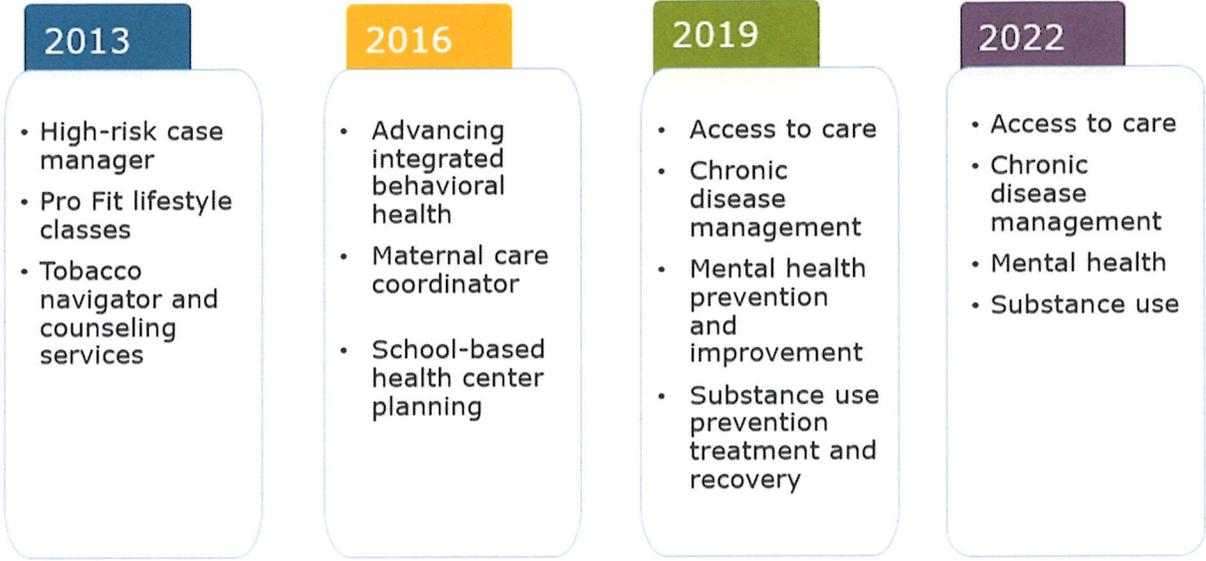


# 2025 CHNA Report

**Summary:** In partnership with the Colorado Health Institute (CHI), San Luis Valley Health (SLVH) has been on the Community Health Needs Assessment (CHNA) journey for several years. The community’s voice in establishing health care priorities impacts and informs the organization’s Strategy Map and the strategic priorities that help address community needs, demands, and the preservation of essential health care services. The graph below illustrates the priorities established since 2013 and how those priorities were addressed based on the 2022 CHNA.

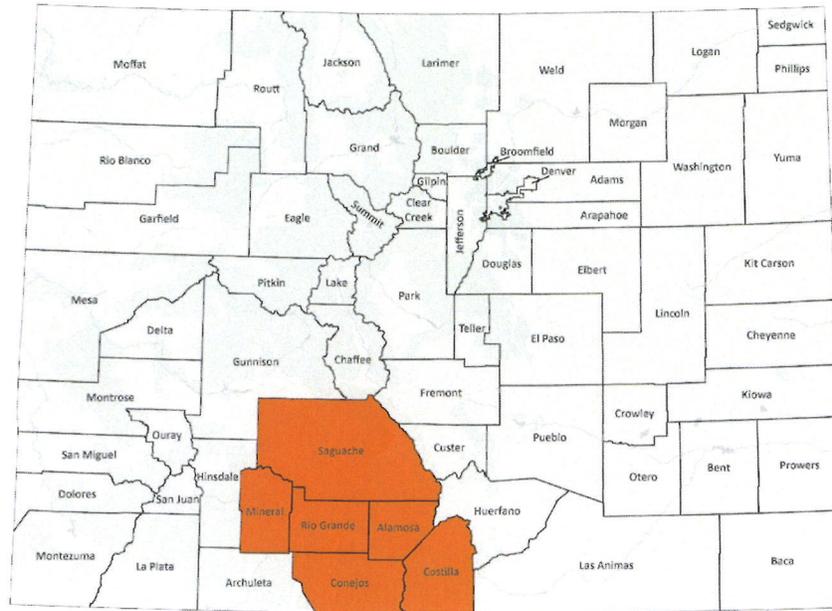


## Overview of Efforts to Address Health Needs Identified in the 2022 CHNA Report:

In 2022, four priority issues were identified: Access to Care, Chronic Disease Management, Mental Health Prevention and Improvement, Substance Abuse Prevention, Treatment and Recovery. Through the CHNA Implementation Plan, Hospital Transformation Program (HTP) measures were considered to align efforts when and where possible with identified community needs. Implemented in 2017, HTP was established under the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Act in concert with the Colorado Department of Health Care Policy and Financing. With its focus to improve patient outcomes through care redesign and integration with community-based providers, work plans align naturally and complement SLVH’s aim to maximize use of resources and effort. The table below shows the priorities that were established along with an Implementation Plan to address them:

Access to Care	Chronic Disease Management	Substance Use	Mental Health
<ul style="list-style-type: none"> <li>Increase in health fairs and events</li> <li>Expanded outreach efforts for wellness visits and check-ups</li> <li>Updated patient communication methods</li> <li>Workforce recruitment and retention</li> </ul>	<ul style="list-style-type: none"> <li>Increased education and outreach efforts</li> <li>Telehealth and remote patient monitoring</li> <li>Value-based payment and hospital transformation program involvement</li> <li>Updated staffing technology</li> <li>Updated lab testing</li> </ul>	<ul style="list-style-type: none"> <li>Behavioral health consultant and labor and delivery discharge planner</li> <li>New substance use disorder support groups and projects</li> <li>Medication-assisted treatment options</li> <li>New hospital-based care coordinator</li> <li>Participation in taskforces and trainings</li> </ul>	<ul style="list-style-type: none"> <li>Increased screenings and trainings such as mental health first aid</li> <li>Tele-behavioral health options</li> <li>Behavioral health consultant and labor and delivery discharge planner</li> <li>New programs (AcuDetox and Zero Suicide)</li> </ul>

**Community Defined:** SLVH serves the San Luis Valley (SLV), made up of the 6 counties in the region (Alamosa, Conejos, Costilla, Rio Grande, Saguache, and Mineral). The SLV includes a predominately agricultural, geographically isolated region in the state with limited healthcare access. Due to the vastness of the area, some patients must travel over an hour one way to access healthcare providers, with limited transportation resources. The region includes two of Colorado’s poorest counties, where 21.4% of residents live in poverty as compared to 9% statewide.



**Community Demographics** - The SLV’s diverse population is 45% Hispanic, Latino, or of Spanish descent, and includes a large population of indigent migrant farm workers during planting and harvest seasons. Additionally, the American Community Survey indicates that 25% of SLV residents are 65 or older.

- Between **8%-16%** are **uninsured** (compared with 8% statewide).
- Between **12%-29%** of San Luis Valley residents are covered through **Medicaid** alone (compared with 13% statewide).
- Between **22%-31%** have **employer-sponsored** insurance (compared with 49% statewide).

*Source: American Community Survey 2019 – 2023)*

**Health Needs of the Community, Including Primary and Chronic Disease Needs** - Residents of the SLV have elevated risks, including higher rates of obesity, diabetes, hypertension, tobacco use and high cholesterol. The region has some of the lowest health rankings and health factors in Colorado, based on life expectancy and quality of community life. Key health factors include health behaviors; access to quality clinical care; social and economic factors, such as education, employment, income, and community safety; and the physical environment, such as air and weather quality, housing, and transportation. SLVH’s Regional Medical Center (RMC) also serves communities facing significant mental health and substance use challenges. All six counties of the SLV are ranked as having some of the highest opioid-related overdoses in Colorado, and behavioral health-related emergency department visits are higher as compared to the rest of Colorado. (Colorado Health Institute data 2022, CO Behavioral Health Needs Assessment 2020).

**Existing Health Resources to Respond to These Needs and Gaps in Care** - Because resources are limited in this area of the state, SLVH has strong partnerships and collaborations with community partners to ensure services are not duplicated but optimized. This includes medical (such as Valley-Wide Health Systems, Inc., and Rio Grande Hospital), public health and health and human services spanning all 6 counties, Emergency Medical Service providers throughout the region, educational institutions spanning grade school to post-secondary and trade schools, multiple non-profits, including those that support child care, transportation, housing, food access, financial services, and city and county governmental contacts.

## SLVH's CHNA Process and Methodology:

*Overview* – SLVH and CHI engaged in a robust process to conduct the 2025 CHNA that involved three complimentary methods for data collection: Quantitative and Qualitative Data Collection, Community Engagement, and Strategic Planning. This included a process of **consulting representatives from the communities served** as well as surveying community members directly, ensuring the **broad interests of the community were included and accounted for** – all to **identify the current health needs and priorities** of the SLV. State agencies as well as local partners, including public health, city and county officials, schools and higher education, local government, healthcare partners, and consumer advocacy groups were invited to participate and encouraged to engage their constituents in the assessment process.



*Quantitative Data* – CHI analyzed over 70 secondary data indicators to assess local and regional barriers to care, health outcomes, health behaviors, social and health-related needs, demographics, income, insurance coverage, individualized care needs, and overall health status. Data sources included the Colorado Health Access Survey, the Behavioral Risk Factor Surveillance System, the American Community Survey, and the Community Assessment Survey for Older Adults.

*Community Survey* – In April 2025, SLVH developed and disseminated a survey to the broader community, to gather residents' perspectives on local health needs and priorities. The survey was available in English and Spanish and administered in both online and paper formats. A total of 145 community members responded, where 64% were given by community members, 16% health care workers, 63% who were between 25-54 years old, 47% white and 42% Hispanic/Latino, and 72% females, providing valuable insight into lived experiences and concerns.

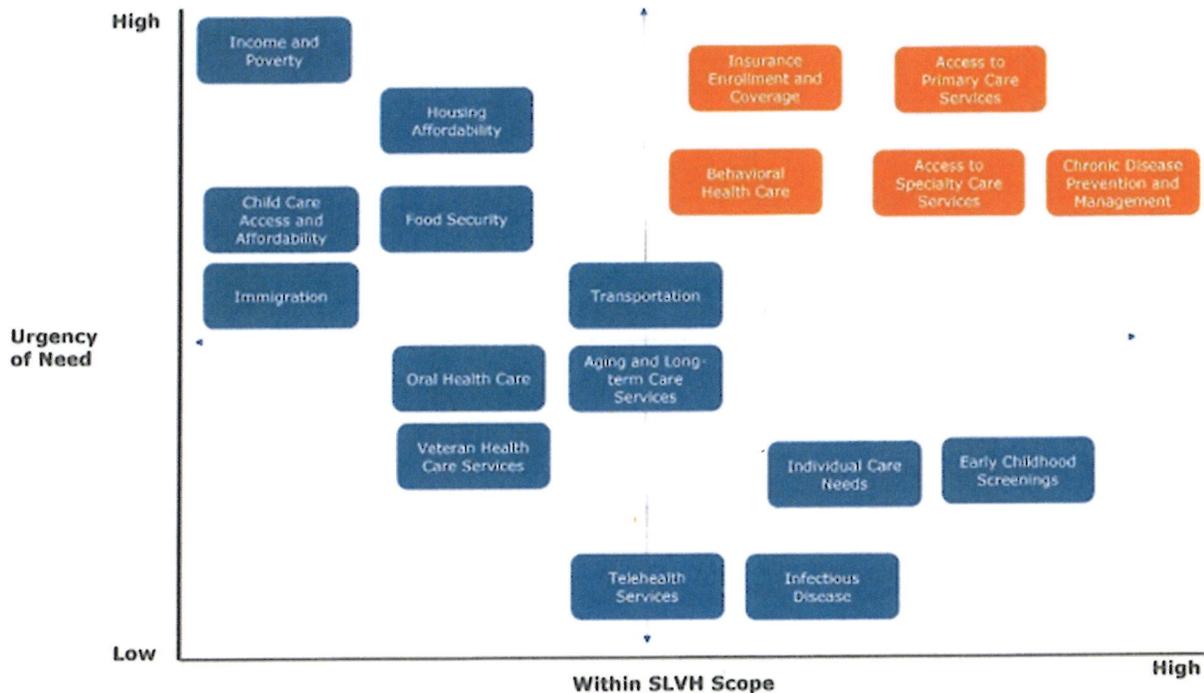
*Community Convenings* – CHI facilitated two hybrid community convenings in Alamosa, attended by approximately 50 local leaders and partners across both meetings. The first convening, held on April 2, gathered insights into pressing health issues and reactions to the initial data findings. The second, held on May 13, focused on refining SLVH's priority areas and collecting community-driven recommendations for action.

## Findings:

Please see **Appendix A** for a complete review of findings from the CHNA process, to determine the five health priorities listed below.

## Prioritized Description of Health Needs:

Through this process, CHI and SLVH identified several needs, with four health priorities identified from the preliminary data collection methods. Further discussion during the final convening resulted in a fifth priority, Assistance with Insurance Coverage and Enrollment due to the changes in health care plan availability, public options for care, and the population served.



## Impact of Actions:

SLVH intends to develop an implementation plan to address Access to Primary Care, Access to Specialty Care, Chronic Disease Management, Behavioral Health Services, and navigating insurance coverage options for those who are under/uninsured. Through the development of the FY26 strategy map, specific tactics will be identified to address each area of priority, with the intent that the SLV will:

- Enhance its utilization of preventative health service
- Enhance its utilization of available specialty services within the region, preventing the need for residents to travel out of the valley for care they can receive locally
- Prevent and improve chronic condition management through primary care prevention and early intervention as well as specialty care management
- Increase behavioral health resources through screening and detection, internal service delivery, and community linkages
- Assist under/uninsured residents with navigating options for healthcare coverage, leading to increased utilization of preventive and chronic care needs

## Available Resources

*Primary Care Access* – Recruitment efforts including onboarding and retention strategies; IT enhancements and software maximization; telehealth and other alternative visit resource supports; support staff to address patient experience, quality, and safety.

*Specialty Care Access* - Recruitment efforts including onboarding and retention strategies; IT enhancements and software maximization; telehealth and other alternative visit resource supports; support staff to address patient experience, quality, and safety.

*Chronic Disease Management* - IT enhancements and software maximization; Development of patient education and outreach efforts and materials; Development of a Quality Improvement committee to review patient outcomes and enhance standards of care; Enhancement of screening for social determinants of health, including linkages to community resources for condition management and social supports; improved quality and safety initiatives.

*Behavioral Health Services* – Continued partnerships with local higher education, workforce pipeline, and grant-funded initiatives that support recruitment, licensure, and retention of behavioral health staff.

*Health Coverage Navigation* - IT enhancements and software maximization; Utilization of care coordination and in-house patient financial counselors to enhance access to screening and connecting to resources.

## Conclusion:

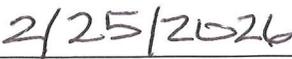
The 2025 CHNA offers a view of the SLV's regional health and healthcare landscape. It highlights strengths and opportunities across the region. SLVH has demonstrated its deep commitment to listening to its community, acting on shared priorities, and working collaboratively to address complex health and social needs. This report provides clear guidance to build on that foundation.

## Approval:

The SLVH Board of Trustees approves the priorities and findings identified in the 2025 Community Health Needs Assessment.

  
\_\_\_\_\_

Board President

  
\_\_\_\_\_

Date

(Approved through  
consent calendar  
approval 6/26/2025.)

# 2025 CHNA Report: Appendices

## Appendix A – Detailed report on Findings from Data Sources

### Chronic Disease Prevention and Management

#### Findings

Residents of the SLV experience disproportionately high rates of chronic illness when compared with other counties in Colorado, and many would benefit from additional prevention and disease management services. Counties in this region have higher rates of diabetes (11% regionally compared with 8% statewide), high blood pressure (32% regionally compared with 26% statewide), and high cholesterol (35% regionally compared with 31% statewide).<sup>1</sup> In the community survey, 65% of respondents listed chronic illness as one of the most pressing health concerns. Conditions such as diabetes, hypertension, and obesity were frequently cited as reasons why respondents rated their community as “unhealthy.” Mortality rates for chronic diseases — like heart disease, cancer, and lower respiratory illness — are higher in the SLV than elsewhere in Colorado.<sup>2</sup>

### Access to Primary Care Services

#### Findings

Accessing primary care is challenging for many residents. According to the Colorado Health Access Survey, about one in five people in the SLV (19%) did not visit a doctor in 2023, and community members believe this number may be rising due to the Medicaid continuous eligibility unwind, which was triggered by the end of COVID-19 public health emergency, and ongoing access to care barriers.<sup>3</sup>

Cost is a major challenge in accessing primary care. More than half of community survey respondents (61%) said out-of-pocket costs were a substantial barrier to getting needed health care, and nearly one in 10 residents said that they skipped seeing a doctor due to cost in the past year.<sup>4</sup> Many community respondents who rated their community as “unhealthy” cited these barriers, explaining that people often delay care because it is too expensive and wait until they are very sick before seeking treatment.

Service availability is another major barrier to care. Nearly one in 10 residents in the valley (9%) were not able to find a doctor who was accepting new patients.<sup>5</sup> Additionally, most older adults (73%) said that the availability of affordable physical health care is fair or poor in the region and about a third said getting the health care they need is a problem (32%).<sup>6</sup>

Many survey respondents reported that there are not enough primary care providers in the community and that many health care settings have limited hours. More than one in three (36%) said they would like to see additional primary care services made available. Local leaders and partners said that some people who use the emergency department do not see or do not have a usual primary care provider.

## Access to Specialty Care Services

### Findings

SLV residents reported that they have limited access to needed specialty care services. Nearly four in 10 community survey respondents said they do not have access to specialty care and that the community needs additional specialty care services. This challenge is common in rural communities, where service lines must be supported by levels of demand that rural hospitals often cannot meet.

While 41% of residents visited a specialist in 2023, many likely had to travel outside of their community to do so.<sup>7</sup> Locals said they often travel long distances to Salida, Colorado Springs, or Pueblo to access services such as pulmonology, endocrinology, nephrology, and neurology. And when services are available, cost barriers remain. More than one in 10 residents in the valley (12%) said they did not get specialty care due to cost in 2023.<sup>8</sup>

## Insurance Coverage and Enrollment

### Findings

SLV residents are often uninsured or have public insurance. Depending on the county, between 6% and 16% have no coverage (compared with 8% statewide), and 12% to 33% are insured through Medicaid (compared with 13% statewide).<sup>9</sup>

People with Medicaid or no health insurance coverage often face added barriers accessing health care due to high costs and limited service availability. In 2023, about 12% of residents didn't get care they needed in the past year because their insurance wasn't accepted.<sup>10</sup> This was echoed by the community survey, where 19% of respondents said their insurance was not accepted by a provider. Additionally, people without insurance were over twice as likely to not get care (50%) compared with those with insurance (22%).<sup>11</sup>

Local leaders and partners said the effects of the Medicaid unwind are still unfolding. Some residents were disenrolled after exceeding income eligibility requirements, while others lost coverage because they did not complete the recertification process. Many community advocates are also concerned about ongoing federal disruptions and anticipated funding cuts to Medicaid.

Without insurance, people may delay needed care or visit emergency departments, which are more expensive, and costs are absorbed through the hospital's charity care program.

## Behavioral Health Care

### Findings

Residents in the SLV have unmet behavioral health needs. Most community survey respondents said substance use (71%) and behavioral and mental health issues (59%) were the most pressing issues in the community.

About one in four adults (27%) reported poor mental health in 2023, and 23% of youth reported feeling depressed in the past year.<sup>12, 13</sup> Additionally, the region has a very high drug overdose death rate, ranging between 61-225 deaths per 100,000 people depending on the county, compared with the state rate of 31 per 100,000.<sup>14</sup> Yet getting needed substance use and mental health care is a challenge for many in the region.

Many community survey respondents said the community would benefit from more substance use services (54%) and mental health care services (50%), especially to address issues related to appointment availability. Just under half of all residents (43%) who needed but didn't get behavioral health care reported that they couldn't get an appointment.<sup>15</sup>

## Additional Findings

In addition to the findings noted in priority areas, many community health and social topics emerged. These are important for SLVH to recognize and monitor, though this assessment does not include recommendations specific to these areas. SLVH can develop or strengthen community partnerships to help address these health challenges.

### Food Security

Many SLV residents experience food insecurity challenges, which may be associated with the region's high rates of chronic diseases. At least one in eight residents are food insecure, with the highest rates being in Alamosa (18%) and Costilla (19%) counties.<sup>16</sup> Rates are higher for Hispanic or Latino residents, more than one in four of whom report food insecurity.<sup>17</sup> Most food insecure people in each of the six counties are eligible for the Supplemental Nutrition Assistance Program, and the region has an enrollment rate more than double the state average.

### Housing

Housing affordability is a challenge for many SLV renters and homeowners. Nearly half of renters and about a third of homeowners spend at least a third of their income on housing.<sup>18</sup> The limited availability of affordable housing is likely to impact the hospital's ability to attract and retain staff.

### Child Care

Access to affordable child care is an ongoing problem for SLV families. Many residents spend 22% to 37% of their incomes on child care needs.<sup>19</sup>

Significant swaths of the SLV are designated as child care deserts, meaning there are not enough care providers to meet community needs.<sup>20</sup> Local leaders and partners emphasized that this growing child care crisis deserves greater attention and coordinated action.

### Oral Health Care

SLV residents have limited access to oral health services. They are less likely than Coloradans overall to report they have dental insurance (71% versus 81%) and less likely to have visited a dentist in the last year (63% versus 74%).<sup>21</sup> Over 40% of community survey respondents said they do not have access to dental health care when they need it. At the community convening, one resident noted that many dentists in the area require an out-of-pocket payment up front, which creates an additional barrier for those without the means to pay and seek reimbursement later.

One in three residents (33%) said their oral health is fair or poor.<sup>22</sup> Poor oral health is often a precursor for other chronic health conditions.<sup>23</sup>

## **Income and Poverty**

Many people in the SLV do not earn a living wage — the income required to meet an individual or family's basic needs — which can make it hard to pay for medical care, food, and housing.

At least half the region is not making enough annually to meet their basic needs. Depending on the county, between 48% and 66% of the population earns an income below 300% of the federal poverty level (\$96,400 for a family of four), yet a family of four in this area would need anywhere from \$96,796 to \$139,761 to meet their basic needs such as child care, food, health care, housing, internet and phone, transportation, and other necessities.<sup>24, 25, 26</sup>

## **Individualized Care**

People in the SLV have specific needs that are not always being met by health providers. Nearly one in ten residents (9%) said they needed health care that is responsive to a particular need or part of their identity.<sup>27</sup> About a third of these residents (30%) said health care providers were not meeting those individual needs.<sup>28</sup>

These findings are underscored by the community survey, where 23% of respondents said they do not have access to a provider that understands their community's needs.

## **Aging and Long-Term Care**

The San Luis Valley's growing population of older adults faces unmet aging and long-term care needs. Every county in the region is expected to see an increase in residents 65 and older between 2013 and 2033, raising concerns that current services and infrastructure may fall short.<sup>29</sup> A large majority of older adults (82%) rated the availability of long-term care options in their community as fair or poor.<sup>30</sup>

Community members expressed concern about how to meet these needs, especially amid potential federal cuts to Medicaid, which covers long-term care services that Medicare does not. Local leaders noted that about 70% of nursing home residents rely on Medicaid, many of whom previously worked low-wage jobs and cannot afford care on their own.

## **Transportation**

Transportation remains a persistent challenge in the SLV and is often a barrier to accessing health care. Community members emphasized the need for greater awareness of available transportation services. Community members noted that, while Medicaid-covered transportation is available to help residents get to medical appointments both within the region and along the Front Range, these services are underused by those who need them. Additionally, Medicare beneficiaries have very limited transportation options. Although the local Area Agency on Aging offers some services, many residents are unaware that these supports exist.

## Appendix A – Citation of Sources

- <sup>1</sup> Colorado Department of Public Health and Environment. Colorado Behavioral Risk Factor Surveillance System. (2019-2023) <https://cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/behavioral-risk-factor-surveillance-system>
- <sup>2</sup> Colorado Department of Public Health and Environment. Colorado Health Information Dataset. Death Statistics. (2020-2023) <https://cdphe.colorado.gov/colorado-death-statistics>
- <sup>3</sup> Colorado Health Institute. 2023 Colorado Health Access Survey. (2023) <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2023>
- <sup>4</sup> Colorado Health Institute. (2023)
- <sup>5</sup> Colorado Health Institute. (2023)
- <sup>6</sup> Colorado Association of Area Agencies on Aging. Community Assessment Survey for Older Adults. South-Central Colorado Seniors Inc. (2022) <https://www.c4a-colorado.org/wp-content/uploads/2022/10/CASOA-South-Central-Colorado-Seniors-Inc.pdf>
- <sup>7</sup> Colorado Health Institute. (2023)
- <sup>8</sup> Colorado Health Institute. (2023)
- <sup>9</sup> United States Census Bureau. American Community Survey, 2023: ACS 5-Year Estimates. (2023) <https://data.census.gov/>
- <sup>10</sup> Colorado Health Institute. (2023)
- <sup>11</sup> Colorado Health Institute. (2021-2023)
- <sup>12</sup> Colorado Health Institute. (2023)
- <sup>13</sup> Colorado Department of Public Health and Environment. Healthy Kids Colorado Survey. (2023) <https://cdphe.colorado.gov/healthy-kids-colorado-survey-information/healthy-kids-colorado-survey-dashboard>
- <sup>14</sup> Colorado Department of Public Health and Environment. Drug Overdose Statistics. (2020-2023) <https://cdphe.colorado.gov/colorado-drug-overdose-statistics>
- <sup>15</sup> Colorado Health Institute. (2023)
- <sup>16</sup> Feeding America. Map the Meal Gap. (2023) <https://map.feedingamerica.org/county/2023/overall/colorado>
- <sup>17</sup> Feeding America. (2023)
- <sup>18</sup> United States Census Bureau. (2023)
- <sup>19</sup> County Health Rankings. The Living Wage Institute. Small Area Income and Poverty Estimates. (2024) <https://www.countyhealthrankings.org/health-data/county-health-rankings-measures>
- <sup>20</sup> University of Minnesota. Child Care Deserts. (2014-2018) <https://childcaredeserts.org/>
- <sup>21</sup> Colorado Health Institute. (2023)
- <sup>22</sup> Colorado Health Institute. (2023)
- <sup>23</sup> National Association of Dental Plans. Oral and Overall Health. (2024) <https://www.nadp.org/about-dental-plans-care/oral-overall-health/>
- <sup>24</sup> Living wage data sourced from the Living Wage Institute via <https://livingwage.mit.edu/> Accessed February (2025).

<sup>25</sup> United States Census Bureau. (2023)

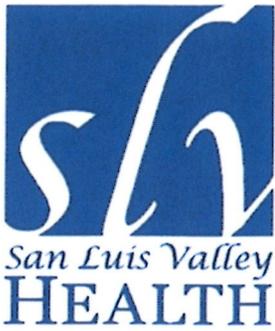
<sup>26</sup> Department of Health and Human Services. Poverty Guidelines 2025. (2025)  
<https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

<sup>27</sup> Colorado Health Institute. (2023)

<sup>28</sup> Colorado Health Institute. (2023)

<sup>29</sup> Colorado State Demography Office. Forecasted population estimates. (2013-2033)  
<https://demography.dola.colorado.gov/>

<sup>30</sup> Colorado Association of Area Agencies on Aging. (2022)



# 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
<b>Access to Primary Care Services</b>	<ul style="list-style-type: none"> <li>11 Grow and sustain our workforce to deliver health care services.</li> <li>11 Improve use of technology to improve patient registration and admission, connection and communication through the patient portal and patient connect.</li> <li>11 Increase clinic visits, access, scheduling governance, pre-visit patient planning and use of registries, monitor capacity, promote expanded hours of operation.</li> <li>11 Increase use of telehealth to support means of access to services (behavioral health, medical, and therapy visits) and follow up.</li> <li>11 Improve and enhance patient experience.</li> <li>11 Develop a plan for a Patient Family Advisory Council</li> </ul>	<ul style="list-style-type: none"> <li>* Recruiting strategy and resources</li> <li>*Implementation of Rev Spring software to modernize and enhance admission process.</li> <li>* IT EMR enhancement workgroup to update workflows and enhance patient-facing modules for improved provider communication and scheduling functionality.</li> <li>* 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.</li> <li>* Patient Experience Coordinator to review Press Ganey reports and develop strategies for improved patient experience.</li> <li>* Quality and Safety team to facilitate a PFAC to garner direct</li> </ul>	<ul style="list-style-type: none"> <li>* 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.</li> <li>* SLVH to continue its partnership with the Attainment network to support workforce pipeline and certification supports for clinical staff that support primary care clinics.</li> </ul>	<ul style="list-style-type: none"> <li>* Increased availability of primary care appointments and improved patient access to timely services.</li> <li>* Improved patient registration, scheduling efficiency, and communication through enhanced use of technology.</li> <li>* Expanded access to care through telehealth and remote patient monitoring services.</li> <li>* Strengthened workforce pipeline to support long-term sustainability of primary care services in the region.</li> <li>* Increased utilization of preventative services through primary care and annual well visit services.</li> <li>* Improved chronic condition management through primary care services.</li> </ul>

	(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.		
<b>Access to Specialty Care Services</b>	<p><b>11</b> Grow and sustain our workforce to deliver health care services.</p> <p><b>11</b> Improve use of technology to improve patient registration and admission, connection and communication through the patient portal and patient connect.</p> <p><b>11</b> Increase clinic visits, access, scheduling governance, pre-visit patient planning and use of registries, monitor capacity, promote expanded hours of operation.</p> <p><b>11</b> Increase use of telehealth to support means of access to services (behavioral health, medical, and therapy visits) and follow up.</p> <p><b>11</b> Improve and enhance patient experience.</p>	<p>* Recruiting strategy and resources</p> <p>* Implementation of Rev Spring software to modernize and enhance admission process.</p> <p>* IT EMR enhancement workgroup to update workflows and enhance patient-facing modules for improved provider communication and scheduling functionality.</p> <p>* 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.</p> <p>* Patient Experience Coordinator to review Press Ganey reports and develop strategies for improved patient experience.</p> <p>* Quality and Safety team to facilitate a PFAC to garner direct feedback and implement strategies.</p> <p>* Clinic management development of customer service training and skill development.</p>	<p>* SLVH to continue its partnership with the Attainment network to support workforce pipeline and certification supports for clinical staff that support specialty care clinics.</p> <p>* 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.</p> <p>* SLVH to continue its partnership with Children's Hospital to support outreach and implementation of visiting pediatric specialists.</p>	<p>* Increased access to specialty care services for residents of the San Luis Valley without the need for extensive travel outside the region.</p> <p>* Reduced wait times for specialty appointments through improved scheduling, expanded clinic capacity, and visiting specialist services.</p> <p>* Improved continuity of care and care coordination between primary and specialty providers.</p> <p>* Strengthened specialty workforce recruitment and retention efforts.</p>
<b>Chronic Disease Prevention and Management</b>	<p><b>11</b> Assess and optimize use of current technology supporting all key aspects of care, reporting and analytics.</p> <p><b>11</b> Increase and promote wellness visits.</p>	<p>* IT to lead EMR enhancement to ensure workflows capture data accurately to develop usable reports to guide patient care and quality improvement.</p> <p>* Marketing strategy and patient education</p>	<p>* 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.</p>	<p>* Improved identification and management of patients with chronic conditions through enhanced data reporting, registries, and care coordination.</p> <p>* Increased utilization of preventive and wellness visits to help identify</p>

	<ul style="list-style-type: none"> <li>√ Improve provider quality metric performance ensuring delivery of evidence-based and best practice standards for primary and specialty care services.</li> <li>√ Continue social determinants of health screening to help identify patient needs for whole-person care.</li> <li>√ Conduct Lunch 'n Learns to educate the public on health care literacy, insurance coverage and enrollment opportunities, 5 Wishes, bereavement, and other topics.</li> <li>√ Improve infection control processes.</li> </ul>	<p>developed to promote well visits.</p> <ul style="list-style-type: none"> <li>* Development of a Quality Improvement committee within the clinics to review quality metrics and workflows to optimize patient outcomes.</li> <li>* Providers and staff to be re-trained on SDOH workflows and utilize care coordinators to connect patients to community resources.</li> <li>* Staff identified to present relevant patient and community education.</li> <li>* SLVH to continue to provide patients with care coordination and condition management supports through various programs.</li> <li>* Quality and Safety team have developed a safety committee that is reviewing infection control processes to implement improvements.</li> </ul>	<ul style="list-style-type: none"> <li>* 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.</li> <li>* 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.</li> <li>* 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.</li> </ul>	<p>ongoing health care needs.</p> <ul style="list-style-type: none"> <li>* Improved performance on quality measures related to chronic disease management and preventive care.</li> <li>* Increased patient knowledge of chronic disease prevention, self-management, and available community resources.</li> <li>* Improved infection prevention practices and patient safety outcomes.</li> <li>* Strengthened patient relationships that support whole-person care and address social determinants of health.</li> </ul>
<p><b>Behavioral and Mental Health Care Services</b></p>	<ul style="list-style-type: none"> <li>√ Grow and sustain our workforce to deliver health care services.</li> <li>√ Increase use of telehealth to support means of access to services (behavioral health, medical, and therapy visits) and follow up.</li> </ul>	<ul style="list-style-type: none"> <li>* Utilize "grow your own" opportunities for supporting workforce pipeline opportunities, such as internships and apprenticeship opportunities.</li> <li>* Grant funding to support efforts toward education and licensure support.</li> <li>* Project manager to support implementation of telehealth opportunities more robustly.</li> </ul>	<ul style="list-style-type: none"> <li>* SLVH to continue its partnership with Adams State University to recruit and retain Counselor Education Master's internships.</li> <li>* SLVH to continue its partnership with the Attainment Network on workforce pipeline and access to education resources.</li> <li>* 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.</li> </ul>	<ul style="list-style-type: none"> <li>* Increased access to behavioral and mental health services through workforce development and expanded telehealth capacity.</li> <li>* Improved availability of licensed and trained behavioral health providers in SLVH facilities or community partner services.</li> <li>* Reduced barriers to behavioral health care related to workforce shortages and geographic isolation.</li> <li>* Improved continuity of care and coordination between behavioral health and medical providers.</li> <li>* Enhanced long-term sustainability of behavioral health services through workforce pipeline development.</li> </ul>

<b>Assistance with Insurance Coverage and Enrollment</b>	<ul style="list-style-type: none"> <li>√ 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.</li> <li>√ Standardize patient registration and insurance verification processes by implementing Rev Spring registration software to improve accuracy and expedite insurance verification.</li> <li>√ Utilize dedicated care coordinators and patient financial counselors to support patients in connecting with enrollment opportunities.</li> <li>√ Maintain collaboration with external agencies to connect patients with enrollment and benefit opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>* Rev Spring registration software and supporting IT infrastructure.</li> <li>* Existing care coordination and patient financial counselors.</li> <li>* Clinic and registration staff time for standardizing workflows.</li> </ul>	<ul style="list-style-type: none"> <li>* SLVH continues to partner with the Department of Human Services to connect patients with enrollment and benefit opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>* Increased identification of uninsured and underinsured patients.</li> <li>* Improved patient information/connection to insurance coverage and financial assistance programs.</li> <li>* Reduced barriers to accessing care due to lack of insurance.</li> <li>* Improved patient understanding of coverage options and payment responsibilities.</li> <li>* Improve the registration and verification processes across service lines.</li> </ul>
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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

- Consent calendar approval 6/26/2025.
- Unanimous board approval 2/25/2026.