Implementation Strategy Summary

Community Health Needs Assessment
FHN Memorial Hospital

We're here, for you.

FHN

December 2022

2022 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 2022 FHN Community Health Needs Assessment (CHNA) as it relates to each category:

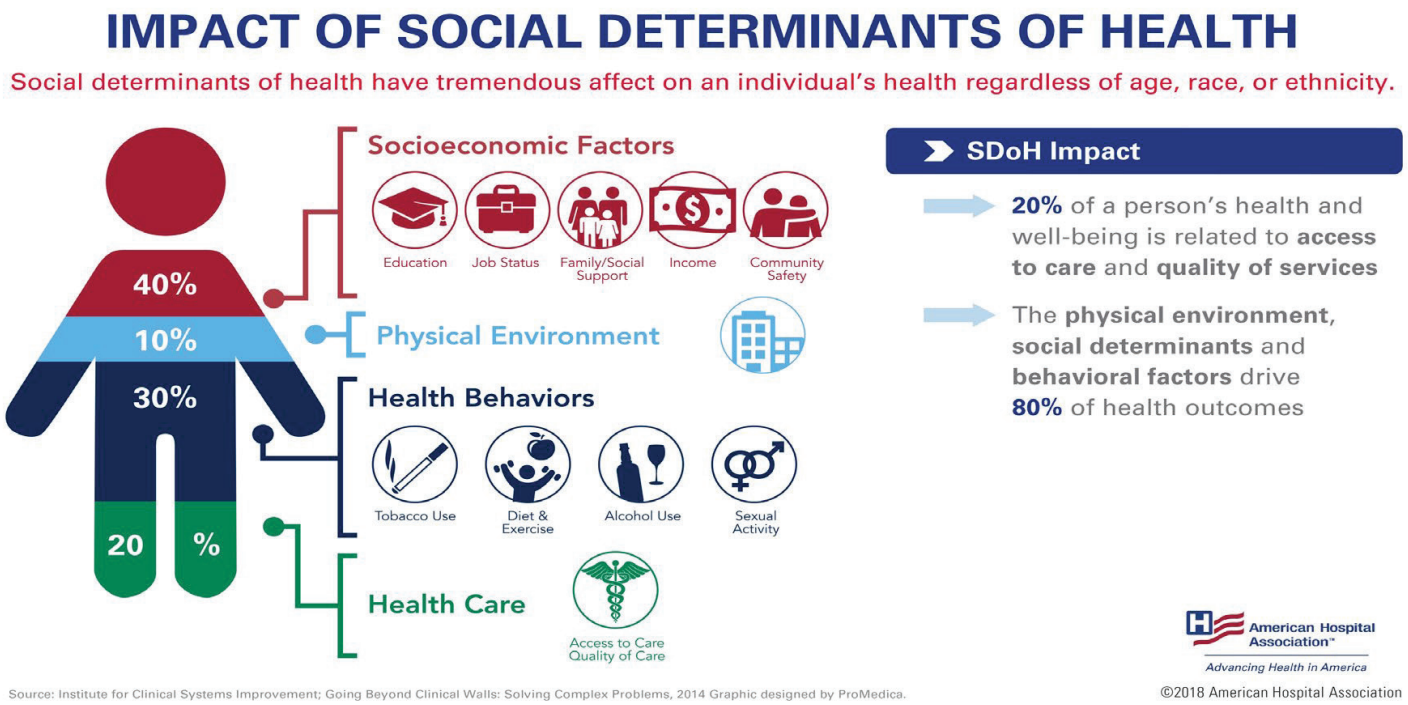
1. Mortality
2. Efficiency
3. Safety
4. Effectiveness
5. Patient centeredness
6. Equity

Action items in the table may address one or more areas of community concern as indicated. The listed action Items are prioritized, address all populations unless otherwise indicated, are designed with the continuum of care in mind, and are planned to be executed over the time frame of this CHNA (through year-end 2025).

*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...and action. As noted in this visual, however, 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 2022 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 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 (particularly as it relates to being a well-trusted source of health information), and the importance of behavioral/mental health throughout most if not all aspects of healthcare today.

Connect the D.O.T.S.

Although exacerbated by the COVID-19 pandemic, these broad concerns are not new. In fact, FHN began to lead a community effort in 2016 called Connect the D.O.T.S. (Doors of Team Support) to help address these needs. Connect the D.O.T.S. is an ongoing, regularly meeting, multi-entity group designed to play a leading role in improving overall community health.

CONNECT the D.O.T.S.
Doors Of Team Support

The Connect the D.O.T.S. initiative is not FHN-branded; FHN plays a coordination role but it is the involvement of dozens of community partners from first responders to transportation providers to various agencies whose missions include the type of expanded assistance these people need – as well as schools and other entities who are both providers and receivers of necessary care from a wide spectrum of organizations – that has led to its continuing existence and success.

The community-wide goals of Connect the D.O.T.S. are to promote well-being – and being well – by helping individuals meet their basic physical, emotional, social, and spiritual needs, while the team member organizations work together as partners to ensure that processes that connect them are clear, strong, well understood, and well-communicated.

Striving to achieve these goals will help both FHN and the other Connect the D.O.T.S. members to continue to improve the well-being of our whole community by reducing the impact and cost of non-existent or ineffective connections between our organizations that can result in inefficient use of the overall community's limited resources in time, dollars, and human expertise.

For more information on Connect the D.O.T.S., please visit www.fhn.org.

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 2025 while delivering healthcare excellence to our community for every patient, every time.

		Mortality	Efficiency	Safety	Effectiveness	Patient Centeredness	Equity
Community Identified Needs	2025 Goal	All patients over the age of 55 will have goals of care documented in medical record and annually reviewed by care team and updated as needed to ensure patient wishes are understood and honored.	Implement value driven best practices to achieve quality improvement goals, reduce costs, and mitigate risk.	Engage patients to become more active partners with their healthcare team to improve overall health and wellbeing.	Proactively optimize care utilization across the continuum to ensure the right care at the right place and right time.	Implement new care delivery models to enhance patient experience and value.	Deliver excellence in our community, every patient, every time.
Community Health & Well Being	Provide targeted community screenings to our community.	Increase number of educational programs regarding chronic disease management.	Expand FHN walk-in services, locations and methods of delivering care.	Provide targeted behavioral health and substance use disorder screenings and education.	Provide financial resources assistance, including education on when to use which facilities/services.	Develop programs on wellness, increasing physical activity and disease prevention	Improve Cultural Competencies among FHN staff and providers.
		Care team documents conversation with patient and support regarding goals of care.	Expand post discharge clinical follow-up calls.	Develop and implement sepsis campaign.	Expand FHN Electronic Health Record portal access.	Implement Patient Family Advisory Council Programs.	Engage community partners to address social determinants of health.
		Provide education on goals of care.	Provide targeted campaign to promote annual wellness visits.	Provide targeted cancer screening programs.	Expand FHN walk-in services, locations and methods of delivering care.	Continue to invest in development of the area's workforce to help meet the future needs of FHN and the community overall.	Identify areas of low healthcare utilization and provide screenings there.
Chronic Disease Management	Improve Chronic Disease Management	Utilize Electronic Health Record to identify patients with 3 or more chronic diseases without goals of care.	Implement value driven program specific to Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease, and Behavioral Health.	Develop and implement quarterly educational programs specific to CHF, COPD, Chronic Kidney Disease and Behavioral Health.	Expand FHN Care Transition Services to assist both patient and support system in the healthcare navigation needs.	Develop and implement non-traditional care delivery models such as telehealth.	Collaborate with community partners in management of chronic disease.