
Chief of Obstetrics, San Martín Campus

Victoria Napoles-Laza
Executive, Latin Chamber of Commerce

Sandy Peltyn
VP Business Development
DeSimone Consulting

M. Helena Sanfilippo, RSM
Adjunct Faculty, Chabot College

Jacqueline Stoll, OP, APRN
Adrian Dominican Sister
Nurse Practitioner

Appendix C

Dignity Health Summary of Patient Financial Assistance Policy

DIGNITY HEALTH
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY
(June 2012)

Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.

- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
    a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
    b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
    c. a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.

- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.

- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;

- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any

other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;

- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;

- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.

- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.

- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.

- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

In implementing this policy, dignity health management and dignity health facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.

Appendix D

Community Needs/Assets Assessment Sample Characteristics

Community Needs/Assets Assessment - Demographics

Demographic Characteristics of Clark County Residents

In general, the population of the St. Rose service area includes slightly fewer children under age 18 than in the overall Clark County population. About 23% of residents in the St. Rose area are under age 18, while 27% of residents in Clark County are children (see Table 1 in Appendix A). Conversely, the St. Rose service area includes slightly older residents; approximately 25% of the population in this area is 55 years of age or older, while 22% of the Clark County population is in this age bracket.

The table below displays population figures for residents of the St. Rose service area and Clark County as a whole, as well as the proportion of county residents who live in the St. Rose area, by age group. St. Rose area children under the age of 18 make up about 39% of all children in the county. In the 18-64 age range, St. Rose residents comprise about 48% of all county residents. About 50% of all county residents ages 65 and older live in the St. Rose area. With regard to occupied housing units in the county, about 49% are within the St. Rose service area.

Table 1: Residents and Housing Units Within the St. Rose Service Area and Clark County, by Age

	Residents of St. Rose Area Zip Codes			Residents of Clark County	
		Percent of			
	Number	St. Rose Area Population (Column Percent)	Clark County Population (Row Percent)	Number	Clark County Population (Column Percent)
Residents by Age					
Under 18	205,247	22.6	38.8	528,315	26.6
18-24	74,091	8.1	49.7	148,961	7.5
25-34	133,039	14.6	45.3	293,950	14.8
35-44	135,267	14.9	45.4	297,922	15.0
45-54	134,130	14.7	49.3	272,102	13.7
55-64	114,341	12.6	52.3	218,476	11.0
18-64	590,869	165.0	48.0	1,231,411	167.3
65+	113,709	12.5	50.2	226,421	11.4
Total	909,825	100.0	45.8	1,986,146	100.0
Occupied Housing Units	358,046	100.0	48.6	735,979	100.0

"Residents by Age" Source: Applied Analysis. (2009). LV Perspective. Las Vegas, NV: Metropolitan Research Association.

"Occupied Housing Units" Source: Clark County Department of Comprehensive Planning. (2009). Southern Nevada Consensus Population Estimate, July 2009.

The St. Rose service area contains fewer individuals of Hispanic origin than in Clark County as a whole (22% versus 28%, respectively) (see Table 1 in Appendix A). The majority of the population in both the St. Rose service area and in Clark County are Caucasian (more than 71%), while Black/African American (more than 6%) and Filipino (more than 3%) race/ethnicity categories are the next highest sub-groups. However, 6% of St. Rose service area residents self-identify as an "other" race, as do 7% of Clark County residents. It is possible that these residents would classify themselves as Latino, which was a category not listed as an option to select within U.S. Census Bureau data.

More St. Rose service area residents have college degrees and advanced college degrees (15% and 5%, respectively) than Clark County residents (12% versus 4%, respectively), and the percent of individuals unemployed is smaller in the St. Rose area (13% versus 14% in Clark County) (see Table 1 in Appendix A). Approximately 11% of Clark County residents live below the Federal Poverty Level (FPL) (the FPL for a family of two living in Nevada in 2010 is $14,570; for a family of four it is $22,050). Twenty-nine percent of residents live below 200% of the FPL ($29,140 for a family of two; $44,100 for a family of four). Of the estimated 13,000 Clark County residents who are homeless, over half (53%) of these individuals live in emergency shelters and 23% live on the streets. About 25% of homeless individuals are considered to be "hidden" homeless, meaning that they are not officially identified as homeless but are presumed to be given local data trends.

Finally, the St. Rose service area has a similar rate of household linguistic isolation as Clark County. Approximately 8% of individuals residing in the St. Rose area and responding to the study's phone survey indicated that a language other than English was the primary language spoken in their home (see Table 1 in Appendix A). Likewise, U.S. Census Bureau data also identify about 7-8% of households in the St. Rose service area and Clark County, respectively, as linguistically isolated.

Appendix
E
Community Benefit Programs
Activity Detail

Other Programs

Baby Rose

Description: The Baby Rose program encourages early, continuous prenatal care by offering free services such as physician referral, childbirth education, prenatal vitamins, and referral to Nevada Welfare and WIC programs.

Objective: Prenatal care allows women and their health care providers to identify, and when possible, treat or correct health problems and health compromising behaviors that can be particularly damaging during the initial stages of fetal development. Increasing the number of women who receive prenatal care, and who do so early in their pregnancies, can improve birth outcomes and lower health care costs by reducing the likelihood of complications during pregnancy and childbirth.

Partners: Participating OB/GYN physicians, Nevada Welfare, Barbara Greenspun Womens*Care* Centers and WIC Nutrition Program.

Baseline/Goal: Assist 300 uninsured pregnant women in accessing affordable prenatal care and increase the number of pregnant women seeking and accessing prenatal care prior to third trimester. Improve knowledge of pregnancy health related issues and concerns and parenting skills through referral to community education and support resources, including Family to Family, Womens*Care* Centers and WIC.

Outcomes: **241 uninsured pregnant women participated in Baby Rose and received prenatal care. 143 pregnant women who did not have the ability to obtain prenatal vitamins were provided prenatal vitamins.**

Breastfeeding

Description: St. Rose is committed to protecting new mothers milk supply and the nutrition of the baby. According to the CDD, breastfeeding is beneficial to both mothers and their babies. Breast milk contains antibodies that can protect newborns from infections, and studies have found breastfed babies are less likely to become overweight than those fed with formula. As the only outpatient lactation center in the community, provide breastfeeding classes, support groups, phone support, individual consultations, inpatient rounding, pump rentals and specialty medical products to establish early and successful breastfeeding.

Objective: Increase the number of mothers who initiate breastfeeding within the first few hours of birth and continue at least 6 months. Maternity practices in hospitals throughout the intrapartum period, such as ensuring mother-newborn skin-to-skin contact, keeping mother and newborn together, and not giving supplemental feedings to breastfed newborns unless medically indicated, can influence breastfeeding behaviors during a period critical to successful establishment of lactation.

Partners: Nevada Breastfeeding Task Force, Medela, La Leche League, Staff Pediatricians, OB/GYNs, Barbara Greenspun Womens*Care* Centers and WIC.

Baseline/Goal: Work toward Baby Friendly designation by supporting the breastfeeding mother and baby. Reach new mothers with inpatient and outpatient programs. Create policies and procedures that support breastfeeding and provide training to all L&D staff on how to support the breastfeeding mother.

Outcomes: **1,240 Outpatient Lactation Consultations, 1,849 Phone Consultations, 1,276 breastpump rentals, 2,738 breastfeeding support group encounters, 374 prenatal breastfeeding class participants, 609 lactation weight checks. Completed Baby Friendly Training at San Martin and currently in the designation phase.**

Enrollment Assistance

Description: Assist individuals with a Financial Assistance Application Procedure – Medicaid and all other Las Vegas area programs. If not eligible for these programs forward information to St. Rose Charity Care Assistance. Also provide assistance with Cobra Payments for those who are unable to afford payment.

Objective: Assist individual to be eligible for Financial Assistance or to qualify for St. Rose Charity Care Program.

Baseline/Goal: To provide access to care for patients who have limited/no resources to pay for such care.

Outcomes: **1,590 individuals received assistance.**

Family to Family Connection

Description: Family to Family Connection provides parenting education, safety education and support services to families with young children up through age four. Services include classes, developmental assessments and referrals, car seat safety checks, resource lending library and referrals for additional support resources as needed. Support and education services specifically for teen parents are also provided.

Objective: Provide families with classes, resources and activities to answer questions about new baby care, parenting and discipline, child development, nutrition, health and safety. Through support and education, these services are designed to decrease child abuse and neglect, reduce childhood injuries, reduce health care costs, increase immunization rates and other objectives.

Partners: St. Rose Dominican Health Foundation, Barbara Greenspun Womens*Care* Centers of Excellence, SafeKids Coalition, WIC, HopeLink Family Resource Center, Henderson Libraries, St. Judes Ranch, Living Grace Home for Pregnant Teens, Storks Nest, Nevada Early Intervention Services, Three Square, Giving Life Mnistries, Southern Nevada Immunization and Health Coalition (SNIHC), Prevent Child Abuse Nevada

Baseline/Goal: Address health promotion, disease prevention and health protection activities through parent education and car seat safety inspections. Increase access to affordable health insurance through referral and assistance with NV Check Up application process. Provide 335 classes, 300 car seat safety checks and assist with the preparation and submission of NV Check Up applications for 36 uninsured children. Provide 3 teen childbirth classes and 4 teen parenting preparation classes.

Outcomes: **5,906 education encounters in 408 classes and 132 car seat safety checks; 32 NV Check-Up applications submitted; 5 teen childbirth classes and 4 teen parenting classes held.**

Fertility Care

Description: The Fertility Care program teaches Fertility Care to married couples attempting to achieve or avoid pregnancy.

Objective: Help women understand their fertility and assist infertile couples in achieving pregnancy. Provide infertility awareness and STD education to married couples and teens. Teach Fertility Care to married couples attempting to achieve or avoid pregnancy.

Partners: Diocese of Las Vegas, medical consultants, Spanish practitioners

Outcomes: **Reached 64 people with fertility education, consultations and follow-up.**

Fitness Programs

Description: Provide free and low cost fitness programs to the community. Incorporate mind, body and spirit into these programs and teach flowing body movements that create focus, balance, core strength, flexibility and emotional well being.

Objective: Encourage healthy lifestyles by staying active through every stage of life. Provide a core group of innovative programs that enhance various fitness levels.

Partners: St. Rose Cardiac Rehab and PT, City of Henderson Parks & Recreation, instructors

Baseline/Goal: Improve cardiovascular fitness, flexibility, strength and balance. Provide a supportive environment for women and men to engage in free/low-cost physical activity including walking club, Pilates, chair exercise, Ageless Woman Workout Osteoporosis Prevention, Healing Yoga, Beginner Yoga, Mixed Level Yoga, Vinyasa Flow Yoga, Beginner Tai Chi, Intermediate Tai Chi, Advanced Tai Chi, Zumba Latin Fitness, Belly Dancing, Prenatal Yoga, Mommy Baby Yoga, Dancing with Miss Jenny, Dragon Boat Beginner Paddling Workshops, Pink Paddlers Breast Cancer Floating Support Group, Advanced Paddling Clinics.

Outcomes: **Offered 32 different ongoing weekly exercise programs generating 16,150 encounters. 100% of participants reported improvements in fitness level, 97.6% improved balance, 98% improved flexibility, 95% improved strength, 100% improved mood and state of mind as well as motivation to make healthy lifestyle choices.**

Health and Wellness Programs

Description: 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.

Objective: Provide programs that increase health knowledge, reduce stress, enhance socialization and reduce isolation. Meditation programs have demonstrated a reduction in blood pressure and an increase in mood and feelings of well being.

Partners: American Cancer Society, Center for Compassionate Care

Baseline/Goal: Offer a core of ongoing wellness programs designed to offer physical and emotional benefits including: Girl Talk, Meditation, Labyrinth Walks, The Art of Assertiveness, Drum Circle, Knit to Heal, Balancing Energy Fields, Medicare ABCD's, Tea & Talk Book Club, Art Therapy, Positive Self Talk, Intention Collage.

Outcomes: **Reached 1,625 participants with classes.**

Health Conditions/Disease Management

Description: Chronic illness accounts for 70 percent of all health care expenditures in the US. Most chronic illness can be prevented through lifestyle changes. There is strong evidence that programs focused on disease management have a beneficial effect on physical and emotional outcomes and health related quality of life. Research points to a reduction in health care expenditures - fewer emergency room visits, hospitalizations and length of stay. Outpatient visit reductions and more appropriate utilization of healthcare resources are strongly correlated.

Objective: To improve the effectiveness and efficiency of the health care partnership

between the patient with a chronic condition and his/her health care team by motivating positive patient health behavior actions and changes. Provide educational resources and support to increase participant knowledge, confidence and skills. Emphasize the participant's role in managing illness.

Partners: American Cancer Society, Nevada Cancer Coalition, Southern NV Health District, American Stroke Association, Stanford, Arthritis Foundation, American Heart Association, City of Henderson Parks and Recreation and hospital physicians.

Baseline/Goal: Implement the Stanford "Living Healthy with Chronic Disease" Program. Provide a core curriculum of healthy lifestyle programs that impact all chronic disease – nutrition, exercise, stress reduction, smoking cessation, blood pressure management, cholesterol control and weight management. Provide monthly physician lectures on specific chronic diseases. Programs include: Arthritis, Alzheimer's, CHF, Smoking Cessation, Stroke, Hypertension, Diabetes Update, Vein Lecture, Colon Cancer, Cholesterol Control, Parkinson's Disease, Neuropathy, Eye Aging, Migraines, Heart Health, Food Allergies, Cancer Quality of Life, Breast Cancer Prosthesis Program.

Outcomes: **A total of 4,689 encounters. Freedom from Smoking Program quit rate of 60%. Ninety-four percent of participants reported an increase in knowledge because of this program. Ninety-four percent of participants reported they are motivated to make a healthy lifestyle change because of this program.**

Hispanic Outreach

Description: The Hispanic Outreach program is dedicated exclusively to the implementation of the Hispanic Outreach initiative by developing a Hispanic-friendly health care culture on behalf of St. Rose Dominican consisting of collaboration and referrals to hospital sponsored outreach programs.

Objective: Provide program activities to address health-related concerns of the Hispanic population, including youth and family classes focused on nutrition, injury prevention and general health. Provide the Stanford Chronic Disease Self Management and Diabetes Self Management program in Spanish. Participate in at least four outreach events such as health fairs and educational events. The Spanish Womens*Care* magazine will be provided to 25,000 Spanish-speaking homes people annually.

Partners: James I. Gibson Library in Henderson, Family to Family Connection, American Heart Association, Latin Chamber of Commerce, Caesars Foundation, Southern Nevada Health District, HopeLink, the Boulevard Mall, Southern Nevada Adult Day Care, Women Infants Children (WIC)

Baseline/Goal: Provide ongoing program activities targeted to Hispanic families, youth and adults coping which chronic health conditions. Participate in 4 health fairs, focusing on those aimed at reaching the Hispanic community; provide 8 Spanish health education classes, distribute 25,000 copies of the Spanish Womens*Care* Magazine to Spanish-speaking members of the community, focusing on places of employment and cultural community centers.

Outcomes: **2,488 total Hispanic encounters.**

Infants, Children & Parenting Programs

Description: Provide programs to enhance baby safety, early bonding, baby development and

parenting.

Objective: Support mothers and fathers in their new roles by providing classes and support groups. Outreach to moms of babies in the NICU, WIC moms and mothers of multiples.

Partners: NICU, Baby Rose, Family to Family Connection, Safe Kids Coalition

Baseline/Goal: Provide 12 ongoing programs each year and annual Baby Bonanza event.

Outcomes: **8,002 Encounters in classes and Baby Bonanza.**

Integrative Medicine

Description: Provide high quality, research based, integrative modality lectures and services to the community. Identify special program areas in which we focus such as hypnosis, herbology, massage, aromatherapy, reflexology, craniosacral massage, healing touch, acupuncture.

Objective: Educate the community about integrative medicine. Provide alternative types of treatment.

Partners: Area physicians, massage therapists, hypnotherapy providers, Healing Touch Spiritual Ministry, Acupuncture Providers, Herbologists.

Baseline/Goal: To provide quality research-based, integrative lectures to those in need. Provide programs based on changing needs and requests of our Community. Research, review and recruit appropriate providers in the areas of hypnosis, healing touch, etc.

Outcomes: **A total of 236 encounters in classes.**

Nutrition

Description: Sixty-three percent of U.S. adults are overweight or obese. Reduce overweight and obesity through education on proper nutrition guidelines – US Dietary Guidelines for Healthy Americans, American Heart Association, Stanford University Wellness Center and USDA. Manage or prevent chronic disease, cardiovascular disease, stroke and diabetes.

Objective: Provide programs based on scientific dietary guidelines for heart health, weight loss and balanced nutrition.

Partners: St. Rose Nutrition Services, UNLV Nutrition Department, UNR Nutrition Department, St. Rose Physicians

Baseline/Goal: Educate and motivate community about proper nutrition for managing or preventing chronic disease, overweight and balanced eating for proper nutritional needs. Offer a core of nutrition programs aimed at chronic disease – DASH, Cardiovascular Nutrition, Cholesterol Control, Diabetes, Nutrition 101, Carbs the New Evil, Hormones and You, Emotional Eating, Fire Up Your Metabolism and Weight Management Club. Demonstrate an increase in participant's knowledge and motivation to make a positive behavior change.

Outcomes: **A total of 830 encounters in nutrition programs.**

Pregnancy and Childbirth Classes

Description: Provide programs to improve birth outcomes focusing on high-risk and teen pregnancies as well as enhancing baby bonding and dad support skills. Classes are provided for all family members.

Objective: Promote healthy pregnancy through prenatal education classes and support. Provide programs to enhance baby safety, early bonding and development. Outreach to teens and at-risk mothers by providing scholarship programs.

Educate about the labor and birthing process, taking care of baby, shaken baby syndrome and coping mechanisms.

Partners: March of Dimes, Baby Rose Program, Clark County School District, Clark County Teen Pregnancy Prevention Coalition, Staff Pediatricians and OB/Gyn's

Baseline/Goal: Reach high risk moms; reach pregnant women concerning drugs, smoking and alcohol.

Outcomes: **A total of 3,436 expecting parents attended 214 classes. Ninety-nine percent of participants in childbirth classes reported that because of this program, they have more knowledge and feel more confident in their ability to prepare for the birth of their baby. Ninety-nine percent feel they are better able to communicate with their health care providers.**

Safety/Injury Prevention

Description: 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.

Objective: Reduce injury and accidental death rates in southern Nevada. Increase the number of properly installed car seats, number of people in the community who are able to provide CPR to those in need. Educate women about self defense and sexual assault. Implement fall prevention program. Improve senior driver safety.

Partners: American Heart Association, Safe Sitters, City of Henderson Police, Metro Police, AARP, Safe Kids coalition, Family to Family, Southern Nevada Health District, Southern Nevada Injury Prevention Partnership

Outcome: **Installed 312 Car Seats; 92 teens trained and certified in Safe Sitter (4 classes); 256 seniors graduated from the AARP Senior Driver Safety Program (18 classes); 903 new parents attended Baby Basics and Infant CPR (58 classes); 72 certifications in Heartsaver CPR (9 classes); 42 women trained in Sexual Assault Prevention (3 classes)**

Screenings

Description: Provide low or no cost medical and health screenings for the uninsured in our community to detect the early onset of illness and disease. Provide referrals to follow up care as needed.

Objective: Provide core groups of screenings through the Womens*Care* Centers and Community Outreach.

Partners: St. Rose Lab, Participating Physicians, St. Rose Radiology

Outcomes: **Provided 2,821 screenings open to the community. Sixty-eight PVD, 63 skin cancer, 79 eye, 474 blood pressure, 631 labs (lipid panel, glucose, HbA1c, PSA, T3&T4/TSH, liver), 72 Colorectal FIT Kits, 36 diabetic foot checks. 51% of participants in screenings were uninsured or underinsured.**

Senior Peer Counseling

Description: Nevada has one of the highest senior suicide rates in the nation. In response to this crisis, St. Rose implemented a Peer Counseling program for seniors that utilize the skills and life experiences of older adults in providing emotional support for people of similar ages and backgrounds. Carefully trained volunteers provide supportive counseling under the close supervision of mental health

professionals.

Objective: To reduce the senior suicide rate in Nevada by providing a needed free/low-cost option for seniors facing loneliness, chronic conditions and aging.

Partners: Division of Aging Services, Nevada Suicide Prevention Coalition

Outcomes: **18 Trained Counselors provided 906 counseling sessions for 57 clients.**

Support Groups

Description: Provide support to individuals working through the healing process. A study conducted by Spiegel, et al., determined that psychosocial intervention, in the form of support groups, has a positive effect on survival for patients.

Objective: Assist people suffering from various chronic diseases, addictions, illnesses, mental health issues and loss with support and a caring environment for sharing. Support groups are developed based on community needs.

Partners: Alcoholics Anonymous, Alzheimer's Association, St. Rose Hospice, St. Rose Palliative Care, Komen Foundation, Fibromyalgia Friends, American Cancer Society, MS Society, State of Nevada Suicide Prevention, Nevada Tobacco Users Helpline, St. Rose Diabetes Education Department, St. Rose Nutrition Services, Gamblers Anonymous, MS Society, St. Rose Maternal Child, Senior Peer Counselors

Outcomes: Provided 21 different support groups, 33 different meetings for a total of 16,369 encounters in FY13. **These support groups include: AA, AA for Women, Alzheimer's, Aphasia Lunch Bunch, Bereavement, Breast Cancer, Daughters without Mothers, Diabetes, Diabetes for Tykes & Tweens, Eating Disorder Recovery, Fibromyalgia Friends, Gamblers Anonymous, Infertility, Multiple Sclerosis, Narcotics Anonymous, Pediatric Seizure and Epilepsy, Stroke Club, Surviving Suicide, Sweet Peas NICU Parent Support, Transitions, Widow Support**

Transportation Assistance

Description: Transportation program for patients and families to enhance patient access to care including cabs, bus tokens, gas vouchers and other transportation services with a specific focus on vulnerable populations.

Objective: Health care support services are provided by the hospital to increase access and quality of care in health services to individuals, especially persons living in poverty and those in other vulnerable populations.

Baseline/Goal: Assist the uninsured and underinsured with transportation service.

Outcomes: **Over the course of the year, St. Rose Dominican assisted 227 individuals with both medical and residential transportation. In addition to assisting with medical transports and taxi transportation, over 227 24-hour bus passes were distributed to individuals in need.**

WIC Nutrition Program

Description: A nutrition program for women, infants and children under age 5 providing healthy food, nutritional counseling and education, breastfeeding counseling and breast pumps for low income families. This program provides federally-mandated nutrition services to improve the health of nutritionally and at risk low-income women, pregnant women, infants, and children.

Objective: Outreach to all low-income at risk women in our community

Partners: Nevada WIC, Barbara Greenspun Women's*Care* Centers and Family to Family

connection

Baseline/Goal: Reach 2,500 women, infants and children each year with ongoing services.

Outcomes: **2,893 clients enrolled in the program.**