

FISCAL YEAR 2025 (JULY 2024-JUNE 2025)

# COMMUNITY IMPACT REPORT

Saint Alphonsus Regional Medical Center (SARMC)



**Saint Alphonsus**

A Member of Trinity Health

## Our **Community Impact** by the Numbers

**\$47,322,219 in IRS-defined Community Benefit**

**\$17,697,612 in Financial Assistance at Cost** (patient's co-pays, co-insurance, and deductibles for patients with incomes up to 400% of the Federal Poverty Level)

**\$12,484,237 in Unpaid Cost of Medicaid**

**\$17,140,370 in Community Benefit Programs**

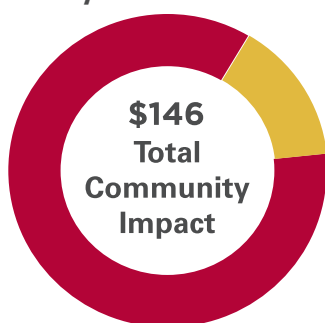
**\$99,025,182 in Community Impact Activities**

Community Impact meets the spirit of community benefit and acknowledges the investments made that are making an impact in the community that the IRS does not consider, such as unpaid cost of Medicare.

**\$939,087 in Community Contributions**

In our continuous commitment to building a healthier community, SARMC provided contributions to vital community-based initiatives that address a broad spectrum of needs related to the prioritized CHNA needs. Partners include, but are not limited to:

- Allumbaugh House, the Idaho Youth Ranch, and the Family Home Partnership Foundation provided critical housing and behavioral health support to individuals, including youth, experiencing housing insecurity and behavioral health and/or substance use needs.
- Ada County Victim Services Center, Family Advocates, Women's and Children's Alliance, and the Children's Home Society provided legal, behavioral health, healthcare, and other wraparound services to support women, children, and families throughout the county.
- Roundhouse Developers and the Idaho Community Foundation supported a pipeline of permanent supportive housing units in Ada County.
- Valley Regional Transit provided transportation to patients and community members with financial or healthcare needs to and from healthcare appointments as well as to obtain prescriptions, food, and other basic need items.



## Community Collaborations & Coalitions

SARMC is committed to being not only a trusted healthcare partner for life for our patients, but a partner in addressing the leading social influencers of health by working in collaboration with governmental agencies, community-based organizations, and service providers to assure we are helping our communities not just to survive but to thrive. SARMC plays an active role in community groups such as the Treasure Valley YMCA Board of Directors, Idaho Suicide Prevention Coalition, Boise Public Library Board of Trustees, Western Idaho Community Health Collaborative, FindHelp Idaho Steering Committee, and the Our Path Home Community Resource Committee.

## 2023 Community Health Needs Assessment and Implementation Strategy Priorities

A Community Health Needs Assessment (CHNA) identifies community assets, needs, and the current state of health and social well-being of a community. The process requires input from those who live in the community on both identifying and prioritizing the needs that will be addressed in the three-year Implementation Strategy. SARMC found these three needs to be the most significant in the 2023 CHNA:

- Safe, Affordable Housing
- Behavioral Health, Including Substance Use
- Access to Affordable Healthcare

For a more in-depth explanation of the CHNA and Implementation Strategy, visit: <https://qrco.de/bgP8cA>

## STORY SPOTLIGHT

The Tobacco Free Living program has expanded its community presence by conducting educational presentations in middle and high schools across Boise,

Meridian, Nampa and surrounding rural areas, in large part due to partnerships with the Saint Alphonsus School Nursing Team. A highlight for many students was the interactive demonstration using diseased pig lungs. This hands-on visual provides a compelling representation of the consequences of smoking and vaping, offering an engaging, evidence-based approach to prevention education.



# Community Impact at a Glance



## Integrating Social & Clinical Care

Each year we ask our patients about their health-related social needs. Questions include things that make it hard to be healthy like problems with work, housing, food, safety, and transportation. This information helps us:

- Understand our patients' needs and their barriers to care
- Connect patients to resources and services specific to their needs

**Last year at SARMC, nearly 73,000 patients seen in primary care settings were screened for social needs. Of those, nearly 24% of those screened identified at least one need. Top needs include:**



**Financial Insecurity**



**Social Isolation**



**Food Access or Food Insecurity**

## COMMUNITY RESOURCE DIRECTORY

### Need a little help?

Call (208) 367-4482 (4HUB)

Community Health Workers are available to assist in finding community resources in your area. Services are **free** to anyone.

Available 8am - 5pm Monday through Friday.



### Community Health Worker Program



## Key Community Initiatives

Community interventions are hospital-based services, programs, and activities that promote health and healing as a response to identified community needs. Some examples of our community interventions include:

**Community Health Workers (CHWs)** are trusted members of the community and work closely with patients by assessing their social needs, home environment and other social risk factors, and ultimately connect the patient and their family to services within the community. SARMC employs 10 CHWs as part of our care teams serving the Treasure Valley. In FY25, CHWs received nearly 1,100 referrals to assist patients with social needs and helped more than 1,200 patients successfully achieve their goals.

**Boise Family Center:** The Family Center provides a variety of services to patients and community members to ensure families get off to a great start. In FY25, the Family Center Food and Diaper Pantry distributed 74,352 diapers to 2,182 children. More than 13,000 individuals were provided with nearly 4,000 servings of food. The SARMC lactation consultants supported just shy of 3,000 new mothers and babies with support, providing outpatient follow up to 375 patients. The region's only hospital-based perinatal support counselors supported nearly 2,000 patients with their mental health needs. Outpatient dietitians saw nearly 1,500 patients for nutrition support. The team provided 192 families with car seat checks, held support groups for more than 1,500 individuals, and provided community education classes for more than 1,600 attendees between Boise and Nampa.

**School Nurse Program:** Saint Alphonsus has a long-standing partnership with the Catholic Diocese to provide nurses in the seven Treasure Valley Catholic Schools to support students, families and school staff in supporting the health and well-being of children. In FY25, the school nurse team had more than 14,000 office visits from students. They conducted nearly 1,500 screenings for vision, hearing, speech, etc. and provided nearly 1,400 students with health education on a variety of topics such as nutrition, dental care, tobacco prevention, etc.

## Support Your local CHWB Fund

Not all communities have equal opportunities to be healthy, or the same needs. That's where SARMC steps in and steps up. We do what is necessary to promote good health for everyone.

To make a donation, visit [Saint Alphonsus Boise Foundation - Donate Now - Alphonsus](#) and select "Community Health Initiatives" from the Designations drop down menu or by calling 208-367-2121.

# Community Impact at a Glance



**Tobacco Free Living Program** In FY25, the Saint Alphonsus Health System Tobacco Free Living program provided 1:1 tobacco- and vape-cessation coaching to nearly 500 patients. The program also offered 22 no-cost classes and delivered health-education sessions about the risks of tobacco and vaping at schools and community health fairs.

## STORY SPOTLIGHT

An oncology patient was referred to the Family Center Food Pantry while she was going through her treatments. She was living out of her van and needed a place to park it. In addition to giving her food, colleagues printed off applications for several mobile home parks who allow for long term placement and connected her with resources and hours for showering and clothing in the community. She came in weekly until her treatments were complete and reported consistent housing, improved health, and she had connected with resources who were helping her get back on track.



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