Implementation Strategy Summary 2025

Community Health Needs Assessment FHN Memorial Hospital

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FHN

2025 FHN Memorial Hospital CHNA Implementation Strategy

FHN Memorial Hospital measures healthcare excellence with an evidence- and data-based interdisciplinary approach to continuous improvement that aligns cost, quality, and competitive market performance leading to highly valued, vitally necessary, intentionally responsive care*

The Implementation Strategy gird in this document represents the services, programs and partnerships FHN Memorial Hospital will directly use to address major categories of care, incorporating community input from the 2025 FHN Community Health Needs Assessment (CHNA) over the next three years as it relates to each category:

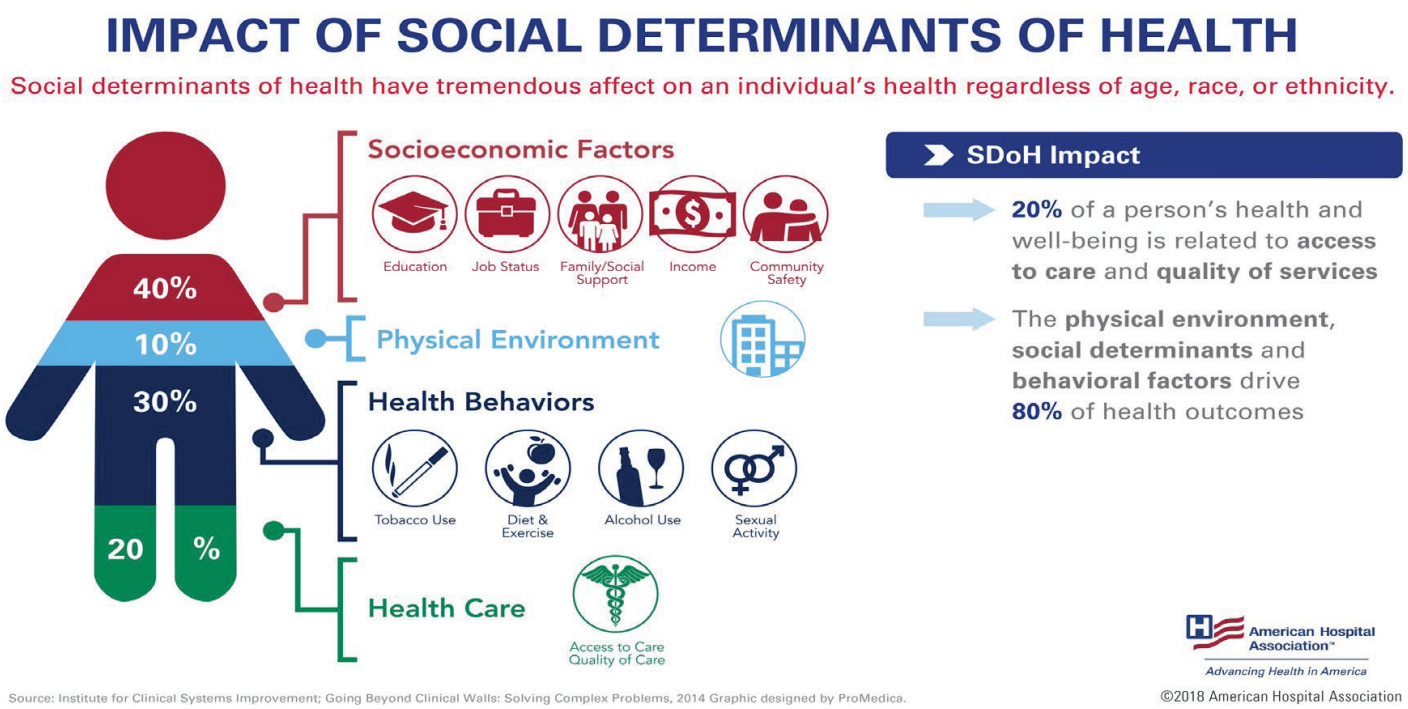
1. Mortality
2. Efficiency
3. Safety
4. Effectiveness
5. Patient-centeredness
6. Equity

Action items in the table may address one or more areas of community concern as indicated and are designed with the continuum of care in mind for all populations.

*To facilitate the ability to measure itself against a broad cohort of like-sized hospitals with similar services and capabilities, FHN works with Vizient, Inc., the nation's largest healthcare performance measurement company, serving more than 50% of the nation's acute care providers including 97% of the nation's academic medical centers and more than 20% of ambulatory care providers.

The Role and Impact of Social Determinants of Health

As with most communities, the FHN service area has individuals with significant health and wellness challenges that impact nearly every part of their lives, every day. The resources they need are available; they're just not always easy to connect together into an effective, efficient plan of care outside the walls of FHN facilities since, as noted in this visual, the majority of the elements that actually impact individual health are in fact not provided within the walls of any hospital or healthcare organization



Since FHN overall is a broad healthcare organization consisting of FHN Memorial Hospital as well as specialty clinics and a network of primary care clinics serving five counties (although as noted in the 2025 CHNA report, the majority of inpatients and emergency department patients come primarily from three of those), much of the commentary and survey data received from the extensive community input process, while potentially having origins for improvement within FHN Memorial Hospital, was not hospital-specific but instead reflected experiences and concerns throughout the entire continuum of care provided at many offices and locations beyond the hospital (and for that matter, beyond FHN since there are other less-utilized healthcare entities in the region as well). This extremely important and useful input relative to non-hospital-specific concerns will be utilized by FHN in strategic planning and tactics for implementation both in and beyond the hospital setting.

For reference, however, the input received from the community that includes the hospital proper but then goes beyond its purview can be prioritized in these categories:

- Community Identified Needs
- Community Health & Well-being
- Chronic Disease Management

Common areas of need throughout all three community priorities include health education, accessibility, community involvement and leadership.

> The biggest challenges I see are access, especially to specialists, and finding transportation to appointments.
>
> – 2025 FHN Survey Comment

FHN CHNA Implementation Strategy

The goals and tactics for FHN's CHNA Implementation Strategy have been incorporated in an easy-to-follow grid that also demonstrates the connection between all of the various elements that will need to be integrated for success. FHN anticipates completing these objectives by 2028 while delivering healthcare excellence to our community for every patient, every time.

	Mortality	Efficiency	Safety	Effectiveness	Patient Centeredness	Equity
2028 Goal	All patients over the age of 55 will have goals of care documented in medical record and annually reviewed by care team to ensure patient wishes are understood and honored. All Medicare eligible patients will have an annual wellness visit each year.	Implement value driven best practices to achieve quality improvement goals, reduce costs, and mitigate risk.	Engage patients and families to become more active partners with their healthcare team.	Proactively optimize care utilization across the continuum to ensure the right care at the right place and right time.	Increase access to specialties in rural clinics on a routine basis/schedule.	Ensure equitable access, quality and outcomes for all populations served by FHN using a data driven approach to identify potential/ actual inequities.
Develop and implement targeted information and marketing (live and virtual) on wellness and disease specific topics.	Provide education on goals of care and ensures that care team documents conversation with patient in electronic medical record.	Promote Financial Resource awareness using focused interventions for all patient populations.	Provide targeted regular educational programs using multimodal methods about cancer screening, chronic disease management (such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), diabetes, hypertension) and sepsis.	Provide targeted education related to provider 24/7 on-call availability.	Conduct live/virtual education programs to include caregiver support, care of aging family members, gun safety, medication safety, cybersecurity, etc.	Implement annual implicit bias and cultural competence training.
	Utilize Electronic Health Record to identify patients with 3 or more chronic diseases without goals of care. Targeted education and outreach to high risk patients will occur to coordinate care.	Enhance outreach to patients overdue for testing, annual wellness exams, follow-up appointments, medication management, and referrals.	Provide Social Determinants of Health (SDOH) resources and personal/family safety education biannually.	Implement evidence based discharge process (i.e. Project Red) to targeted Chronic Disease patient populations.	Community resource handouts available in a variety of options.	Partner with community agencies and events to provide outreach incorporating preventive-care education (i.e. food and nutrition programs, chronic disease management).
Establish Systems to enhance communication, connections, and care.	Encourage patients to schedule their annual wellness visits using internal and external marketing/education.	Implement patient self-scheduling throughout FHN.	Provide individualized assistance to maximize insurance offerings thereby reducing barriers to seeking care.	Expand FHN walk-in services, locations and methods of delivering care.	Assess feasibility of after hours triage line with access to schedule with any and all providers.	Reduce transportation, financial, and digital barriers (i.e. launch Mobile Health pop-up program rotating through Zip codes with low utilization).
	Complete outreach to ensure that patients are scheduled for follow-up appointments on chronic disease management and annual wellness visits using registry population health tools.	Promote utilization of FHN Electronic Health Record portal access and telehealth availability.	Decrease days to first intervention post discharge (select specific diagnosis) for cancer care and cardiology.	Expand FHN Care Transition Services to assist both patient and support system in the healthcare navigation needs.	Utilize Transitional Pharmacist and Clinical Nurse Leaders for targeted diagnosis population offering series of classes on chronic disease management with a reward/certificate for those that complete.	Assess and increase access to behavioral health partners among all patient populations (i.e. prescreening, more intensive follow-ups after discharge from the hospital to Rosecrance, etc.)