# 2022 Community Health Need Assessment
# Response and Implementation Plan
# Annual Community Benefit Meeting Review
# May 9, 2023

San Luis Valley Health (SLVH) is a private, non-profit comprehensive health care organization that includes two hospitals with Emergency Departments (ED), and five ambulatory care clinics providing primary, specialty, and behavioral health services to San Luis Valley (SLV) residents regardless of ability to pay. SLVH serves six counties that define the region. Five counties are federally designated as Medically Underserved, and all six counties are designated as Health Professional Shortage Areas. The SLV has a diverse population of 46,889 residents; 45% identify as Hispanic, Latino, or Spanish. The SLV is one of the poorest areas in Colorado with 21% of the population living in poverty, compared to 9% statewide.

SLVH completed its most recent full Community Health Needs Assessment (CHNA) in 2022. A response and implementation plan monitors progress of key organizational measures on an ongoing annual basis which is reported back to the organization and key stakeholders. May 9, 2023 SLVH hosted an annual Community Benefit meeting with a goal to re-engage key stakeholders to review the 2022 CHNA priorities and implementation response plan. Emailed "Save the Date" and "Please Join Us" announcements and invitations were sent to key community and state stakeholders April 6, 2023. 86 invitations were sent locally and 10 were sent to statewide partners. The meeting was open to the public and a notice was placed in the local news media May 3, 2023.

SLVH's 2022 CHNA identified four health priority areas: Substance Use; Mental Health; Chronic Disease Management; and Access to Care. During the 2023 community benefit convening, participants reviewed priority areas and SLVH's implementation plan. More than 25 community members attended the in-person and virtual convening, representing public health and behavioral health care providers, private family practice, financial services, local government, higher education, human services, housing, and other community representatives.

"Thank you for hosting the community conversations event yesterday. Much needed! Interesting that everyone in that room plays a critical role; it's just finding the strengths and "lanes" for each to garner success. The Valley is getting better with your leadership."
Bruce A. Rosengrant, Vice President, Community Engagement & Communication
Adams State University, Alamosa, CO

SLVH uses feedback gathered to help determine the availability and direction of future resources, build capacity of existing programs, or when it makes sense to support efforts of community partnerships where the priority is better suited. The overall aim is to use SLVH resources, time, and capacity in the most efficacious manner to help us shape our health care services to meet the needs of our community, circling right back to the organizational mission of "...providing patient centered services," and vision to be a "trusted partner in health."

There were no new priorities identified, however new strategic tactics were included in the organization's Strategic Roadmap based on input from the community discussion including:

- Continued focus on screening patients for Social Determinants of Health (SDOH) to better address health inequities;

- Developing processes for preventive care and wellness visit outreach and assistance to improve patient healthcare access, options for access to care, and promote continuity of care; and
- Strengthen community health education and presentations on health literacy, enrollment opportunities, 5 Wishes, and other timely topics to improve patients' utilization of healthcare resources and services.

Please see SLVH's CHNA response, implementation plan, and progress.

## Priority Health Issue: Substance Use

### Related HTP Focus Areas: ALTO, ED Follow Up

**Anticipated Impact: Provide a multispecialty medical approach to address the opioid epidemic, utilizing a more robust whole-person, multi-disciplinary approach to improve transitions of care through a safe discharge plan, improved access to integrated primary health care services, care coordination, and follow up in its health care system.**

**Identified community strengths in this area: Community Opioid Task Force, harm reduction programs, community collaboration, broad MAT services.**

- Continued participation in Alternatives to Long Term Opioids (ALTO) project.
- A Behavioral Health Consultant and Care Coordinator were hired to support SLVH's Emergency Departments, Labor and Delivery unit, hospital floors, and specialty clinics at SLVH Regional Medical Center and Conejos County Hospital. These positions provide short, brief interventions and warm hand offs and follow up tracking to ensure patients are connected to integrated ongoing behavioral health and substance use disorder (SUD) services when appropriate. The support also ensures immediate and social determinate (SDOH) needs of patients transitioning from inpatient care and emergency departments who are discharging to home or other lower levels of care, to ensure resources are available to meet patients' ongoing health care needs. This role is intended to support patients in acquiring community-based resources to prevent the need for non-medically necessary higher levels of care.
    - SBIRT, Crisis Stabilization, Warm Hand-Offs, Follow-Ups
    - SDOH, Transitions of Care support, Community-Based Resources, connection back to primary care provider
    - Connection to community referrals
- Screening all patients for SUD, standardized across locations.
- Host Circle of Parents in Recovery Support Group.
- Other supportive initiatives:
    - Participation with Integrated Care for Women and Babies – funding Care Coordination in Women's Health Clinic targeting substance using, or at risk, women of reproductive age.
    - Participation with Neonatal Abstinence Syndrome HRSA Grant (NAS) to support Care Coordination for all patients of reproductive age who are at risk for SUD and reduce incidents of exposure to children and families.
    - Participation with the SLV Neonatal Task Force (data sharing, training and education activities, public awareness, referrals and linkages, coordinating with the Colorado Hospital Substance Exposed Newborn Collaborative and Illuminate regarding best practices for caring for infants with Neonatal Alcohol Syndrome.
    - Participation in the High-Risk Families Cash Fund – funding to support Care Coordination and Behavioral Health Consultation, along with capital and infrastructure change, to increase capacity for high-risk parents in need of behavioral health/SUD services.

## Priority Health Issue: Mental Health

### Related HTP Focus Areas: Readmissions, ED Follow Up, RAE Notification

**Anticipated Impact: Advance integrated behavioral health services in SLVH's health care system and strengthen the continuum of care by identifying patients during acute, inpatient encounters and ensuring a safe and effective**

**transition of care to integrated health care and other community-based services for ongoing care and management.**

**Identified community strengths in this area: Boys & Girls programming, Youth of the Year; de-stigmatizing and talking about behavioral health and physical health together; supportive housing resources (SLVBHG), Valley-Wide Health Systems expanded behavioral health services.**

- Zero Suicide Implementation
- Question/Persuade/Refer (QPR) Train the Trainer completed. QPR trainings rolled out to SLVH Departments. QPR training was also completed with Adams State University athletic staff including approximately 50 staff. Future trainings are being planned with community partners, such as Center for Restorative Justice and 12th Judicial District staff.
- A Behavioral Health Consultant and Care Coordinator were hired to support SLVH's Emergency Departments, Labor and Delivery unit, hospital floors, and specialty clinics at SLVH Regional Medical Center and Conejos County Hospital. These positions provide short, brief interventions and warm hand offs and follow up tracking to ensure patients are connected to integrated ongoing behavioral health and substance use disorder (SUD) services when appropriate. The support also ensures immediate and social determinate (SDOH) needs of patients transitioning from inpatient care and emergency departments who are discharging to home or other lower levels of care, to ensure resources are available to meet patients' ongoing health care needs. This role is intended to support patients in acquiring community-based resources to prevent the need for non-medically necessary higher levels of care.
    - SBIRT, Crisis Stabilization, Warm Hand-Offs, Follow-Ups
    - SDOH, Transitions of Care support, Community-Based Resources, connection back to primary care provider
    - Connection to community referrals
- Implementing depression screening (PHQ9, EPDS, SBIRT), followed by the Columbia Suicide Risk Assessment for patients at risk, throughout the continuum of care.
- Screening all patients for mental health risks, standardized, across locations
- Other supportive initiatives:
    - Participation in the High-Risk Families Cash Fund – funding to support Care Coordination and Behavioral Health Consultation, along with capital and infrastructure change, to increase capacity for high-risk parents in need of behavioral health/SUD services.
    - Healthy Steps – To implement an integrated behavioral health and care coordination model for children and families, ages 0-3, in meeting developmental milestones, address parental depression, and support families with challenges to accessing SDOH and healthcare needs.

## Priority Health Issue: Chronic Disease Management

### Related HTP Focus Areas: Readmissions, Transitions of Care, Cost of Care, ED Follow Up, RAE Notification, Wellness Visits

**Anticipated Impact: Provide a system of care that supports patient's ongoing health care needs throughout the continuum of care through the appropriate and accurate exchange of health information, technology tools, care coordination, and transitions that are managed effectively to enhance patient's health care status and health outcomes.**

**Identified community strengths in this area: diabetes education; cardiac rehab; public enrollment assistance supports, Valley-Wide Health Systems Valley-Wide Ride.**

- Developing infrastructure for population health management, including staffing workflows and technology to support work.
- Provide diabetes education program in all integrated primary care clinics.
- Provide community nutrition and outreach classes to cancer support group, pulmonary and cardiac rehab group, Alamosa City employees, Adams State University and Trinidad State College guest lectures, high schools, Adams State Swim Team, and health fairs.

- Direct to Consumer Lab Testing – 1,633 on-demand consumer tests past 12 months
- Wellness Visit outreach for children and adults
- Participation in value-based programs and care coordination activities to improve organizational systems and patient outcomes.
- Participation in The Colorado Health Foundation's Advancing Team-Based Care (TBC) program to enhance and implement the TBC model throughout all primary care clinics, with a particular focus on increased access, enhanced service delivery, addressing health equity, and improved health outcomes.
- Participation in the CO Governor's Office on Information Technology, Project Broadband, to enhance access to care through the following initiatives:
    - Increased utilization of the Patient Portal
    - Implementation of telehealth services, including between patient and provider; between patient and out-of-region provider; and between consulting providers, to address geographic disparities.
    - Implementation of Remote Patient Monitoring to support ongoing management of chronic conditions, as it relates to decreasing hospital length of stay, avoidance of unnecessary ED utilization, and improved access to outpatient medical care.

## Priority Health Issue: Access to Care

### Related HTP Focus Areas: Transitions of Care, Cost of Care, ED Follow Up, RAE Notification, Wellness Visits

**Anticipated Impact: New provider staff will positively impact the number of patients who can be seen with a goal panel size of 1250 patients for full-time staff.**
**Meet patient expectations to provide appointments within three days. (According to research, 3rd next available national average for hospital-owned clinics is 3 days per MGMA, but best practice/the ultimate goal, is 0 days for primary care; 2 days for specialty care).**

**Identified community strengths in this area: Cancer survivor exercise program with ASU support; workforce career pathways.**

- Primary Care Provider Staffing – Two primary care providers joined SLVH October 2022: Bailey Buhr, PAC and Gina Stephens, FNP. In January 2023 Dr. Mugabee Walker, Internal Medicine, Tylen Pavlosky, APP joined SLVH's cardiology and general surgery department, and Dr. Schnaderbeck joined Women's Health. April 2023, Dr. Rojas, Pediatrician, joined the pediatric clinic April 2023. Continue recruitment efforts for family practice and oncology.
- Recruitment event hosted in conjunction with CHA to recruit providers to rural Colorado October 7 thru 9, 2022. Recruitment efforts ongoing to for permanent placements in SLVH practices including primary care, oncology/infusion, OB/GYN.
- Annual "Love My Portal Campaign" to promote access to clinical services, follow up, and requests.
- Breast Health Outreach events on weekends to provide barrier-free, one-stop screening mammograms.
- Men's Health promotion campaign.
- Provide outreach and appointment assistance for targeted wellness visits—children and patients $\geq$ 65 years old. Explore opportunity to combine with sports physicals.
- Optimize clinic schedules and staffing patterns so that patients are scheduled with their primary care provider (PCP as a first choice or another provider on their health team as a second choice), or offered an acute care visit with the acute care provider. Monitor schedule capacity of ambulatory care providers.
- Improve phone technology and capacity to ensure patients are connected to the right person in a timely manner to address their needs.
- Provide consumer Lunch 'n Learn opportunities to educate the public on health care literacy, health coverage benefits, enrollment opportunities, and other timely topics to improve patient's utilization of health care resources and services.

- Other supportive initiatives:
    - Participation in The Colorado Health Foundation's Advancing Team-Based Care (TBC) program to enhance and implement the TBC model throughout all primary care clinics, with a particular focus on increased access, enhanced service delivery, addressing health equity, and improved health outcomes.
    - System-wide effort to address Diversity/Equity/Inclusion through the development of targeted guidelines and education.
    - Participation in the CO Governor's Office on Information Technology, Project Broadband, to enhance access to care through the following initiatives:
        - Increased utilization of the Patient Portal
        - Implementation of telehealth services, including between patient and provider; between patient and out-of-region provider; and between consulting providers, to address geographic disparities.
        - Implementation of Remote Patient Monitoring to support ongoing management of chronic conditions, as it relates to decreasing hospital length of stay, avoidance of unnecessary ED utilization, and improved access to outpatient medical care.

## Additional community benefit activities to address identified health-related priorities:

- Community blood draws
- Community outreach – VA, transportation, workforce, supports for food and supply drives
- Coordinating access to insurance coverage
- Health Equity initiatives and collaboration
- Health Fairs
- Providing student and senior outreach as it relates to injury prevention and management
- Precepting and education for future workforce – rural providers, nurses, certified medical assistants, imaging and OT/PT students

## Next Steps and Future Activities

1. SLVH Annual Strategic Planning: FY24
2. HTP Community Advisory activities and committees
3. Annual Public Meeting and review of Community Benefit program, anticipated Spring 2024

## Approval

The SLVH Board of Trustees approves the priorities, response, and implementation plan identified in the 2022 community health needs assessment.

Karla Hardesty

Karla Hardesty, President

7/26/2023

Date