



Community Health Needs Assessment Implementation Plan FY 2025 – 2028



Golden Valley Memorial Healthcare Community Health Needs Assessment Implementation Plan FY 2025-2028

Mission

The Golden Valley Memorial Healthcare (GVMH) mission is to provide exceptional healthcare with friendliness and compassion.

Vision

Great people committed to innovative healthcare; recognized by our families, friends and neighbors as the provider and employer of choice

Values

Quality - We are committed to providing exceptional care and services.

Professionalism - We are a learning organization that maintains a competent, qualified and progressive staff.

Accountability - We are committed to being responsible to our communities and the cost-effective utilization of resources and financial soundness.

Compassion - We are a caring organization, valuing human dignity and quality of life.

Excellence - We are committed to providing exceptional healthcare experience.

This implementation plan serves a dual purpose: first, to detail how Golden Valley Memorial Healthcare plans to address the priority health issues identified through the Community Health Needs Assessment (CHNA); and second, to ensure compliance with the regulatory requirements outlined in Section 501(r)(3) of the Internal Revenue Service (IRS) code. This section mandates that nonprofit hospitals conduct a CHNA every three years and develop an implementation strategy to address identified needs.

The CHNA conducted by GVMH focused on Henry and Benton counties which represent the hospital's primary service area. Through a collaborative and data-driven process, GVMH engaged community stakeholders, reviewed public health data, and gathered input from residents to identify the most pressing health concerns affecting the region. This CHNA implementation plan outlines the strategies, partnerships, and measurable objectives GVMH will pursue over the next three years to improve health outcomes and promote health for individuals, population and the community at large.

2025 CHNA Priority Issues

Below is a list of the top priority issues identified by GVMH partners.

1. Social Determinants of Health and Poverty
2. Chronic diseases (including cancer, diabetes, heart disease, and obesity)
3. Affordable healthcare

CHNA Implementation Process

The Quality Works CHNA consultant presented 2022 CHNA findings, 2025 community survey results and current secondary data findings derived from the [exploreMOhealth](https://exploremohealth.org/) (<https://exploremohealth.org/>) platform and the [Health Equity Dashboard](#). GVMH staff and key partners provided updates on the actions taken and progress made toward addressing the 2022 priority areas. The table on the following page presents the methodology used to identify and prioritize the key health issues for 2025.

Examples of Prioritization Criteria	
Magnitude of the Problem	The health need affects many people within the community.
Severity of the Problem	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Health Disparities	The health need disproportionately impacts the health status of one or more vulnerable population groups.
Community Assets	The community can make a meaningful contribution to addressing the health need because of its relevant expertise and/or assets as a community, and because of an organization's commitment to addressing the need.
Ability to Leverage	There is an opportunity to collaborate with existing community partnerships working to address health needs, or to build on current programs emerging opportunities, etc.

Golden Valley Memorial Healthcare (GVMH) held its initial implementation planning meeting on November 11, 2025, at 4:00 p.m., with 12 participants attending in person. The meeting brought together a diverse group to begin shaping the strategic response to the priority health issues identified through the Community Health Needs Assessment (CHNA).

To facilitate focused discussion and collaborative planning, attendees were divided into three working groups. Each group was tasked with developing key components of the implementation strategy, including defining specific goals, outlining actionable tactics, identifying measurable outcomes, and proposing strategies tailored to each priority area. This collaborative approach ensured that a broad range of perspectives and expertise were incorporated into the planning process from the outset.

During the meeting, each group engaged in collaborative dialogue, drawing on local expertise, community insights, and available data to shape actionable responses to the identified health needs. At the conclusion of the session, each group reviewed and summarized the outcomes of their discussions. To support documentation and consistency, participants were provided with CHNA Implementation Plan templates developed by the Missouri Hospital Association. These templates were used to capture the information generated during the in-person meeting.

Once completed, GVMH compiled and forwarded the filled templates to Quality Works for review, refinement, and integration into the final implementation report. It is important to note that while several health issues were identified during the CHNA process, only a subset was selected as priority areas for focused action. However, GVMH remains committed to addressing the broader spectrum of community health concerns through ongoing initiatives and partnerships.

The final implementation plan will clearly distinguish between the health needs GVMH intends to address directly and those it will support through collaboration with other community organizations, ensuring a comprehensive and coordinated approach to improving health outcomes in Johnson County.

Under the IRS final rule, an implementation strategy is officially considered “adopted” once it receives formal approval from a hospital Board of Directors, a designated board committee, or another entity legally authorized to act on the board’s behalf. This approval must take place within the same taxable year in which the CHNA report is made publicly available.

To comply with these regulations, hospitals must maintain a written policy that outlines the process for adopting and executing the implementation strategy. This policy should detail the steps for approval, how the strategy will be put into practice, and how progress will be monitored.

Additionally, the IRS has expanded reporting requirements under Section 501(r), which must be addressed in the hospital’s annual filing via Schedule H of Form 990. Hospitals are now required to describe the actions taken during the taxable year to address each significant health need identified in the CHNA. If any identified needs were not addressed, the hospital must provide a clear explanation for why no action was taken such as resource limitations or strategic alignment with other community efforts.

In alignment with IRS regulations, nonprofit hospitals are required to conduct a Community Health Needs Assessment (CHNA) and develop an implementation plan every three years to remain compliant with federal law. However, the strategies outlined in these plans may need to be revised more frequently to reflect evolving community needs, shifting priorities, changes in available resources, and insights gained through ongoing evaluation. This adaptive approach is like performance improvement models commonly used in healthcare and other industries, emphasizing continuous assessment and refinement. Maintaining this momentum is essential for ensuring that implementation efforts remain relevant and effective.

Regular evaluation is a critical component of this process. It enables the implementation team to assess progress and determine the most appropriate next steps. Based on the findings, the team may choose to continue with the current strategy, make targeted adjustments, or pivot to a new approach altogether. This flexibility ensures that the hospital remains responsive and accountable to the community it serves.

Golden Valley Memorial Healthcare (GVMH) is dedicated to investing both financial and in-kind resources to effectively address the top health priorities identified through the Community Health Needs Assessment (CHNA). These resources may include staff time, program funding, facility use, and strategic partnerships with local organizations to support implementation efforts. To ensure accountability and transparency, the implementation plan will be reviewed on a regular basis and shared with the CHNA Steering Committee. These reviews will include updates from the various workgroups leading initiatives highlighting both successes and challenges encountered during execution. This ongoing feedback loop allows for real-time adjustments and fosters collaboration among stakeholders.

The Steering Committee will play a key role in monitoring progress, identifying barriers, and recommending solutions to enhance impact. By maintaining open communication and regularly evaluating outcomes, GVMH aims to ensure that the implementation plan remains responsive to community needs and aligns with its mission to improve health and well-being across the region.

Attached are the templates for priority issues.

1. Social Determinants of Health and Poverty
2. Chronic diseases (including cancer, diabetes, heart disease, and obesity)
3. Affordable healthcare

Community Partners

The implementation plan includes a list of key external partners who will be responsible for carrying out specific activities aligned with the three priority health areas identified through the CHNA process. These partners bring essential expertise, resources, and community connections that are critical to the success of each initiative. In addition to identifying contributing organizations, a group leader has been designated for each priority area. Workgroup leaders will play a central role in coordinating efforts, convening stakeholders, and facilitating collaboration across sectors. They are also tasked with providing regular updates to their respective focus groups, ensuring transparency and accountability throughout the implementation process.

This structured approach helps maintain momentum, foster shared ownership, and ensures that each priority area is supported by a network of committed partners working toward measurable outcomes.

SOCIAL DETERMINANTS OF HEALTH/POVERTY

Goal : Deploy initiatives to reduce Social Determinants of Health (SDOH) by addressing non-medical factors that impact health outcomes, such as housing stability, food security, transportation access, education, and economic opportunities.

Strategy: Provide the necessary education, training and outreach in the primary service area of Golden Valley Memorial Healthcare

Activity or Action	Lead	External Partners	Key Process or Outcome Measure	Timeline
Explore transitional care partnership opportunities.	Lynnette/Ranae	Consultant or Subject Matter Expert in Transitional Care Long-term care facilities	<ul style="list-style-type: none"> • Perform needs assessment • Survey demand from a minimum of three facilities 	December 2026
<p>Develop strategies to increase internal and external communication on community resources and assistance</p> <p>Deploy two outreach campaigns to identify external partners</p> <p>Increase Unite Us partners by 5%</p> <p>Publish outreach calendar for community caseworkers</p> <p>Schedule 2026 Project Connect</p>	Dull/Neale	Compass Public Health Schools Churches Local Community Betterment Organizations Law Enforcement	<ul style="list-style-type: none"> • Number of strategies deployed. • Number of outreach campaigns held. • Current UniteUS partners v/s partners in the intervention period. • One calendar developed for caseworkers 	July 2026

<p>Identify opportunities to create community synergy around the development of a multipurpose building as a resource center based in Henry County to provide access to food, shelter, bathing and other basic needs</p> <p>Curate a minimum of three meetings with identified partners to evaluate feasibility of resource center</p>	Dull	Local Community Betterment Organizations Public Health	<ul style="list-style-type: none"> • Number of meetings held to discuss the feasibility of a resource center. • Number of partners attending the meeting. 	October 2026
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CHRONIC CONDITIONS (Heart Disease, Cancer, Diabetes, Obesity)

Goal: Develop an integrated health outreach strategy focused on chronic conditions i.e., obesity

Strategy: Leverage education, technology deployment and outreach to help in the prevention and management of chronic conditions.

Activity or Action	Lead	External Partners	Key Process or Outcome Measure	Timeline
<p>Reduce obesity by integrating clinical care, community outreach, and environmental support to prevent and manage obesity</p> <p>Standardize BMI capture in EHR across all Specialties</p> <p>Identify, partner with, and publish free or discounted community centers /gyms</p> <p>Identify and promote GVMH Providers experienced in clinically managing obesity, motivational interviewing, and goal setting</p>	<p>Renee Bellamy</p>	<p>Compass Community Centers Pharmacies Schools Churches Public Health</p>	<p>Percent of specialties where BMI capture has been standardized.</p> <p>Number of partners with free or discounted community centers or gyms</p>	<p>March 2027</p>
<p>Complete community health fair/events for the next 3 years</p> <p>Providing community members with convenient access to comprehensive screenings for a variety of chronic health conditions, including diabetes, hypertension, and heart disease. These screenings aim to promote early detection, improve health outcomes, and connect individuals to appropriate follow-up care and resources.</p>	<p>Renee Bellamy/Stacy Neale</p>		<p>Number of community fair events completed with GVMH representation.</p> <p>Types of screenings completed during community fair events.</p> <p>Number of individuals attending community fair events.</p>	<p>December 2028</p>

<p>Offering educational programs to help community members understand and manage various chronic health conditions.</p>			<p>Number of educational opportunities offered on key chronic conditions.</p> <p>Number of people attending educational events relating to chronic disease prevention and management</p>	
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AFFORDABLE HEALTH CARE

Goals:

Increase the number of patients with access to primary care services within the next 12 months through partnerships with local clinics and telehealth expansion.

Deliver community education sessions on preventive health (e.g., screenings, vaccinations) and increase participants annually, measured by attendance and post-session surveys.

Assist eligible individuals in completing Medicaid and SSI applications by the end of the fiscal year, with application submission rate tracked through outreach logs.

Strategy: Enhance community knowledge and engagement by delivering targeted education programs, comprehensive training sessions, and proactive outreach initiatives that empower individuals and organizations to make informed health decisions and access available resources.

Activity or Action	Lead	External Partners	Key Process or Outcome Measure	Timeline
Increase opportunities for preventative care in different locations in the community	Tammy/Taylor	FQHC's Health Department Schools Other community-based organizations	<ul style="list-style-type: none"> • Increase % of Annual Wellness Visits by "x" from CY 2025 base line. • Increase Mammo & Colonoscopy compliance by "x" % from baseline. 	Dec 2026
Expand workforce capacity by promoting and supporting residency program, internships, job shadowing and clinical rotations	Molly/Jessica	Hospitals (HCA) Schools State Fair College Career Center Other Community-based organizations	<ul style="list-style-type: none"> • Number of individuals participating in one of the programs 	Dec 2026

Investment in mobile clinics (ex: mobile Mammography, dental, primary care, etc)	Bentley/Elwell	<ul style="list-style-type: none"> • Compass • Health Departments • Community based organizations 	<ul style="list-style-type: none"> • Number of mobile clinics implemented • Number of patients that utilized the mobile clinic 	Dec 2026
<p>Expand Primary Care Access</p> <ul style="list-style-type: none"> • telehealth at schools and employers place of business • Same day visits • Look at expanding hours of existing same day care clinics in outlying communities. • Community education around how to utilize healthcare sources, healthcare coverage and cost. 	Molly/Taylor	<p>Schools Local employers LUMA Relate Care Local Insurance Agencies</p>	<p>Number of established telehealth locations.</p> <p>Reduce wait time for initial appointment for primary care by “x” days from baseline.</p> <p>Track number of community education offerings.</p>	Dec 2026
Work with community partners to increase Medicaid enrollment, including assistance with documentation of work requirement. Provide education and assistance with SSI enrollment.	Neale/Walrath	<p>Centauri Health Department Mo Dept of Social Services Community Health Centers Other community-based organizations</p>	<p>Number of new individuals enrolled in Medicaid</p> <p>Number of individuals assisted with work requirement documentation</p>	Dec 2026