SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

STRATEGIC PLANNING COMMITTEE MEETING

AGENDA

- Board Requirement for Strategic Planning
- Summary Review of Strategic Plan
- Summary Review of Updates through CY 2025
- Plan Changes Proposed
- New Monitoring Tool

GOVERNING BOARD HRSA REQUIREMENTS FOR STRATEGIC PLANNING

BOARD REQUIREMENT FOR STRATEGIC PLANNING

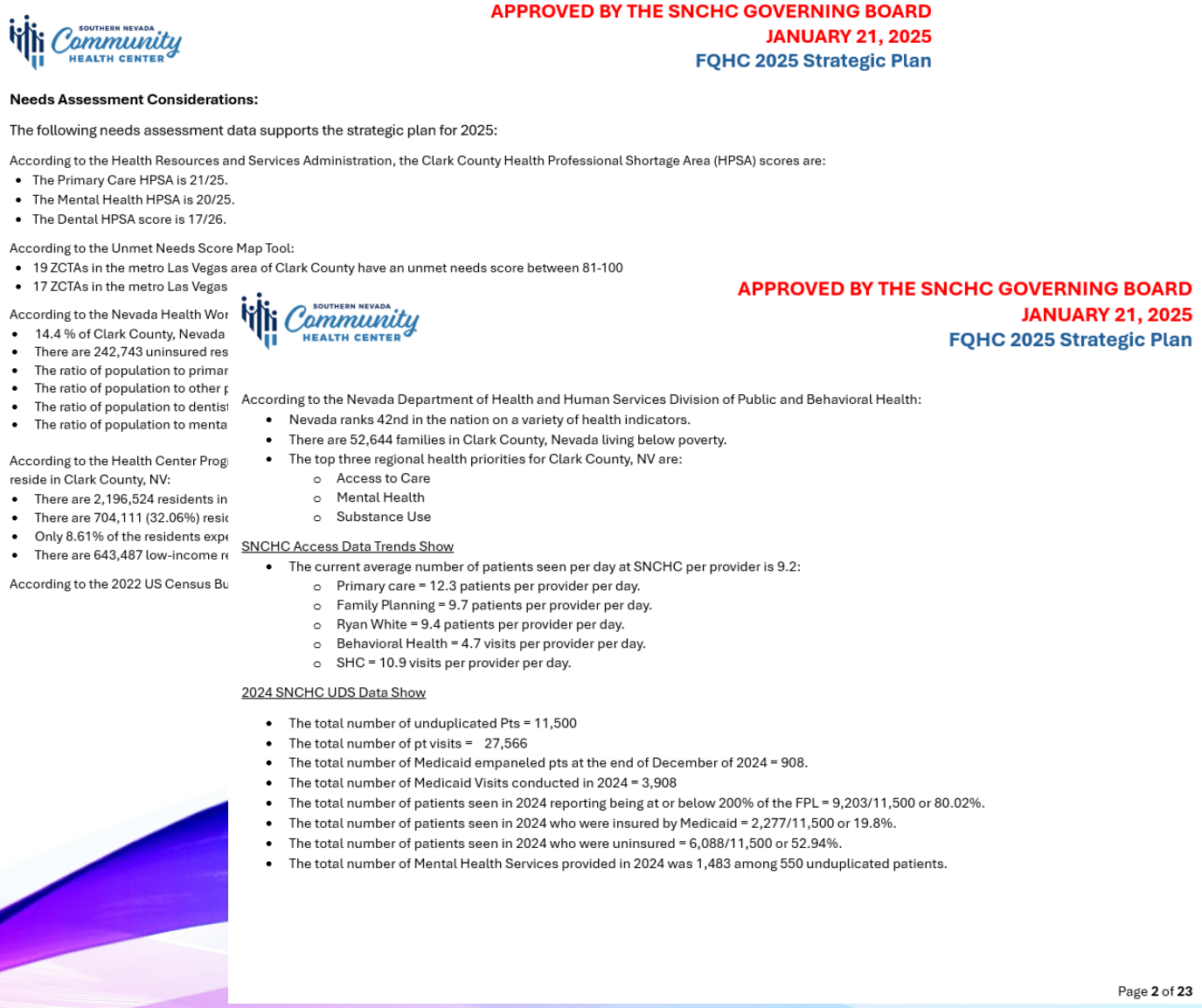
HRSA Health Center Program Compliance Manual states-
The board exercises, without restriction, the following authority and function: Conducting long-range/strategic planning at least once every three years, which at a minimum address financial management and capital expenditure needs.

The following strategic plan updates are current through the end of calendar year 2025.

SUMMARY REVIEW OF STRATEGIC PLAN

NEEDS ASSESSMENT

The Community Needs Assessment is strategically placed at the beginning of the full 25-page strategic plan. This was identified by the HRSA OSV reviewer in 2025 as a best practice and the reviewer stated they will be recommending this practice to other Health Centers.



APPROVED BY THE SNCHC GOVERNING BOARD
JANUARY 21, 2025
FQHC 2025 Strategic Plan

Needs Assessment Considerations:

The following needs assessment data supports the strategic plan for 2025:

According to the Health Resources and Services Administration, the Clark County Health Professional Shortage Area (HPSA) scores are:

- The Primary Care HPSA is 21/25.
- The Mental Health HPSA is 20/25.
- The Dental HPSA score is 17/26.

According to the Unmet Needs Score Map Tool:

- 19 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score between 81-100
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FQHC 2025 Strategic Plan

According to the Nevada Department of Health and Human Services Division of Public and Behavioral Health:

- Nevada ranks 42nd in the nation on a variety of health indicators.
- There are 52,644 families in Clark County, Nevada living below poverty.
- The top three regional health priorities for Clark County, NV are:
  - Access to Care
  - Mental Health
  - Substance Use

SNCHC Access Data Trends Show

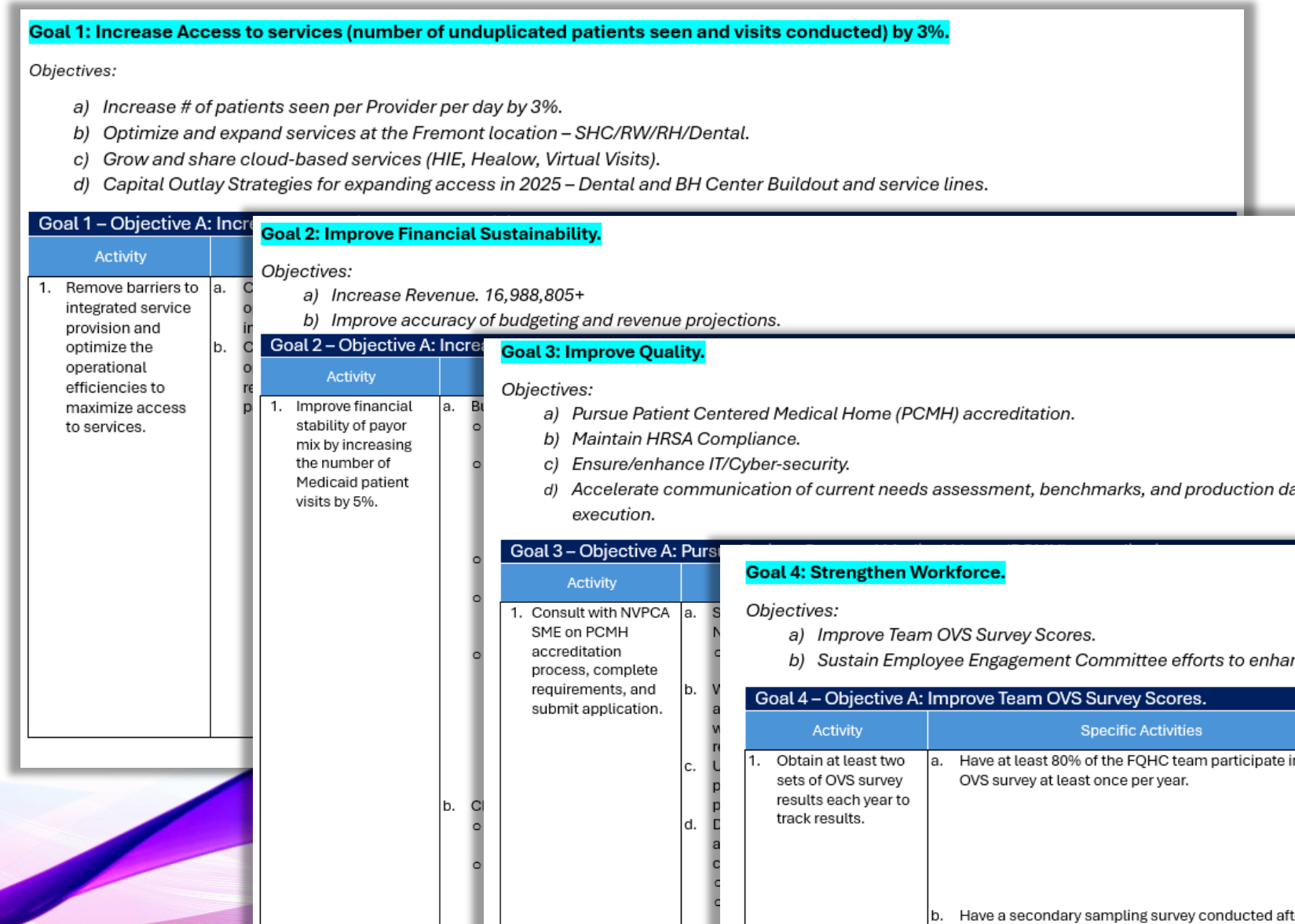
- The current average number of patients seen per day at SNCHC per provider is 9.2:
  - Primary care = 12.3 patients per provider per day.
  - Family Planning = 9.7 patients per provider per day.
  - Ryan White = 9.4 patients per provider per day.
  - Behavioral Health = 4.7 visits per provider per day.
  - SHC = 10.9 visits per provider per day.

2024 SNCHC UDS Data Show

- The total number of unduplicated Pts = 11,500
- The total number of pt visits = 27,566
- The total number of Medicaid empaneled pts at the end of December of 2024 = 908.
- The total number of Medicaid Visits conducted in 2024 = 3,908
- The total number of patients seen in 2024 reporting being at or below 200% of the FPL = 9,203/11,500 or 80.02%.
- The total number of patients seen in 2024 who were insured by Medicaid = 2,277/11,500 or 19.8%.
- The total number of patients seen in 2024 who were uninsured = 6,088/11,500 or 52.94%.
- The total number of Mental Health Services provided in 2024 was 1,483 among 550 unduplicated patients.

STRATEGIC PLAN

The full, 25-page strategic plan with specific goal, objective, and activity update details was sent for detailed review.



Goal 1: Increase Access to services (number of unduplicated patients seen and visits conducted) by 3%.

Objectives:

a) *Increase # of patients seen per Provider per day by 3%.*
b) *Optimize and expand services at the Fremont location – SHC/RW/RH/Dental.*
c) *Grow and share cloud-based services (HIE, Healow, Virtual Visits).*
d) *Capital Outlay Strategies for expanding access in 2025 – Dental and BH Center Buildout and service lines.*

Goal 1 – Objective A: Incr

Activity	
1. Remove barriers to integrated service provision and optimize the operational efficiencies to maximize access to services.	a. C o ir b. C o re p

Goal 2: Improve Financial Sustainability.

Objectives:

a) *Increase Revenue. 16,988,805+*
b) *Improve accuracy of budgeting and revenue projections.*

Goal 2 – Objective A: Increa

Activity	
1. Improve financial stability of payor mix by increasing the number of Medicaid patient visits by 5%.	a. Bu o o o o o b. C o o

Goal 3: Improve Quality.

Objectives:

a) *Pursue Patient Centered Medical Home (PCMH) accreditation.*
b) *Maintain HRSA Compliance.*
c) *Ensure/enhance IT/Cyber-security.*
d) *Accelerate communication of current needs assessment, benchmarks, and production da execution.*

Goal 3 – Objective A: Purs

Activity	
1. Consult with NVPCA SME on PCMH accreditation process, complete requirements, and submit application.	a. S N c b. V a w re c. U p p d. D a c c c

Goal 4: Strengthen Workforce.

Objectives:

a) *Improve Team OVS Survey Scores.*
b) *Sustain Employee Engagement Committee efforts to enhar*

Goal 4 – Objective A: Improve Team OVS Survey Scores.

Activity	Specific Activities
1. Obtain at least two sets of OVS survey results each year to track results.	a. Have at least 80% of the FQHC team participate i OVS survey at least once per year. b. Have a secondary sampling survey conducted aft

SUMMARY REVIEW OF STRATEGIC PLAN UPDATES THROUGH CALENDAR YEAR 2025

STRATEGIC PLAN SUMMARY

SOUTHERN NEVADA Community HEALTH CENTER

2025 Strategic Plan – Goals & Objectives

1) **Increase Access to services (# of unduplicated patients and visits) by 3%.**
   a) Increase # of patients seen per Provider per day by 3%.
      i) Remove barriers to integrated service provision.
      ii) Optimize operational efficiencies.
   b) Optimize and expand services at the Fremont location – SHC/RW/RH/Dental.
   c) Grow and share cloud-based services (HIE, Healow, Virtual Visits).
   d) Capital Outlay Strategies for expanding access in 2025 –
      i) Build a dental clinic at Fremont and develop an operational plan.
      ii) Open and optimize integrated care workflow at BH Center at Decatur.
   e) Create and implement new external marketing and promotional practices.
      i) Collaborate with other like-minded individuals and organizations to explore and create opportunities to forge new external community partnerships.
      ii) Develop, implement, test, and launch new external marketing practices to bolster SNCHC's brand recognition in the community.

2) **Improve Financial Sustainability**
   a) Increase Revenue.
      i) Improve the number of Medicaid visits by 5% YOY.
   b) Improve accuracy of budgeting and revenue projections.

3) **Improve Quality**
   a) Pursue Patient Centered Medical Home (PCMH) accreditation.
   b) Maintain HRSA Compliance.
   c) Ensure/enhance IT/Cyber-security.
   d) Accelerate communication of current needs assessment, benchmark, and production data for timely decision-enhancing execution.
   e) Purchase and implement a Chronic Care Management (CCM) Program.

4) **Strengthen Workforce**
   a) Improve Team OVS Survey Scores.
   b) Sustain Employee Engagement Committee efforts to enhance workforce experience.
      i) Develop and Sustain Inclusive and Competent Workforce.

Strategic Plan Update – Goal #1

CY25 Goals	CY25 Goal Objectives	CY25 Performance
		Increase Access
Goal #1: Increase Access to services (# of unduplicated patients and visits) by 3%.	a) Increase # of patients seen per Provider per day by 3%. (1) Remove barriers to integrated service provision. (2) Optimize operational efficiencies. b) Optimize and expand services at the Fremont location – SHC/RW/RH/Dental. c) Grow and share cloud-based services (HIE, Healow, Virtual Visits). d) Capital Outlay Strategies for expanding access in 2025 – (1) Build a dental clinic at Fremont and develop an operational plan. (2) Open and optimize integrated care workflow at BH Center at Decatur. e) Create and implement new external marketing and promotional practices. (1) Collaborate with other like-minded individuals and organizations to explore and create opportunities to forge new external community partnerships. (2) Develop, implement, test, and launch new external marketing practices to bolster SNCHC's brand recognition in the community.	**Unduplicated pts** Previous Year: 11,501 Goal: 11,846 FY25: **13,431** Result: **+13.8%** above goal & **+16.8%** above 2024 **Qualified Visits** Previous Year: 27,566 Goal: 28,393 FY25: **34,346** Result: **+21%** above goal & **+24.6%** above 2024 Dental program was cancelled due to funding, timing, and executive orders that required some financial pivoting. BH underwent a Behavioral Health Integration Benchmarking study conducted by the BeNCH Study Team, a third-party evaluation company. SNCHC received a total Practice Integration Profile (PIP) score of **85.4** compared to regional average of 68.8 and a national average of 66.9. Also, SNCHC received a level integration score of **5** compared to a regional average rating of 4.8 and a national average of 4.7. According to UDS data, 2,365 virtual services were provided in 2025, a change in YOY virtual services provided by -235 or -9%. This is 391 visits short of the goal, or -14.2%. This is still an area of opportunity for the clinic. Genie and Healow systems are being purchased and launched to increase virtual access to patients. Internal marketing and care integration occurring, but external is still in development.

Strategic Plan Update – Goal #2

		Improve Financial Sustainability
Goal #2: Improve Financial Sustainability	a) Increase Revenue. (1) Improve the number of Medicaid visits by 5% YOY. b) Improve accuracy of budgeting and revenue projections.	Medicaid is an FQHC's best payer source because of the PPS rate, so a focus on growing Medicaid patients and visits is at the forefront of efforts being made in to increase revenue and net income. **Unduplicated MCD pts** Previous Year: 2,827 Goal: 2,969 FY25: **3,019** Result: **+1.8%** above goal & **+6.8%** above 2024 **Qualified MCD Visits** Previous Year: 2,831 Goal: 4,104 FY25: **4,052** Result: -1.2% below goal & **+3.8%** above 2024 **Revenue** **2024 - $38,028,074** **2025 - $47,407,541 +9,379,467 YOY** **Net Income** **2024 – ($6,355,559)** **2025 – ($4,603,826) +$1,751,733 YOY** Projections and budget updates are managed throughout the year with budget augmentations and financial reports presented to the board and financial committees regularly.

Strategic Plan Update Goal #3

		Improve Quality
Goal #3: **Improve Quality**	a) Pursue Patient Centered Medical Home (PCMH) accreditation. b) Maintain HRSA Compliance. c) Ensure/enhance IT/Cyber-security. d) Accelerate communication of current needs assessment, benchmark, and production data for timely decision-enhancing execution. e) Purchase and implement a Chronic Care Management (CCM) Program.	PCMH process was initiated with HRSA at the end of 2025, and first attestations will occur at the end of July 2026. PCMH accreditation is scheduled **and is on pace to be completed by end of 2026 calendar year** with the Quality Management Coordinator leading this project. HRSA on-site visit was successful with **88/93 or 94.6%** of criteria met at the time of the site visit, and the 5 measures needing improvement were corrected within one month of the review resulting in **100%** compliance and no conditions placed on the NoA. **0** cyber-security breaches. Data is being shared with providers **by the 8th of every month** for timely interventions. Monthly data quality meetings are occurring to refine quality and accuracy of data reported. **2025 data had the fewest data inquiries from reviewers since program inception**. **CCM is in place and is being tested.**

Strategic Plan Update Goal #4

Strengthen Workforce

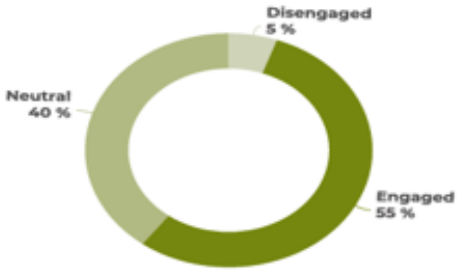
Goal #4: Strengthen Workforce

a) Improve Team OVS Survey Scores.
b) Sustain Employee Engagement Committee efforts to enhance workforce experience.
   (1) Develop and Sustain Inclusive and Competent Workforce.

Individual view

On the graph to the right, you'll see what percentage of the individuals in the organization land in each category. This graph can be used as a benchmark for the members of your organization. An average organization would have 25% of people in the Disengaged category, 50% in Neutral and 25% in Engaged.

Engaged = Fully involved, connected, and committed.
Neutral = Meeting requirements, following, passive.
Disengaged = Isolated, disconnected, moving away.



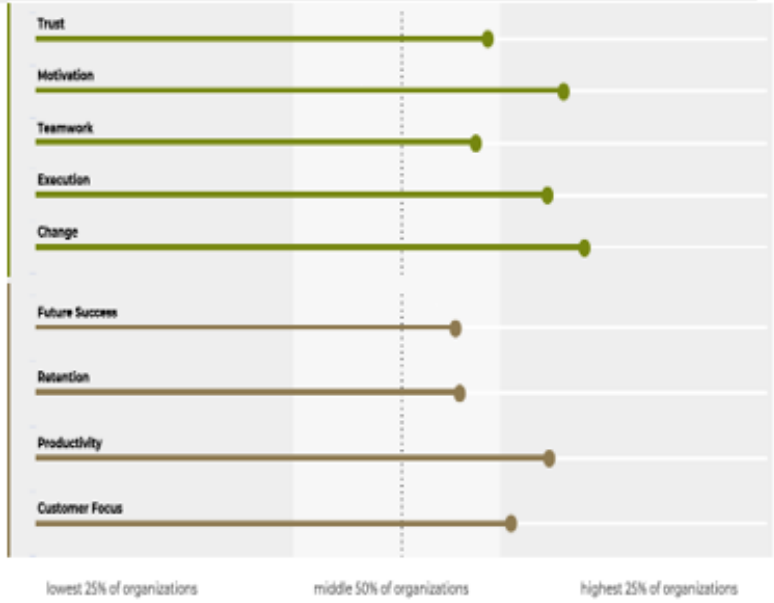
Organizational view

The graph below summarizes the organization as a whole, in comparison to the OVS database. The worldwide average is 50 out of 100.

Survey results are comprised of 73 responses, the most responses received by the FQHC team since surveys began.

A multitude of SNHD Employees of the Month are coming from the FQHC, the SNHD Employee of the Year has come from the FQHC two years in a row, two Managers of the Quarter have come from the FQHC, and the Manager of the Year in 2025 came from the FQHC.

EEC structure was realigned based on work, feedback, and preserving preferences of the site-specific teams.



STRATEGIC PLAN CHANGES PROPOSED

STRATEGIC PLAN PROPOSED ELIMINATIONS

- Dental clinic removed from multiple sections due to challenges with funding, timing, and executive orders that required some financial pivoting.

STRATEGIC PLAN PROPOSED ADDITIONS

- Possible addition of new location in ZIP Code 89103
- Pediatric visit tracking and service line growth with an aim to increase by 3% YOY.
- Nutrition visit tracking and service line growth with an aim to increase by 3% YOY.
- Implement Healow and Genie workflows to increase patient virtual access.
- Added new Business Office support staff to help with the workload and regularly updating the plan.
- Activities to track expectations and the effects of new exclusive Title X and Medicaid eligibility requirements that are coming soon.

NEW STRATEGIC PLAN MONITORING TOOL COMING SOON

Dashboard Components

Possible Strategic Plan Dashboard Components

- Total unduplicated patients: Previous Year, Target, Goal, Current
- BH/MH unduplicated patients: Previous Year, Target, Goal, Current
- Pediatric unduplicated patients: Previous Year, Target, Goal, Current
- MCD unduplicated patients: Previous Year, Target, Goal, Current
- PrEP unduplicated patients: Previous Year, Target, Goal, Current

- Qualified visits: Previous Year, Target, Goal, Current
- Qualified virtual visits Qualified visits: Previous Year, Target, Goal, Current
- Qualified BH/MH visits Qualified visits: Previous Year, Target, Goal, Current
- Qualified pediatric visits Qualified visits: Previous Year, Target, Goal, Current
- Qualified MCD visits: Previous Year, Target, Goal, Current
- Qualified PrEP visits: Previous Year, Target, Goal, Current

- No show rates: Previous Year, Goal, Current
- MCD Empanelment #s: Previous Year, Current
- Average # of Pts Seen Per Provider Per Program: Previous Year, Goal, Current
- # of HIPAA incidents reported: Previous Year, Goal, Current
- # of incidents and near-misses reported: Previous Year, Goal, Current
- Projected revenue per program vs. Actual revenue per program
- Net income original budget vs. Actual net income
- Spend downs

QUESTIONS?

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Community
HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

THANK YOU.

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- 19 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score between 81-100
- 17 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score of 61-80.

According to the Nevada Health Workforce Research Center, the 2024 Clark County Health Rankings state:

- 14.4 % of Clark County, Nevada residents under the age of 65 are uninsured,
- There are 242,743 uninsured residents that are not served by health centers.
- The ratio of population to primary care physicians is 1,831:1.
- The ratio of population to other primary care providers is 919:1.
- The ratio of population to dentists is 1,495:1.
- The ratio of population to mental health providers is 417:1

According to the Health Center Program GeoCare Navigator's 2023 UDS Data for the ZIP Code Tabulation Area's (ZCTA) where current SNCHC patients reside in Clark County, NV:

- There are 2,196,524 residents in the identified area.
- There are 704,111 (32.06%) residents experiencing low income.
- Only 8.61% of the residents experiencing low income (60,624) are utilizing available health center services, meaning
- There are 643,487 low-income residents who have not found access to a health center for services yet.

According to the 2022 US Census Bureau data, 12.9% of Clark County, Nevada lives in poverty.

According to the Nevada Department of Health and Human Services Division of Public and Behavioral Health:

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- The total number of patients seen in 2024 who were insured by Medicaid = 2,277/11,500 or 19.8%.
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- The total number of Mental Health Services provided in 2024 was 1,483 among 550 unduplicated patients.

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d) *Capital Outlay Strategies for expanding access in 2025 – Dental and BH Center Buildout and service lines.*

Goal 1 – Objective A: Increase # of patients seen and visits conducted by 3% YOY.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Remove barriers to integrated service provision and optimize the operational efficiencies to maximize access to services.	a. Create/implement/and leverage internal marketing opportunities to appropriately increase the number of internal integrated care referrals. b. Create/implement/and leverage internal marketing opportunities to become the medical home for patients receiving SNHD services but are not yet primary care patients. (Immunizations, TB, Refugee, & SHC)	CEO, Ops Managers, Admin Manager, Admin Analyst, QMC, Billing Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, and other divisional teams.	A&B internal marketing and service integration.	**A & B - BH underwent a Behavioral Health Integration Benchmarking study conducted by the BeNCH Study Team, a third-party evaluation company. SNCHC received a total Practice Integration Profile (PIP) score of 85.4 compared to regional average of 68.8 and a national average of 66.9. Also, SNCHC received a level integration score of 5 compared to a regional average rating of 4.8 and a national average of 4.7.**

	c. Optimize number of patient visits scheduled to increase the quantity of patient visits conducted per provider per day.		C - 2025 Unduplicated Pt Count for CY 2025 goal = 11,846	**C- 2025 UDS Report shows 13,431 unduplicated patients seen. An increase of 1,585 unduplicated pts, or +13.8% over the 2025 goal. (1,930 unduplicated patients seen over CY 2024, or +16.8%.)**
			C- CY 2025 Pt visit count goal = 28,393, which reflects a growth of 3% YOY.	**C- 2025 UDS Report shows 34,346 qualified visits conducted, an increase of 5,953 visits, or +20.97%**
	d. Reduce no show rate/maximize access on patient schedule.		D- CY 2024 No show rate = 56.1%	**D- CY 2025 No show rate = 56.9%**
	~~e. Use quality improvement, personnel, and technology resources to optimize access to care.~~		E- Monthly data quality meetings scheduled, PDSA cycles implemented to improve data quality.	**E- Monthly data quality meetings occurred. Most accurate reporting for 2025 thus far.**
	f. Increase the number of Medicaid empaneled patients assigned to SNCHC providers by 5%. ○ Covered in Goal 2, Objective A, Activity 1.		F- Medicaid empanelment number from end of 2024 = 1,540	**F- Medicaid empanelment number from end of 2025 = 2,295, an increase of 755 empaneled patients, or +49% over previous year empanelment numbers.**

Goal 1 – Objective B: Optimize and expand services at the Fremont location – SHC/RW/RH/Dental				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Collaborate with SHC, Dental Consultant / Dentist, and BH Manager to optimize operational workflows and procedures.	a. Ensure the IT/Cyber-security, and EMR functionality is conducive to appropriately documenting in patient charts, billing for services, and tracking statistical progress and results. b. Ensure all necessary credentialing is completed for new service lines, to ensure services are reimbursable. c. Continue meeting regularly with billing for revenue cycle collaboration and optimization of credentialing process and needs. d. Create/implement/and leverage internal marketing opportunities to appropriately increase the number of internal integrated care referrals. e. Create/implement/and leverage external marketing opportunities get the word out about the new service lines.	CEO, Ops Managers, Admin Manager, Admin Analyst, QMC, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk	A- Monthly data quality meetings scheduled, PDSA cycles implemented to improve data quality. B- Verify that all credentialing is complete or at least underway prior to services being provided. All should be completed by September 2025. C- Monthly Revenue Cycle meetings scheduled D&E- internal marketing and service integration.	**A- Monthly data quality meetings occurred. Most accurate reporting for 2025 thus far.** **B- Credentialing and privileging is monitored by the FTCA Credentialing and Privileging Portal in the EHB. HR is alerted three months out for upcoming recredentialing needed.** **C- Monthly Revenue Cycle meetings occurring.** **D&E- BH underwent a Behavioral Health Integration Benchmarking study conducted by the BeNCH Study Team, a third-party evaluation company. SNCHC received a total Practice Integration Profile (PIP) score of 85.4 compared to regional average of 68.8 and a national average of 66.9. Also,**

	f. Create and implement a work plan for each new service line with the help of SMEs and test workflows with team.		F-Draft workplans for each new service line with the expertise of collaborators and feedback from staff by May 2025. Implement new workflows by end of June 2025.	**SNCHC received a level integration score of 5 compared to a regional average rating of 4.8 and a national average of 4.7.** **External division cooperation is still a barrier.** **F- Nutrition integration is still underway and occurring.** **F- SHC integration workflows were implemented with the leadership of the Medical Director, the Operational Manger, and clinic supervisors.** **F- BH integration workflows were implemented with the leadership of the Medical Director, BH Manager and the Operational Manger. BH underwent a Behavioral Health Integration Benchmarking study conducted by the BeNCH Study Team, a third-party evaluation company. SNCHC**

	g. Introduce a new goal in 2026 to track pediatric visits and unduplicated patients. – PPC Collab, sports physicals, care gqps – 3% increase goal. h. Increase access to nutrition services – 3% (HCENS_27 New RD and TA) i.			**received a total Practice Integration Profile (PIP) score of 85.4 compared to regional average of 68.8 and a national average of 66.9. Also, SNCHC received a level integration score of 5 compared to a regional average rating of 4.8 and a national average of 4.7.** **F- DENTAL PROJECT DISCONTINUED TO REALLOCATE FUNDING AND BUDGET TO OTHER PROGRAMS.** **G- This new goal to be introduced for 2026 tracking**

Goal 1 – Objective C: Grow and share cloud-based services e.g., HIE, Healow, Virtual Visits.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Research, identify, create, implement, and test workflows and opportunities to increase patient	a. Verify ongoing IT/Cyber-security, and EMR functionality is conducive to appropriately conducting patient-interfacing activities through HIPAA compliant practices.	Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT	A- HIPAA compliance coordination with IT and Compliance Officer	A- Ongoing incident reporting and coordination with Compliance Officer and involving IT when

and team utilization and efficiency of cloud-based services, care coordination, and other virtual activities, such as the Health Information Exchange, Healow, Insurance Portals, and Virtual Visits.		Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director		appropriate. Only 1 HIPAA incident was reported in 2025.
	b. Research, identify, create, implement, and test workflows to conduct interfacing communication with the patients in between visits, and to ensure timely action is taken on communication when a message is sent or received to or from patients, or referred providers.		B- ON HOLD while other systems and workflows are tested.	**B- ON HOLD while other systems and workflows are tested.**
	c. Research, identify, create, implement, and test workflows to conduct pre-visit planning that includes use of AZARA, HIE, care coordination with other providers, test results, insurance portal or other quality care gap data, and internal care integration.		C- Create a regular IT check-in meeting to review any potential or past issues.	**C- Pre-visit planning and care planning coordination is still in development and testing, especially with use of available AZARA and eCW data.**
	d. Research, identify, create, implement, and test workflows to support growth in the number of virtual visits, especially for medication refill appointments and other simple follow up visits.		D- According to UDS data, 2,600 virtual services were provided in 2024. Increase number of virtual visits by 5%. 2025 Goal = 2,756	**D- According to UDS data, 2,365 virtual services were provided in 2025, a change in YOY virtual services provided by -235 or -9%. This is 391 visits short of the goal, or -14.2%. This is still an area of opportunity for the clinic.**
	e. Create/implement/and leverage internal and external marketing opportunities to get the word out about the technological services provided. Healow and Genie – increase pt virtual access		E- Develop marketing campaigns to market/promote technological support systems and processes to	**E- On hold for other priorities.**

	f. Work care gaps for MCO empaneled patients.		existing and potential patients. and execute. Close 50% of the number of empaneled-patient care gaps identified by insurance companies by the end of the year.	**F- Statistical tracking is not yet established due to evolving empanelment lists and contact information gaps.**

Goal 1 – Objective D: Capital Outlay Strategies for expanding access in 2025 – Buildout and Optimize Dental and BH Center service lines.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Build a dental clinic at Fremont and develop an operational plan.	a. Engage Chief Facilities Officer on architect, construction, and buildout plans. b. Work with appropriate SNHD team members and Dental Consultant/Dentist to organize the layout design, operational workflow, timeline, budget, EMR, Billing credentialing, and IT setup needed to operate the dental clinic. c. Research, identify, create, implement, and test workflows to provide integrated dental services. d. Track progress with regular meetings. e. Create/implement/and leverage internal and external marketing opportunities get the word out about the dental clinic. f. Facilitate the Dental PPS rate process with Nevada State Medicaid.	Chief Facilities Officer, Facilities Manager, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, FQHC CEO, Dental Consultant / Dentist, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, Revenue Cycle Manager	Set up regular meetings to collaborate and follow up on progress of project. Complete buildout and operationalization of Dental clinic at Fremont by June 30, 2025, for service provision beginning July 1, 2025. Develop an internal/external marketing program to promote upcoming dental services. Deploy the marketing program in the neighborhood and inside all FQHC clinics one month prior to opening.	**A, B, C, D, E &F- DENTAL PROJECT PLACED ON HOLD INDEFINITELY TO REALLOCATE FUNDING AND BUDGET TO OTHER PROGRAMS.**

2. Open and optimize integrated care workflow at BH Center at Decatur.	a. Increase number of unduplicated patients and services provided by 5% YOY. b. Test and refine workflows to provide integrate mental/behavioral health services.	FQHC CEO, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, BH Manager	Increase the number of unduplicated patients who received mental health services at SNCHC YOY by 5%. 2025 CY Goal = 578 (546 in 2024) 1,447 MH services were provided in 2024. Increase the number of mental health services provided at SNCHC YOY by 5%. 2025 CY Goal = 1,558	**A- 830 unduplicated patients in 2025, an increase of 284, or 52% growth of unduplicated patients YOY, and 252 unduplicated patients, or +46.2% over the +5% goal. 2,880 mental health services were provided in 2025 vs. 1,447 in 2024 resulting in a 99% increase in services provided YOY, and an 84.9% increase in service provision versus the goal.** **B- BH underwent a Behavioral Health Integration Benchmarking study conducted by the BeNCH Study Team, a third-party evaluation company. SNCHC received a total Practice Integration Profile (PIP) score of 85.4 compared to regional average of 68.8 and a national average of 66.9. Also, SNCHC received a level integration score of 5**

	c. Track progress with regular meetings. d. Create/implement/and leverage internal and external marketing opportunities get the word out about Behavioral Health Center.			**compared to a regional average rating of 4.8 and a national average of 4.7.** **C – Regular meetings with BH Manager and Medical Director occurring.** **D- Social medical campaign launched and paid for in 2026.**

Goal 1 – Objective E: Create and implement new external marketing and promotional practices.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Collaborate with other like-minded individuals and organizations to explore and create opportunities to forge new external community partnerships.	a. Research and identify other like-minded organizations that serve the same target population as SNCHC and facilitate a working relationship. b. Establish new MOU/MOAs and other partnerships to provide more access to services and broaden SNCHC's reach in the community. ○ Establish a method of exchanging medical records, results, and reports for improved care coordination. c. Track referrals to existing and new community partners to monitor activity and trends. d. Enhance insurance company relations, partnerships, and empanelment.	Board Members, CEO, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, Contracts department, procurement department	Identify three new potential community partners by the end of the year. Create a community partnership with one new partner by the end of the year. Aim to have more than 67% of referred patients have reports/results/progress notes for referred services. Increase frequency of insurance meetings to	A, B, & C- New partners and agreements were not assertively sought after during 2025 due to competing priorities and Form 5A services being adequately provided. Some Form 5A services were discontinued by MOU partners and new partnerships will need to be established, and workflows for exchanging medical records. D- Much progress has been made throughout 2025 to establish regular

			monthly with more than just Medicaid orgs.	meetings and collaboration with MCOs, but not all MCOs have agreed to establish regular meetings and collaboration.
2. Develop, implement, test, and launch new external marketing practices to bolster SNCHC's brand recognition in the community.	a. Research, identify, create, implement, and test workflows to and launch new external marketing practices to bolster SNCHC's brand recognition in the community b. Discover affordable options to promote SNCHC through media, word of mouth, external provider referrals, and partnerships.	Board Members, CEO, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, Contracts department, procurement department, Communications Department	Create and implement an external marketing/promotional program to bolster community awareness of SNCHC and its services by end of calendar year.	This has not been started yet due to competing priorities.

Goal 2: Improve Financial Sustainability.

Objectives:

a) Increase Revenue. 16,988,805+

b) Improve accuracy of budgeting and revenue projections.

Goal 2 – Objective A: Increase Revenue.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Improve financial stability of payor mix by increasing the number of Medicaid patient visits by 5%.	a. Build trust with Medicaid insurance organizations. ○ Work with insurance provider representatives to develop a working collaborative relationship. ○ Work with QMC/QWG and clinical teams to optimize the quality P4P metrics and reporting required by insurance providers to become a preferred provider to increase the number of patients being empaneled to SNCHC. ○ Organize and deploy an ongoing campaign to outreach to empaneled patients to establish care. ○ Close quality care gaps identified by the empanelment documentation, and any other gaps identified during patient visits. ○ Ensure there is available access on the patient schedule to see empaneled patients. b. CHW CCM services – ○ provide services to free up more provider space on the patient schedule. ○ Leverage internal workflows and community partnerships to ensure uninsured patients are assisted in applying for Medicaid and other SDOH services.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director	Increase the number of SNCHC's CY 2025 Medicaid Visits by 5% YOY. Goal = 4,104 Increase the number of SNCHC's CY 2025 unduplicated Medicaid patients by 5% YOY. Goal = 2,969	A- New MCO contacts have been established, and full coordination is taking place with 2/4 MCOs regularly to coordinate all components. Total Medicaid Visits for 2025 = 4,052. This goal was missed by 52 visits, or one visit per week. Although there were 144 more visits in 2025 versus 2024, the increase was only 3.7% missing the goal by 1.3%. Total Medicaid unduplicated patients seen in 2025 = 3,019 an increase of 6.8% B-CCM workflows have been designed and tested. More work to do in this space to establish a regular, billable cycle of CCM activity.

	c. PrEP expansion – Pharmacist provide services to free up more provider space on the patient schedule. d. Ongoing revenue cycle meeting review of Medicaid payor activity.			C- PrEP expansion is underway with a new clinical pharmacist on the way. Data still needs to be pulled and tracked to measure once the new provider onboards. New Medicaid Growth meeting is now a monthly review of where payor activity is and what next steps must occur to grow. Growth is happening in this space, however.

Goal 2 – Objective B: Improve accuracy of budgeting and revenue projections.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Improve accuracy of budgeting and revenue projections.	a. Set up regular Business Office meetings to review: ○ Financial spend down schedule updates with the FQHC Accountant. ○ Actual spending versus budget. ○ Update payer mix data.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, FQHC Accountant, Financial Analyst	Goal = No grant dollars unspent. Goal = Meet or exceed budgeted expenses Goal = Current revenue projections for clinic	A- Regular administrative meetings occur to review all business office tasks and priorities. In 2025, all grant dollars were spent down prior to grant periods ending. FY 2024-2025, the FQHC beat its original budget by more than $8 million dollars, Current FY 2025-2026 through May of 2026 show the FQHC is beating its budget $4.9 million.

	b. Update revenue projection workbook.		services are off by 25.88%. Improve accuracy of revenue projection to 15% or less.	B- Revenue projection workbook updated with current fiscal year data. Need analysis from finance to calculate since fiscal years overlap during a calendar year.

Goal 3: Improve Quality.

Objectives:

a) Pursue Patient Centered Medical Home (PCMH) accreditation.
b) Maintain HRSA Compliance.
c) Ensure/enhance IT/Cyber-security.
d) Accelerate communication of current needs assessment, benchmarks, and production data for timely decision-enhancing execution.

Goal 3 – Objective A: Pursue Patient Centered Medical Home (PCMH) accreditation.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Consult with NVPCA SME on PCMH accreditation process, complete requirements, and submit application.	a. Set up regular meetings and progress reviews with the NVPCA PCHM consultant to discuss: ○ Collaborate with FQHC team to determine which PCMH criteria will be pursued for compliance. b. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test the workflows and processes to comply with selected required and elected PCMH criteria. c. Using the PDSA Cycle method, refine workflows and procedures to create a culture of PCMH compliant practices. d. Document and track electronic recorded evidence of adherence to selected required and elected PCMH criteria for ○ Demonstrate to NCQA SNCHC is compliant ○ Presentation to the Leadership team for issues that need correction or celebration. e. Submit PCMH application. f. Receive PCMH accreditation.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, NVPCA Consultant, Quality Work Group	Commit to becoming a PCMH and begin the accreditation process by meeting with the NVPCA Consultant by March 2025. Determine the required and selected PCMH criteria that SNCHC will comply with by May of 2025. Develop, implement, test, and refine workflows and procedures to comply with and have evidentiary support for PCMH regulations by November 2025. Submit the PCMH application to NCQA by December of 2025.	A, B, C, D, E, & F-This was postponed to 2026 due to several other competing priorities; The project is underway right now for a 2026 completion date led by the QMC.

			Receive PCMH accreditation by April of 2026.	

Goal 3 – Objective B: Maintain HRSA Compliance.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Health Center Program compliance.	a. Continue adhering to HRSA requirements for Federally Qualified Health Center designation. ○ The annual Patient Target is 9,980 minimum. ▪ 95%, or 9,482 is the threshold. ○ Submit Catchment Area CIS after 2024 UDS report is submitted, if necessary. ○ Successfully complete and correct any findings from the on-site visit in February 2025. b. Continue adhering to FTCA requirements for FTCA redeeming. ○ Quarterly Risk Assessments need to be completed and presented. ○ The annual risk management report needs to be presented to the board. ○ Risk mgmt. training needs to be completed by all clinical staff for OB and other clinical risk factors, and HIPAA compliance.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, NVPCA Consultant, Quality Work Group, CFO, Financial Analyst, Associate General Counsel	Provide services for 9,980 or more unduplicated patients in CY 2025. Conduct and complete the HRSA on-site visit for compliance in February 2025 and work to have no findings listed on the NOA. Update HRSA EHB form 5b service sites and form 5a required and additional services as needed. Submit redeeming FTCA application for redeeming by June 27, 2025. Submit 2024 UDS report by February 15, 2025.	A- According to UDS Data, 13,431 unduplicated patients were seen in 2025. HRSA OSV was conducted in early 2025, with five findings, meaning 94.6% of all requirements were discovered to be compliant. Of the five findings, all were corrected within a month, and no conditions were placed on the NoA. UDS Report was submitted on time. B- FTCA application was successfully submitted on-time and redeeming was granted by HRSA for the 2026 calendar year.

	○ The Risk Manager must complete annual risk management training. c. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test workflows and processes to comply with required reporting and quality requirements. d. Continue pursuing and obtain the new PPS rate.		Acquire final PPS Rate by June 2025.	C- PDSA cycles were regularly reviewed and improvements were made during 2025, insomuch that the 2026 UDS report for CY 2025 had the fewest errors since the health center's inception. D- New PPS rate was calculated and obtained.

Goal 3 – Objective C: Ensure/enhance IT/Cyber-security.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Conduct regular checks on cyber-security threats, issues, challenges, training, and incidents.	a. Set up regular meetings with IT to determine ○ If there were any cyber incidents, or near misses that could have been prevented. ○ If training on process enhancement, accuracy, or other pertinent issues is necessary. ○ If data is accurate and consistent throughout eCW, CAREWare, and AZARA. b. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test workflows and processes to comply with required reporting and quality requirements. c. Upcoming migrations, updates, or changes to existing or new software or hardware.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental	Regular meetings are set up at least bi-annually to review potential or existing cyber-security issues. Help Desk tickets being submitted within a week of discovering problems with systems, reporting, accuracy, or other data issues. PDSA cycles being created and regularly reviewed until the desired outcome is achieved.	A- No known attacks on SNCHC's IT systems. No regular meetings to review cyber-attacks were held. B & C- Help desk tickets being submitted and resolved in a timely manner by IT/Informatic support personnel. PDSA cycles were regularly reviewed and improvements were made during 2025,

	d. Patient portal and virtual patient access and services (Healow & Genie)	Consultant, Chief Information Officer, Quality Work Group		insomuch that the 2026 UDS report for CY 2025 had the fewest errors since the health center's inception.

Goal 3 – Objective D: Accelerate communication of current needs assessment, benchmarks, and production data for timely decision-enhancing execution.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Obtain accurate data as quickly as possible each month to have a greater impact on leadership's decision-making capacity.	a. Request data for the next five weeks' worth of reports due, and for the previous month. b. Verify accuracy of data by cross checking multiple data sources and anecdotal operational information. New Business Office Assistant to support	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Quality Work Group	By the 5th of the month, request data for the prior month, and for any reports that are due in the next 5 weeks. Help Desk tickets being submitted within a week of discovering problems with systems, reporting, accuracy, or other data issues.	A- Requests are made for updated data by the 5th of each month for the prior month to allow for charts to be closed, but to also urgently prepare the data for leadership and the Governing Board report ASAP. B- Data is being cross-checked with several finance reports. Help desk tickets being submitted and resolved in a timely manner by IT/Informatic support personnel.
2. Organize and share data promptly with those who have the most involvement in affecting change and improvement.	a. As soon as the data has been verified, organize the data into a report for the leadership team and send to Tawana.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager,	Send verified data to leadership team and Tawana for monthly reporting on or before the 8th of the month. All pertinent decision-makers need to have	A- Monthly data reports are submitted to Tawana by the 8th of each month. Data is shared at leadership meetings and all staff meetings.

	b. Disseminate data to all pertinent parties that need the data to make better decisions. c. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test PDSA cycles for improved results.	Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Quality Work Group	actionable data by the 10th of each month, so change can affect 2/3 of the month, which should affect monthly trends. PDSA cycles being created and regularly reviewed until the desired outcomes are achieved.	B & C- Monthly data quality meetings with PDSA cycle work occur monthly. Annual data quality reporting with fewest errors on record occurred in 2026 for CY 2025.

Goal 4: Strengthen Workforce.

Objectives:

a) Improve Team OVS Survey Scores.

b) Sustain Employee Engagement Committee efforts to enhance workforce experience.

Goal 4 – Objective A: Improve Team OVS Survey Scores.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Obtain at least two sets of OVS survey results each year to track results.	a. Have at least 80% of the FQHC team participate in the OVS survey at least once per year. b. Have a secondary sampling survey conducted after the first OVS survey to track the progress of results. 25% Engaged & 25% Disengaged vs. actual Employees of the Month Managers of the Month Employees of the Year	Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, Quality Work Group, HR Business Partner, EEC, FQHC Team, HR	80% of FQHC Team participate in the OVS survey at least once per year. Subsequent survey conducted among a sampling of the team within the calendar year to track trends.	A- Main OSV surveys were conducted in March 2025, and a subsequent survey occurred in October 2025. Participation was about 2/3 of the team. B- Pulse survey conducted in October.

2. Organize and share OVS results promptly with the team and those who have the most involvement in affecting change and improvement.	a. Results will be presented to the leadership, and then to the FQHC Team at a Staff Meeting. b. Leadership will take steps to improve issues that are clearly objective c. Employee Engagement Committee (EEC) will organize a subsequent meeting with the team members to discuss results with the team members to understand why the team answered OVS questions the way they did. d. EEC to solicit feedback from the team on how to improve the OVS scores without creating budgetary challenges or operational barriers to care for patients. e. EEC will report the findings of the team's feedback regarding the OVS survey results to leadership within a month of the OVS survey results being available with a proposed plan to improve results.	Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, Quality Work Group, HR Business Partner, EEC, FQHC Team, HR	Results of the OVS survey to be presented to FQHC leadership within 30 days of the results being posted. Results of the OVS survey to be shared with the rest of the FQHC team within 60 days of the results being posted. EEC reports to the leadership team what their findings are, and their recommendations on what to do to improve the scores within 90 days.	A- Results presented to leadership and staff. B- Leadership and EEC identified and worked issues identified by the survey. C- EEC meets monthly D- EEC solicits feedback from the team regularly and anonymously E- EEC reports at each staff meeting. See 2025 scores below table

2025 OVS Survey Data Snapshot

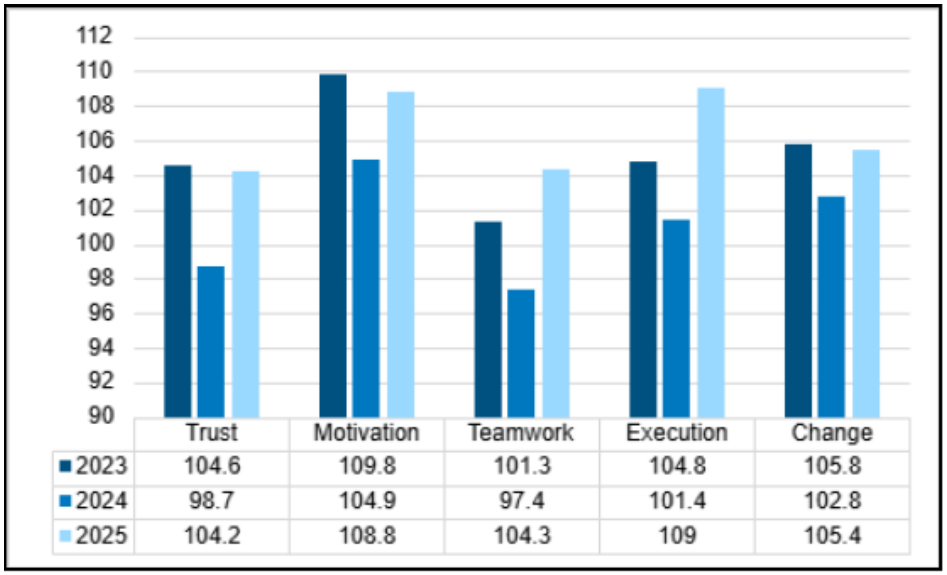

Figure 1: OVS Climate Drivers – FQHC

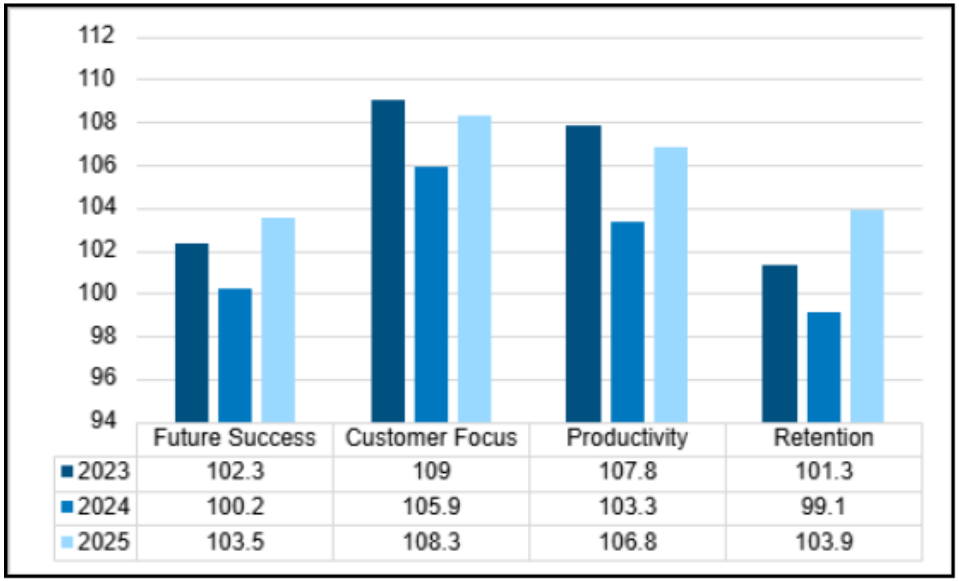

Figure 2: OVS Performance Outcomes - FQHC

Goal 4 – Objective B: Sustain Employee Engagement Committee efforts to enhance workforce experience.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. The Employee Engagement Committee will monitor the effect of their efforts to improve the OVS scores.	a. Once OVS survey results are received, and employee feedback has been received and shared with the leadership team, the Employee Engagement Committee (EEC) will plan events, recognition, or other activities that are most likely to engage the team and improve the OVS scores and the FQHC's culture.	Admin Manager, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director,	OVS survey results to be discussed at every monthly EEC meeting to track progress and efforts being made to improve scores measuring the team's experience.	A- The EEC met monthly, organized and raised funds for, regular site-specific get-togethers, and two major events, health center week and a Christmas party.

	b. EEC will use OVS survey results to identify any training and/or development needs for the team to improve inclusivity, safety and security, enhance the work experience, and/or develop and enhance skill sets. ○ EEC will work with appropriate SNHD professionals, if possible, to provide training and development, where appropriate.	Dental Consultant / Dentist, HR Business Partner, EEC, FQHC Team, HR	EEC will seek leadership's approval of all communication with and for the team. EEC organizes at least one development focused training for the team during 2025.	Recognition and celebration of team members became the norm and SNCHC had an SNHD employee of the month selected from the health center almost every month in 2025. B- The OVS survey results were reviewed, and EEC work and tactics were focused on improving trust among the team to improve future OVS survey results.
2. The EEC will research, develop, implement, and execute ways to finance the projects, events, and recognition they wish to conduct for the next year.	a. The EEC will use its list of planned events, recognition, and other activities, consult with HR on what kind of budget HR has for them, and then estimate how much more funding is needed for the calendar year. b. Once the amount needed has been identified, the EEC will seek ways to financially support their needs sustainability. Redesigned EEC Structure	Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, Quality Work Group, HR Business Partner, EEC, FQHC Team, HR	EEC will present to the leadership team what their plan for sustainability is by the end of March 2025.	A & B-The EEC led efforts all year long to raise funds through raffles, auctions, and donations. Fund-raising targets were derived from projections made about the cost of the events per person and then fund-raising efforts were executed to meet that target.

Possible Strategic Plan Dashboard Components

- Total unduplicated patients: Previous Year, Target, Goal, Current
- BH/MH unduplicated patients: Previous Year, Target, Goal, Current
- Pediatric unduplicated patients: Previous Year, Target, Goal, Current
- MCD unduplicated patients: Previous Year, Target, Goal, Current
- PrEP unduplicated patients: Previous Year, Target, Goal, Current

- Qualified visits: Previous Year, Target, Goal, Current
- Qualified virtual visits Qualified visits: Previous Year, Target, Goal, Current
- Qualified BH/MH visits Qualified visits: Previous Year, Target, Goal, Current
- Qualified pediatric visits Qualified visits: Previous Year, Target, Goal, Current
- Qualified MCD visits: Previous Year, Target, Goal, Current
- Qualified PrEP visits: Previous Year, Target, Goal, Current

- No show rates: Previous Year, Goal, Current
- MCD Empanelment #s: Previous Year, Current
- Average # of Pts Seen Per Provider Per Program: Previous Year, Goal, Current
- # of HIPAA incidents reported: Previous Year, Goal, Current
- # of incidents and near-misses reported: Previous Year, Goal, Current
- Projected revenue per program vs. Actual revenue per program
- Net income original budget vs. Actual net income
- Spend downs