Community Health Needs Assessment Implementation Plan

San Luis Valley Health (SLVH) completed its Community Health Needs Assessment (CHNA) May 13, 2025. The following issues were identified as health priorities:

1) Access to Primary Care Services
2) Access to Specialty Care Services
3) Chronic Disease Prevention and Management
4) Behavioral and Mental Health Care Services
5) Assistance with Insurance Coverage and Enrollment

SLVH's Implementation Plan is aligned with SLVH's 2025-2026 Strategic Roadmap and reflects the recommendations identified during the CHNA. Recommendations were given through 145 community surveys and 50 key community stakeholders. Feedback encouraged SLVH to maintain current efforts and other (new) recommendations follow below, alongside the Implementation Plan and Strategy Map Tactics. (Several tactics cross-over multiple priorities.) SLVH intends to address all health priorities identified, which should contribute to optimal health outcomes for the San Luis Valley; therefore, no needs are excluded.

CHNA Priority	CHNA Implementation and SLVH Tactics	Resources	Community Partner(s)	Anticipated impact
Access to Primary Care Services	✔ Grow and sustain our workforce to deliver health care services. ✔ Improve use of technology to improve patient registration and admission, connection and communication through the patient portal and patient connect. ✔ Increase clinic visits, access, scheduling governance, pre-visit patient planning and use of registries, monitor capacity, promote expanded hours of operation. ✔ Increase use of telehealth to support means of access to services (behavioral health, medical, and therapy visits) and follow up. ✔ Improve and enhance patient experience. ✔ Develop a plan for a Patient Family Advisory Council	* Recruiting strategy and resources *Implementation of Rev Spring software to modernize and enhance admission process. * IT EMR enhancement workgroup to update workflows and enhance patient-facing modules for improved provider communication and scheduling functionality. * Project manager to support implementation of telehealth and remote patient monitoring (RPM) opportunities more robustly. Grant funding has been secured to develop additional RPM opportunities. * Patient Experience Coordinator to review Press Ganey reports and develop strategies for improved patient experience. * Quality and Safety team to facilitate a PFAC to garner direct	* SLVH to continue its partnership with Valley-Wide Health Systems Inc., Rio Grande Hospital, Common Spirit, and various universities to support rural physician residency students, in efforts to build workforce pipeline development and recruitment efforts. * SLVH to continue its partnership with the Attainment network to support workforce pipeline and certification supports for clinical staff that support primary care clinics.	* Increased availability of primary care appointments and improved patient access to timely services. * Improved patient registration, scheduling efficiency, and communication through enhanced use of technology. * Expanded access to care through telehealth and remote patient monitoring services. * Strengthened workforce pipeline to support long-term sustainability of primary care services in the region. * Increased utilization of preventative services through primary care and annual well visit services. * Improved chronic condition management through primary care services.

	(PFAC) to help gather ongoing patient feedback, recommendations, and consideration in service delivery.	feedback and implement strategies. * Clinic management development of customer service training and skill development.		
Access to Specialty Care Services	✔ Grow and sustain our workforce to deliver health care services. ✔ Improve use of technology to improve patient registration and admission, connection and communication through the patient portal and patient connect. ✔ Increase clinic visits, access, scheduling governance, pre-visit patient planning and use of registries, monitor capacity, promote expanded hours of operation. ✔ Increase use of telehealth to support means of access to services (behavioral health, medical, and therapy visits) and follow up. ✔ Improve and enhance patient experience.	* Recruiting strategy and resources *Implementation of Rev Spring software to modernize and enhance admission process. * IT EMR enhancement workgroup to update workflows and enhance patient-facing modules for improved provider communication and scheduling functionality. * Project manager to support implementation of telehealth and remote patient monitoring (RPM) opportunities more robustly. Grant funding has been secured to develop additional RPM opportunities. * Patient Experience Coordinator to review Press Ganey reports and develop strategies for improved patient experience. * Quality and Safety team to facilitate a PFAC to garner direct feedback and implement strategies. * Clinic management development of customer service training and skill development.	* SLVH to continue its partnership with the Attainment network to support workforce pipeline and certification supports for clinical staff that support specialty care clinics. * SLVH to continue its affiliation with Common Spirit to promote and access specialty services and outreach outside of the region, to include implementation of visiting specialists. * SLVH to continue its partnership with Children's Hospital to support outreach and implementation of visiting pediatric specialists.	* Increased access to specialty care services for residents of the San Luis Valley without the need for extensive travel outside the region. * Reduced wait times for specialty appointments through improved scheduling, expanded clinic capacity, and visiting specialist services. * Improved continuity of care and care coordination between primary and specialty providers. * Strengthened specialty workforce recruitment and retention efforts.
Chronic Disease Prevention and Management	✔ Assess and optimize use of current technology supporting all key aspects of care, reporting and analytics. ✔ Increase and promote wellness visits.	* IT to lead EMR enhancement to ensure workflows capture data accurately to develop usable reports to guide patient care and quality improvement. * Marketing strategy and patient education	* SLVH to continue its partnership with the Regional Health Connector to identify new and enhanced community-based resources to support social determinates of health and condition management.	* Improved identification and management of patients with chronic conditions through enhanced data reporting, registries, and care coordination. * Increased utilization of preventive and wellness visits to help identify

	✔ Improve provider quality metric performance ensuring delivery of evidence-based and best practice standards for primary and specialty care services. ✔ Continue social determinants of health screening to help identify patient needs for whole-person care. ✔ Conduct Lunch 'n Learns to educate the public on health care literacy, insurance coverage and enrollment opportunities, 5 Wishes, bereavement, and other topics. ✔ Improve infection control processes.	developed to promote well visits. * Development of a Quality Improvement committee within the clinics to review quality metrics and workflows to optimize patient outcomes. *Providers and staff to be re-trained on SDOH workflows and utilize care coordinators to connect patients to community resources. * Staff identified to present relevant patient and community education. * SLVH to continue to provide patients with care coordination and condition management supports through various programs. * Quality and Safety team have developed a safety committee that is reviewing infection control processes to implement improvements.	* SLVH to establish its partnership with Rocky Mountain Health Partners as it transitions to the new RAE to support community linkages, access to care, and chronic condition management. * SLVH to continue to host "community conversations" with relevant community partners to identify opportunities for enhanced clinic-community linkages, referrals, and shared patient care and outcomes. * SLVH to continue its contract with the Community Care Alliance to provide nurse care management to Medicare patients with chronic conditions and support for transitions of care.	ongoing health care needs. * Improved performance on quality measures related to chronic disease management and preventive care. * Increased patient knowledge of chronic disease prevention, self-management, and available community resources. * Improved infection prevention practices and patient safety outcomes. * Strengthened patient relationships that support whole-person care and address social determinants of health.
Behavioral and Mental Health Care Services	✔ Grow and sustain our workforce to deliver health care services. ✔ Increase use of telehealth to support means of access to services (behavioral health, medical, and therapy visits) and follow up.	* Utilize "grow your own" opportunities for supporting workforce pipeline opportunities, such as internships and apprenticeship opportunities. * Grant funding to support efforts toward education and licensure support. * Project manager to support implementation of telehealth opportunities more robustly.	* SLVH to continue its partnership with Adams State University to recruit and retain Counselor Education Master's internships. * SLVH to continue its partnership with the Attainment Network on workforce pipeline and access to education resources. * SLVH to continue its partnership, including grant-funded resources, with the National Council for Mental Wellbeing, to support unlicensed behavioral health clinicians in completing requirements to achieve licensure, which supports workforce pipeline, recruitment, and retention efforts.	* Increased access to behavioral and mental health services through workforce development and expanded telehealth capacity. * Improved availability of licensed and trained behavioral health providers in SLVH facilities or community partner services. * Reduced barriers to behavioral health care related to workforce shortages and geographic isolation. * Improved continuity of care and coordination between behavioral health and medical providers. * Enhanced long-term sustainability of behavioral health services through workforce pipeline development.

Assistance with Insurance Coverage and Enrollment	✔ Due to regulatory and staffing constraints, SLVH does not directly perform insurance enrollment services, but focuses on screening, education, and referral to the appropriate community partners. ✔ Standardize patient registration and insurance verification processes by implementing Rev Spring registration software to improve accuracy and expedite insurance verification. ✔ Utilize dedicated care coordinators and patient financial counselors to support patients in connecting with enrollment opportunities. ✔ Maintain collaboration with external agencies to connect patients with enrollment and benefit opportunities.	* Rev Spring registration software and supporting IT infrastructure. * Existing care coordination and patient financial counselors. * Clinic and registration staff time for standardizing workflows.	* SLVH continues to partner with the Department of Human Services to connect patients with enrollment and benefit opportunities.	* Increased identification of uninsured and underinsured patients. * Improved patient information/connection to insurance coverage and financial assistance programs. * Reduced barriers to accessing care due to lack of insurance. *Improved patient understanding of coverage options and payment responsibilities. * Improve the registration and verification processes across service lines.

The CHNA process allows SLVH to engage with our community and consider their feedback and recommendations regarding our service delivery. This remains one of the most important partnerships and collaborations to help us address the needs of the community, from the voice of the community.

Reviewed and accepted by SLVH's Governing Board June 26, 2025.

Karla Hardesty

Karla Hardesty, Governing Board Chair