2025 Community Health Implementation Strategy and Plan

Adopted October 2025

Neighborhood Hospitals - Blue Diamond, Centennial, North Las Vegas, Sahara, West Flamingo

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At-a-Glance Summary

Community Served	Dignity Health – St. Rose Dominican provides health services throughout Clark County. Clark County is the most populous county in Nevada, accounting for nearly three-quarters of the state's residents with a total population of 2,293,764. While Clark County's core population has increased in the last decade, its diversity has also increased. For example, Non-Hispanic white individuals no longer account for most of the population. Hispanic and Asian residents have larger shares of the population in Clark County than in the state of Nevada or in the United States.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs the hospitals intends to address with strategies and programs are: • Access to Care • Chronic Disease • Social Determinants of Health
Strategies and Programs to Address Needs	The hospital intends to take several actions and to dedicate resources to these needs, including: Access to care: Nevada Health Link & Medicaid Enrollment, Medicare Assistance Program, Helping Hands Program, GME Family & Internal Medicine Clinics, Engelstad Foundation RED Rose, Pathways Program, HIV Program, Patient Financial Assistance, Community Health Improvement Grants Chronic Disease: Diabetes Program, HIV Program, Innovative Heart Health, Cognitive Stimulation Therapy, Prevention Programs, Chronic Disease Self-Management Programs, Englestad RED Rose Breast Cancer Program, Pathways Program, Community Health Improvement Grants Social Determinants of Health (Housing, Transportation, Food Security): Helping Hands of Henderson, Roundtrip Transportation, Golden Grocery, Fruit & Vegetable RX Program, HIV Food Pantry, RED Rose Financial Support, Pathways, Emergency Housing, Community Health Improvement Grants

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

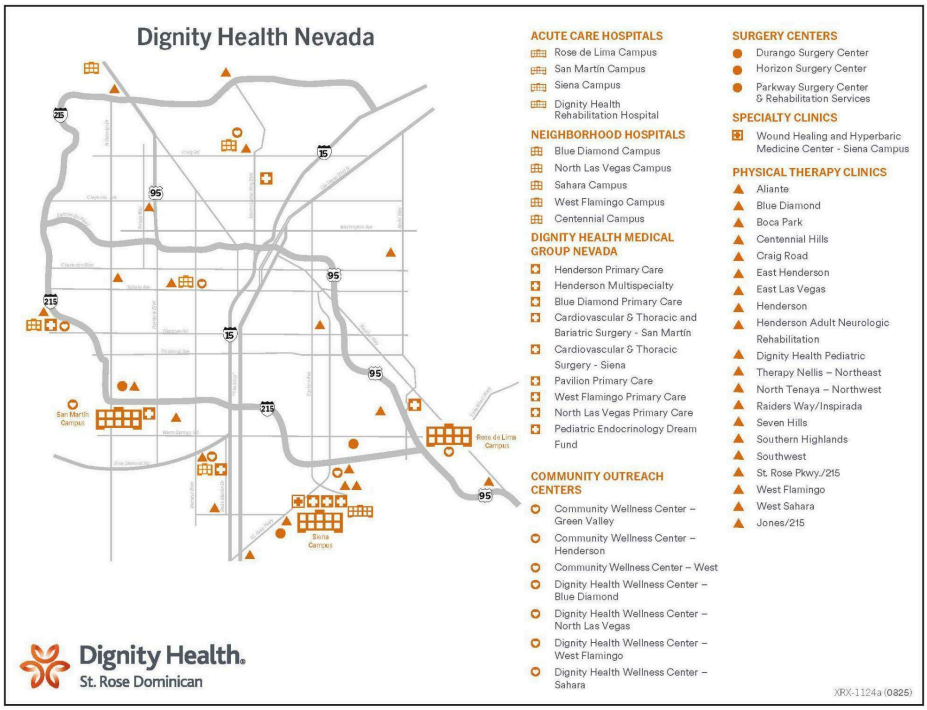
This document is publicly available online at the hospital's website. Written comments on this strategy and plan can be submitted to the Dignity Health - St. Rose Dominican Community Health Program at 2651 Paseo Verde Pkwy, Suite 180, Henderson, NV 89074 or by email to chna-strose@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

Dignity Health - St. Rose Dominican is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

Hospital Locations



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

Rose de Lima Campus on opening day, 1947

The Adrian Dominican Sisters arrived in Henderson, Nevada, the summer of 1947 to run what was then a small community hospital. Over the last 75 years, this small hospital began what has become a large multi-faceted healthcare system. Dignity Health - St. Rose Dominican now has three hospital campuses in the Las Vegas valley, with a total of 490 beds, more than 1,300 physicians, 200 volunteers and more than 3,500 employees.

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

The Rose de Lima Campus

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

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

The Siena Campus

The Siena Campus, the second and largest St. Rose Dominican Hospital in southern Nevada, opened its doors in a rapidly growing Henderson community in 2000. The 366-bed hospital is a Level 3 Trauma Center, operates a Level III Neonatal Intensive Care Unit, and is home to Henderson's only Pediatric Emergency Room and Pediatric Intensive Care Unit.

Among many honors and awards over the past two decades, U.S. News & World Report, the global authority in hospital rankings and consumer advice, recently

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

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

The San Martín Campus

The 30-acre San Martin Campus began providing care amidst the expansive residential growth of the southwest Las Vegas valley in 2006. The 118-bed facility provides 24-hour Emergency Department services, Diagnostic Imaging, Robotic Surgical Suites, Cardiac Catheterization and Electrophysiology Lab, Orthopedics, Cardiovascular and Neurologic Services. The San Martin surgical staff recently achieved accreditation as a Center of Excellence in Robotic Surgery and Metabolic and Bariatric Surgery by Surgical Review Corporation.

San Martin Hospital was also recognized by Healthgrades as a five-Star recipient for the Treatment of Sepsis and Heart Failure. In January 2023 the San Martin Campus was also included as one of only 101 U.S. hospitals on Money.com's first-ever Best Hospitals for Bariatric Surgery list.

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

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

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

Our Mission

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

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

Description of the Community Served

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

Community Demographics – Clark County
Total Population 2,293,764

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

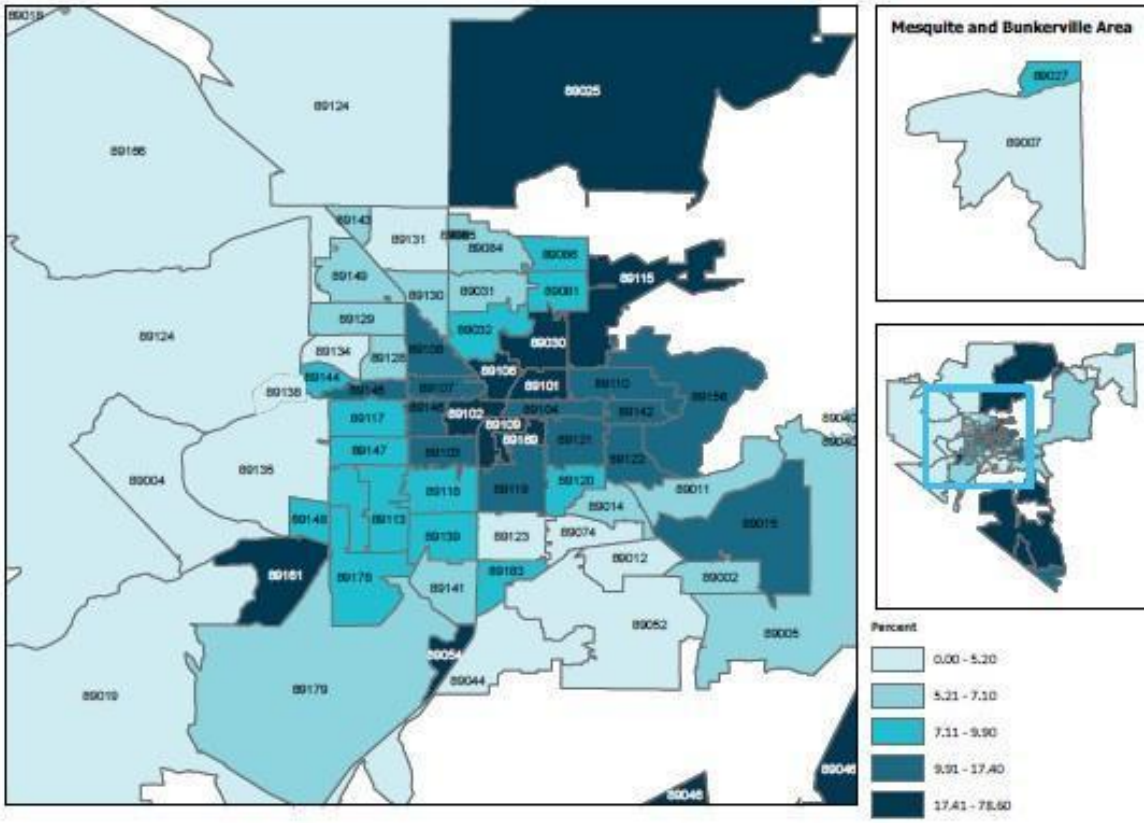
Median Household Income $73,845
% Below Poverty 9.87%
Unemployment 7.42%
No High School Diploma 13.19%
Medicaid 20.72%
Uninsured 12.07%

Clark County, Nevada is the southernmost county in the state. It is also the most populous county, and home to over 73% of Nevada residents. Clark County is primarily urban, especially when considering the Las Vegas metropolitan Area where the majority of the county's population resides. While some areas within Clark County may have suburban or even rural characteristics, the overall demographic and infrastructure of the county reflect a predominantly urban environment.

Clark County is the nation's 14th largest county that serves more than 2.9 million citizens and more than 46 million visitors a year. A key component of the county's economy is tourism, and among its largest industries are accommodation and food service, retail trade and health care and social assistance.

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

PERCENT OF FAMILIES BELOW POVERTY 2019-2023



Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to Care	Promoting health equity within access to care is important as everyone has the right to be healthy. Access to health care is essential for preventing and managing health conditions, reducing early death, and improving health and well-being. Limited access to healthcare can delay treatment, worsen health, and increase financial hardship which can exacerbate health disparities.	☑
Chronic Disease	Chronic diseases are long-lasting illnesses that persist over a long period of time and require on-going medical attention, limited activities of daily living, or both. Between 2016-2018, chronic diseases ranked consistently among the top ten causes of death in Clark County.	☑
Social Determinants of Health (Housing, Food Security, Transportation)	Social determinants of health are the conditions where we grow, live, work, and play. They include factors like income, education, housing, neighborhood environment, and access to healthcare. Addressing these determinants is key to reducing inequities and improving health outcomes across populations.	☑
Environmental Factors	The impacts of heat, based on the Heat Health Index are higher for Clark County. Extreme heat can lead to heat stroke, heat cramps, heat exhaustion, dehydration, and	☐

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

Significant Needs the Hospital Does Not Intend to Address

- Environmental Factors - limited resources
- Public Health Funding - continuing to advocate, but being addressed by other organizations
- Mental Health - continuing Mental Health First Aid and Senior Peer Counseling programs, but limited resources
- Substance Use - being addressed by other organizations in the community

2025 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.

Creating the Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

In partnership with the Southern Nevada Health District Community Health Improvement Plan Steering Committee, and over 30 community partners listed in the CHNA, we identified priorities and strategies to address these areas.

Hospital and health system participants included...

- Community Health Leadership Team
- Community Health Work Group
- Community Boards – Dignity Health, Emerus, Select Medical
- Mission Integration
- Care Coordination Team
- Health Equity Liaison
- Strategy/Planning
- GME Program
- Legislative Advocacy Committee & Director of Nevada Government Relations
- Dignity Health Foundation
- Community Health Improvement Grants Committee
- Dignity Health Medical Group

Community input or contributions to this implementation strategy included...

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

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

1. Existing Dignity Health programs with evidence of success/impact.

2. Researched effective interventions through meeting with key partners and began implementation of new programs.

3. Focused the Dignity Health Grants on the CHNA priorities to leverage the skills and capabilities of community partners.

4. Access to appropriate skills or resources.

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally-identified needs.

- **Core Strategy 1**: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- **Core Strategy 2**: Implement and sustain evidence-informed health improvement strategies and programs.
- **Core Strategy 3**: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs.

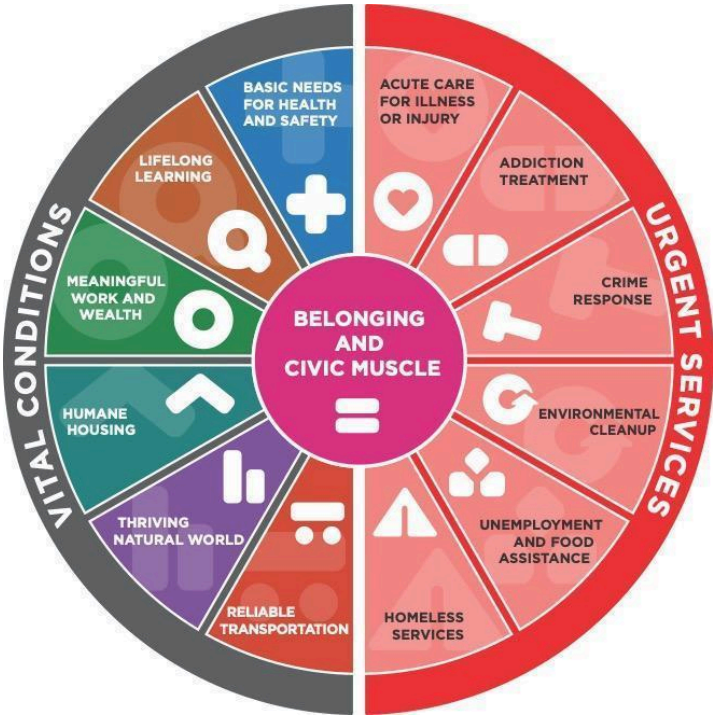
Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.



Well-Being Portfolio in this Strategy and Plan

The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.

This helps to identify the range of approaches taken to address community needs, and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[1] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation, and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need:	Access to Care				
Population(s) of Focus:	Families, low-income seniors, disabled, uninsured, undocumented				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Nevada Health Link & Medicaid Navigation	Enrollment assistance for uninsured individuals and families in Nevada Health Link plans and Medicaid. Total enrollments per year	☑	☑	☑	Basic Needs for Health & Safety (VC)
Helping Hands Transportation Program	Provide home-bound seniors with reliable transportation to doctor appointments, pharmacy, grocery and other needs. Total rides per year	☑	☑	☑	Reliable Transportation (VC)
Medicare Assistance Program	Free, unbiased, local help with: Comparing Medicare health or drug plans and exploring options; finding and applying for programs that help with Medicare costs; protecting, detecting, and reporting healthcare fraud, errors, and abuse. Total Medicare Beneficiaries Served	☑	☑	☑	Basic Needs for Health & Safety (VC)
Pathways Community Hub	Evidence-based model utilizing community health workers to address social determinants of health by following high risk individuals with 21 standardized Pathways such as employment, housing, transportation and access to medical care. Total Clients, Total Pathways Opened/Closed	☑	☑	☑	Basic Needs for Health & Safety (VC), Food Assistance (US), Reliable Transportation (VC), Humane Housing (VC), Meaningful Work (VC)

Health Need:	Access to Care				
Englestad Foundation RED Rose	Provides uninsured women and men access to breast health screenings including clinical breast exams, mammograms, ultrasounds, biopsies and breast surgery. Financial assistance is available to individuals diagnosed with breast cancer and undergoing treatment, including rent, utilities, food and transportation.	☑	☑	☑	Acute Care for Illness (US) Housing, Transportation (VC) & Food Assistance (US)
Internal Medicine Resident Clinic	The Internal Medicine Residents care for continuity patients in the outpatient setting. They will be the doctor of record for a panel of adult patients and provide all care for those patients under the supervision of an attending physician. Residents increase access to care for an under-resourced area in North Las Vegas. The IM Primary Care Track residents provide person-centered care to underserved patients, connect patients to resources to address social determinants that complicate their care, and volunteer and advocate for systemic change to address disparities	☑	☑	☑	Basic Needs for Health & Safety (VC)
Community Health Improvement Grants	Provide over $300,000 in grant funding per year to local non-profit partners who address identified health needs. Report grantees and funding amount in annual Community Benefit Plan & Report.	☑	☑	☑	VC & US Priority Areas
Patient Financial Assistance	Educate and inform patients and the community about our hospital's financial assistance policy.	☑	☐	☑	Acute Care for Illness or Injury (US)
Planned Resources:	The hospital will provide Enrollment Navigators, Medicare Counselors, Community Health Workers, inpatient and outpatient clinical services, Community Health Improvement Grants, 7 wellness centers, grant writer and program management support for these initiatives.				
Planned Collaborators:	The hospital will partner with Nevada Health Link, Catholic Charities, Lend a Hand of Boulder City, State of Nevada Dept of Welfare and Social Services, Nevada WIC, Aging and Disability Services, Fund for a Healthy Nevada, Regional Transportation Commission, Southern Nevada Health District, Libraries, Senior Centers, Local Churches, CARE Coalition, PACT Coalition, Nevada Health Centers, CARE Chest, Roseman University				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Enroll clients in health care programs	● Medicare Assistance Program (MAP) Clients ● Medicaid Enrollment ● Nevada Health Link (NHL) Enrollment	MAP Data Medicaid Data NHL Data
Provide clinical care to underserved clients	● GME Patients ● RED Rose Patients	GME Clinic RED Rose
Provide Navigation	● Pathways clients ○ Total Clinical Pathways Open/Closed ● Ryan White Case Management	Pathways Care Coordination Systems Database
Transportation to access care	● Helping Hands Rountrip Rides ● Ryan White HIV Rides ● RED Rose Rides & Gas Vouchers ● Pathways Rides	Roundtrip Data Helping Hands Rides

Health Need:	Chronic Disease				
Population(s) of Focus:	Minority populations - Spanish-speaking, African American, LGBTQIA, Seniors				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Diabetes	● National Diabetes Prevention Program (English and Spanish) ● Association of Diabetes Care & Education Specialists (ADCES) Accredited Program ●Diabetes Self-Management Program (English and Spanish) ●Medication Therapy Management	☑	☑	☑	Basic Needs for Health & Safety (VC)

Health Need:	Chronic Disease				
HIV	●Universal Testing for HIV, syphilis and Hep C at all 3 campus ERs ●Medical Nutrition Therapy ●Medication Therapy Management ●Medical Case Management ●Food Bank ●Psychosocial Support Group ●Health Education Classes for HIV Risk Reduction	☑	☑	☑	Basic Needs for health & Safety (VC), Food Assistance (US), Reliable Transportation (VC)
Innovative Heart Health	●Self-Measured Blood Pressure Program ●Eating for a Healthy Heart ●Fruit and Vegetable Prescription Program ●Healthy Heart Program ●Buena Salud Para Un Corazon Sano ●Pop-up Farmer's Stand	☑	☑	☑	Basic Needs for Health & Safety (VC)
Cognitive Stimulation Therapy	Group intervention for individuals with mild to moderate dementia. This evidence-based program reduces the progression of dementia.	☑	☑	☑	Basic Needs for Health & Safety (VC)
Prevention of Chronic Disease	●Enhance Fitness ●Stepping On Fall Prevention and Tai Ji Quan Movement for Better Balance ●Nutrition Education, Cooking Demos & Consultation ●Freedom from Smoking ●Other Fitness: Tai Chi, Bingocize, Yoga (Chair, Gentle, Mixed-Level, Vinyasa Flow), Walking Club, High Fitness, UpBeat Barre, Zumba	☑	☑	☑	Basic Needs for Health & Safety (VC)
Breast Cancer	Engelstad RED Rose Program provides uninsured women and men access to breast health screenings including clinical breast exams, mammograms, ultrasounds, biopsies and breast surgery. Financial assistance is available to individuals diagnosed with breast cancer and undergoing treatment. Assistance includes rent, utilities, food and transportation.	☑	☑	☑	Acute Care for Illness (US) Housing, Transportation & Food Assistance (VC)

Health Need:	Chronic Disease				
Chronic Disease Self Management Education	●Chronic Disease Self-Management Program ●Cancer Thriving & Surviving ●Chronic Pain Self-Management	☑	☑	☑	Basic Needs for Health & Safety (VC)
Pathways Community Hub	Evidence-based model utilizing community health workers to address social determinants of health by following high risk individuals with 21 standardized Pathways such as employment, housing, food security, transportation and access to medical care.	☑	☑	☑	Basic Needs for Health & Safety (VC), Food Assistance (US), Reliable Transportation (VC), Humane Housing (VC), Meaningful Work (VC)
Mental & Behavioral Health	●Senior Peer Counseling ●Powerful Tools for Caregivers ●Mental Health First Aid (Adult & Youth) ●safeTALK Suicide Alertness ●Support Groups – AA, NA, SMART Recovery ●Perinatal Mental Health Disorders (PMHD)	☑	☑	☑	Basic Needs for Health & Safety (VC)
Community Health Improvement Grants	Provide over $300,000 in grant funding per year to local non-profit partners who address identified health needs. Report grantees and funding amount in annual Community Benefit Plan & Report.	☑	☐	☑	VC & US Priority Areas
Patient Financial Assistance	Educate and inform patients and the community about our hospital's financial assistance policy	☑	☐	☑	Acute Care for Illness or Injury (US)
Planned Resources:	The hospital will provide nurse/registered dietitian certified diabetes educators, pharmacist, community health educators, fitness instructors, community health workers, Community Health Improvement Grants, 7 wellness centers, grant writer and program management support for these initiatives.				
Planned Collaborators:	The hospital will partner with Nevada Promise, State of Nevada, ADCES, CDC, QTAC, YMCA, Nevada Health Centers, Dignity Health Medical Group, Nevada Diabetes Stakeholder group, Comagine Health, Cardiac Rehab, Wound Care,				

Health Need:	Chronic Disease
	University of Nevada Cooperative Extension, Holy Family Catholic Church, North Las Vegas Church of Christ, Mexican and El Salvadoran Consulate REACH Program, Inpatient Case Managers/Dietitians, Physician groups-cardiology, nephrology, internal medicine, and optometry, College of Southern Nevada, Roseman School of Pharmacy, University of Nevada Las Vegas, Remnant Ministries, Nevada Diabetes Association, Touro University, College of Southern Nevada CHW Program, State of Nevada Department of Public and Behavioral Health, Aging and Disabilities Service Division, Ryan White Part A Program, Cleveland Clinic Lou Ruvo Center for Brain Health, OLLIE, City of Henderson Parks & Recreation, William N. Pennington Life Center, Nevada Health Centers, Volunteers in Medicine of Southern Nevada, Community Counseling Center, Aid Health Foundation, Southern Nevada Health District, Aid for AIDS of Nevada, The Center-LGBTQ, Huntridge Family Clinic, UMC Healthy Living Institute, UMC Wellness Center, Nevada AIDS Research and Education Society (NARES), Pacific AIDS Education and Training Center, Nevada Cancer Coalition

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Expand access to evidence-based programs to prevent, diagnose, educate and manage chronic disease	• HIV Diagnosis, case management, education, enrollment, MNT, Medication Management • Breast cancer screenings, diagnosis, treatment • Diabetes management, % reduction in A1c, pre-diabetes enrollment • Heart health education and enrollment • FVRX clients served • CST improvement in cognitive scores, quality of life and depression • Prevention fitness encounters, nutrition education, fall prevention and Freedom from Smoking • Pathways total clients, total open pathways and closed pathways • Mental health total program enrollment	Program reports, and as entered in community benefit system
Increase access to chronic disease management and prevention programs for minority groups	Total clients served based on demographics • Spanish-Speaking • African American • Native American	See program reports

Health Need:	Social Determinants of Health (Housing, Food Security, Transportation)				
Population(s) of Focus:	Women, Infants, Children, Seniors, Disabled, Pregnant Women, People with HIV and Chronic Conditions, underserved minority populations				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Helping Hands of Henderson	Provide homebound seniors with rides to medical appointments, grocery store, pharmacy and other needed services	☑	☑	☑	Reliable Transportation (VC)
Golden Grocery Food Deliveries	Supplemental food deliveries to low-income, homebound seniors.	☑	☑	☑	Food Assistance (US)
Pathways Community Hub	Evidence-based model utilizing community health workers to address social determinants of health by following high risk individuals with 21 standardized Pathways such as employment, housing, transportation and access to medical care.	☑	☑	☑	Basic Needs for Health & Safety (VC), Food Assistance (US), Reliable Transportation (VC), Humane Housing (VC), Meaningful Work (VC)
WIC Program	Provide Women, Infants and Children (WIC) with supplemental nutritious foods, breastfeeding support services, nutrition education and referrals to health and social services.	☑	☑	☑	Food Assistance (US)
Fruit & Vegetable RX Program	Underserved clients living with a chronic condition who experience barriers accessing fresh fruits and vegetables receive a “prescription” of fresh produce delivered to their door twice per month for six months.	☑	☑	☑	Food Assistance (US)
HIV Fresh Start	Offers carefully curated, dietitian-approved food bags and grocery	☑	☑	☑	Food Assistance

Health Need:	Social Determinants of Health (Housing, Food Security, Transportation)				
Pantry	vouchers. These ensure nutritious, sustainable selections to support the health of food-insecure and unhoused individuals.				(US)
Roundtrip Rides	Expanded our transportation services for clients with Roundtrip, a full-system solution that enables requests for rideshares (Uber, Lyft, taxis, door-to-door ambulatory vehicles, wheelchair-accessible vehicles and a stretcher with an ambulance). Scheduled rides to medical appointments and other services are coordinated through a transportation navigator.	☑	☑	☑	Reliable Transportation (VC)
Emergency Housing Program	Assist at-risk community members with securing housing or maintaining current housing to avoid eviction. Navigate existing programs and provide rental assistance.	☑	☑	☑	Humane Housing (VC)
Engelstad RED Rose Financial Assistance	Provides uninsured women and men access to breast health screenings including clinical breast exams, mammograms, ultrasounds, biopsies and breast surgery. Financial assistance is available to individuals diagnosed with breast cancer and undergoing treatment. Assistance includes rent, utilities, food and transportation.	☑	☑	☑	Acute Care for Illness (US) Housing, Transportation (VC) & Food Assistance (US)
Community Health Improvement Grants	Provide over $300,000 in grant funding per year to local non-profit partners who address identified health needs. Report grantees and funding amount in annual Community Benefit Plan & Report.	☑	☐	☑	VC & US Priority Areas
Planned Resources:	The hospital will provide drivers, vans, community health workers, food pantry, 7 outreach centers, Community Health Improvement Grants, grant writer and program management support for these initiatives.				
Planned Collaborators:	The hospital will partner with Aging and Disability Services Division (ADSD), Regional Transportation Commission (RTC), Fund for a Healthy Nevada, Three Square Food Bank, MGM Grand Resorts Foundation, Caesars Entertainment, Wells Fargo, Lend a Hand of Boulder City, Helping Hands of Vegas Valley, City of Henderson, HopeLink Family Resource Center, Brooke's Good Deeds, Catholic Charities, Living Grace Homes				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Provide transportation to underserved populations	• Total Helping Hands Clients & Rides • Total HIV client rides • Total Pathways rides • Total RED Rose rides & Total Gas cards • Total bus passes distributed	Program reports, and as entered in community benefit system Care Coordination Systems Reports
Provide Housing navigation and assistance for clients at risk of homelessness	• Total Emergency Housing clients served • Total RED Rose rental assistance • Total Pathways housing assistance Open/Closed	Program reports, and as entered in community benefit system Care Coordination Systems Reports
Increase Food Security access	• Total WIC Clients served monthly • Total Fruit & Vegetable Prescription clients and food deliveries • Total Golden Grocery clients and food deliveries • Total RED Rose grocery cards provided • Total Ryan White Food Pantry Clients • Total Ryan White grocery cards provided	Program reports, and as entered in community benefit system

Program Highlights

Helping Hands	
Significant Health Needs Addressed	☑ Access to Care ☐ Chronic Disease ☑ Social Determinants of Health
Program Description	Helping Hands of Henderson assists homebound individuals 60 years of age and older who live in Henderson with transportation to medical/dental/optical appointments, prescription drop off/pickup, grocery shopping, food pantry, congregate meals and social activities. Provide Golden Grocery food deliveries.
Planned Actions for 2025 – 2027	
Program Goal / Anticipated Impact	Assist in meeting the needs of seniors living in Henderson so they can remain independent in their homes thereby postponing the costly expense of assisted living. The program provides access to physicians, food, pharmacy and other needed services to allow the senior to maintain an independent and healthy life.
Measurable Objective(s) with Indicator(s)	Total unduplicated clients Total round trip rides Total active volunteers Total Golden Grocery Senior Food Bank Participants and deliveries As a result of Helping Hands Services, clients will report: o 100% able to access food o 95% were able to maintain medical appointments o 100% will report an increase in feelings of independence

Engelstad Foundation RED Rose	
Significant Health Needs Addressed	☑ Access to Care ☑ Chronic Disease ☑ Social Determinants of Health
Program Description	The RED Rose program provides free mammography, ultrasound, biopsy and surgical consultations for individuals 49 years and younger who are uninsured or underinsured. The bi-lingual Breast Health Navigator coordinates care from screening to treatment. Support services are also available, such as payment of monthly utilities, transportation costs, groceries, rent and other incidentals while healing from breast cancer.
Planned Actions for 2025 - 2027	
Program Goal / Anticipated Impact	Increase breast cancer screening rates to diagnose breast cancer as early as possible for uninsured and/or undocumented clients. Provide financial assistance for housing, food and transportation during cancer treatment

Measurable Objective(s) with Indicator(s)	Total Eligibility Screenings Total Clinical Breast Exams Total Mammograms Total Ultrasounds Total Biopsies Total Cancer diagnosis Total Breast Surgeries Total Temporary Financial Assistance Provided

Pathways Community Hub

Significant Health Needs Addressed	☑ Access to Care ☑ Chronic Disease ☑ Social Determinants of Health
Program Description	The Pathways Community HUB (PCH) program identifies individuals in the community who are at risk for poor outcomes, engaging them in the process to complete a comprehensive risk assessment, matching them with a Community Health Worker who is their Care Coordinator, assisting them in addressing all their risks through 21 Pathways. Pathways include: Adult Education, Developmental Referral, Employment, Food Security, Healthcare Coverage, Housing Pathway, Immunization Referral, Learning, Medical Home, Medical Referral, Medication Adherence, Medication Reconciliation, Medication Screening, Mental Health, Oral Health, Postpartum, Pregnancy, Social Service, Substance Use, Transportation

Planned Actions for 2025 - 2027

Program Goal / Anticipated Impact	The CHW will assist participants to access services and overcome barriers to address their risks and track outcomes. When risks are addressed through completed Pathways, participants can gain risk reduction, improved outcomes and reduce spending on healthcare.
Measurable Objective(s) with Indicator(s)	Total Participants Total Visits by CHW to address risk and coordinate care Total Pathways Opened Total Pathways Successfully Closed Total CHWs Trained in Pathways

HIV Program

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

Program Description	The Ryan White HIV program is designed to assist in meeting the needs of people, women, infants, children, and youth living with HIV. Our programs provide access and support for clinical care and support services including: medical case management, medical nutrition therapy, and medication therapy management. Provides supplemental groceries and nutrition supplements to low-income/homebound clients, home delivered meals, HIV management education, and peer support. Clinical hospital inpatient implementation includes a universal HIV, syphilis, and Hepatitis C screening for all patients 18 years old and older who need blood work. Patients who test positive for HIV will be connected to a patient/peer navigator for linkage to care. Comprehensive Prevention Services will be provided to those that test negative for HIV, but positive for syphilis.
Planned Actions for 2025 - 2027	
Program Goal / Anticipated Impact	Provide support, evidence based education, and expand access to core support services for people living with HIV so that they can maintain care, enrich their lives, and manage their health. Provide Ryan White Referral for individuals screened and diagnosed reactive living with HIV for wrap around services.
Measurable Objective(s) with Indicator(s)	Total Ryan White Part A Clients Enrolled Total Medical Nutrition Therapy Unduplicated Clients Total Medical Case Management Unduplicated Clients Total Food Bank/Home Delivered Meals Unduplicated Clients Total Health Education/Risk Reduction Unduplicated Clients Total Psychosocial Support Services Unduplicated Clients Total Medical Transportation Unduplicated Clients and Total Rides Total Outpatient Ambulatory Health Services Clients and Visits Total HIV, Syphilis, Hep C Screenings

Chronic Disease Prevention & Management Programs

Significant Health Needs Addressed	☑ Access to Care ☑ Chronic Disease ☑ Social Determinants of Health
Program Description	Expand access to evidence-based programs for prevention, education and self-management of chronic disease. Prevention programs include physical activity, nutrition, healthy food security and fall prevention. Disease management programs include Diabetes Lifestyle Center, Chronic Disease Self-Management Programs, Diabetes Prevention Program, Innovative Heart Health, Powerful Tools for Caregivers, Cognitive Stimulation Therapy for Dementia.
Planned Actions for 2025 - 2027	

Program Goal / Anticipated Impact	Fall Prevention: Provide Stepping On classes and Tai Ji Quan Movement for Better Balance classes across Clark County. Train additional leaders. Fitness: Provide over 20 Enhance Fitness classes per week at all 7 centers Fruit and Vegetable Prescription Program: Deliver fresh fruit and vegetables to people who are food insecure and living with a chronic disease twice a month for 6 months. WIC: Provide 5000 Women Infants and Children with healthy food, nutrition education and breastfeeding support Golden Grocery Deliveries (also reported in Helping Hands) deliver home-bound seniors healthy food. Nutrition Lectures and Cooking Demos: Provide quarterly nutrition lectures and cooking demos Medical Nutrition Therapy (MNT): Offer MNT with an RD for the community CDSME: Host leader training for CDSMP, DSMP, and CPSMP. Engage with new community partners and increased in-person workshops. Certify community advocates in the rural communities to be able to deliver CDSMP, DSMP, and CPSMP workshops. Continued to support the expansion and development of infrastructure to our partners throughout the state of Nevada. Innovative Heart Health: Expand reach into the African-American community through our partners to provide services to seniors living with hypertension and/or high cholesterol. Provide leader training for lay-leaders to provide the program in the community. Caregivers: Recruit potential PTC leaders for the training. Increase workshops and support groups offered to the underserved population.
Measurable Objective(s) with Indicator(s)	Total Workshops Total Leaders Total Fitness Classes and Fitness Encounters Total Diabetes Clinic Clients Total WIC Clients Total Fruit & Vegetable RX Clients and food deliveries Total Golden Grocery Deliveries Total Nutrition Education Encounters & Total MNT Consults