Memorial Community Hospital & Health System

Community Health Improvement Plan and Implementation Strategy 2026–2027

In Response to MCH's 2025 CHNA Cycle and the 2026 Three Rivers Regional Community Health Assessment

Adopted by the MCH Board of Directors: 11/4/2026

Implementation period: Date of Board adoption through December 31, 2027

Board Action and Adoption

Recommended Motion

I move to approve the Memorial Community Hospital Community Health Improvement Plan and Implementation Strategy for 2026–2027, developed in response to MCH's 2025 CHNA cycle and informed by the 2026 Three Rivers Regional Community Health Assessment, and authorize administration to publish the plan and related assessment documents on the MCH website, monitor progress, and make nonmaterial updates to strategies, measures, and annual work plans as additional baseline information becomes available.

Adoption Record

Date approved: 11/4/2026

Motion made by: Dr. John Simonson

Seconded by: Dave Ladwig

Vote: Passed

President/Chief Executive Officer signature: 

Documents to Publish Together

- 2026 Three Rivers Regional Community Health Assessment
- Three Rivers Community Health Improvement Plan 2026–2030
- This MCH Community Health Improvement Plan and Implementation Strategy 2026–2027
- Annual MCH progress summaries as they become available

1. Executive Summary

Memorial Community Hospital (MCH) is committed to partnering with the community to heal, nurture, and promote wellness. This Community Health Improvement Plan and Implementation Strategy describes the actions MCH will take to address significant community health needs identified through the 2026 Three Rivers Regional Community Health Assessment.

The Three Rivers Health Department regional assessment incorporated approximately 100 local, state, and federal data sources, 886 community surveys, 131 participants in three county forums, 31 youth participants, and a Spanish-language focus group. Mental health and access to care emerged consistently as the two highest priorities.

1. **Mental Health and Wellbeing**
2. **Access to Care and Care Navigation**

The Board-approved plan establishes MCH's strategic direction. A separate internal action plan and quarterly progress tracker will define detailed owners, data sources, baselines, numeric targets, due dates, and results.

Plan Timing

This plan was developed in response to MCH's 2025 CHNA cycle. Following completion of the regional assessment process, the final Three Rivers assessment report was published in 2026. MCH then developed this implementation strategy to address the significant community health needs identified. The MCH Board of Directors adopted this plan on _____, 2026. The implementation period runs from Board adoption through December 31, 2027.

2. Community Served

MCH's primary community includes Washington County and surrounding rural communities served by the hospital, Rural Health Clinics, inpatient and outpatient specialty services, emergency services, and community programs. MCH is based in Blair, Nebraska.

Washington County indicator	Assessment figure
Population	**21,106**
Median age	**42.6 years**
Age 65 and older	**19.2%**
Uninsured adults, ages 19–64	**5.5%**
Renters paying 30%+ of income for housing	**47%**
Skipped care due to cost	**19.1%**

Relatively strong insurance coverage and household income do not eliminate barriers such as deductibles, medication costs, transportation, provider shortages, health literacy, and difficulty navigating available services.

3. Assessment and Priority Selection

The assessment identified five recurring concerns: access to care, mental health, chronic disease, housing, and youth wellbeing. Mental health and access to care were selected because both demonstrated substantial need across multiple sources and because MCH and its community partners have the ability to make measurable progress.

Building on the behavioral health priorities identified in MCH's previous Community Health Improvement Plan, including stigma reduction, increased awareness, depression screening, and improved access to services, this plan expands its focus to address healthcare affordability, care navigation, prevention, provider access, and appropriate utilization of healthcare resources.

4. Priority 1: Mental Health and Wellbeing

Community Need

Mental health was the most frequently named concern, with more than 600 survey mentions. Approximately 32.1% of respondents reported stress related to their own or a family member's substance use or health. Washington County has approximately one mental health provider per 2,345 residents, compared with approximately one per 266 residents statewide.

Goal

Improve access to mental health resources, strengthen identification and referral, and increase community awareness of available behavioral health support.

Objective 1.1 | Improve identification and referral

Strategy	Board-level measure	Responsible areas	Timing
Maintain standardized, age- and setting appropriate behavioral health screenings in applicable patient populations.	Screening baseline established; quarterly results reviewed.	Clinics; Emergency Department; Inpatient Services; Quality; Medical Staff	Baseline by Q2 2027; quarterly review
Maintain and improve internal Psychiatry referral workflows.	Workflow reviewed; available internal referral activity summarized.	Clinics; Social Services; Senior Life Solutions; Quality	By Q2 2027; annual review
Educate staff and community about population appropriate available behavioral health resources and referral options.	Education completed for identified staff groups.	Education; Medical Staff; Emergency Department; Clinics	Beginning Q3 2027
Add resources to applicable discharge and referral materials.	Resources and Epic tools reviewed and updated.	Emergency Department; Inpatient Services; Clinics; Marketing	By Q3 2027; annual review

Objective 1.2 | Increase behavioral health awareness and education

Strategy	Board-level measure	Responsible areas	Timing
Conduct MCH behavioral health education and awareness activities independently and with community partners.	At least four education or awareness activities annually.	Community Engagement; Marketing; Senior Life Solutions	Annually
Maintain and promote information about behavioral health, 988, crisis response, and available local services.	Website and public materials reviewed and updated.	Marketing; Community Engagement; Senior Life Solutions	At least annually
Offer Mental Health First Aid or comparable community education at least twice during the implementation period.	Two offerings completed by December 31, 2027.	Community Engagement; Education; community partners	2027–2028
Use MCH communication channels and community events to recognize behavioral health awareness opportunities.	Activities documented in annual progress report.	Marketing; Community Engagement	Ongoing

Objective 1.3 | Strengthen behavioral health partnerships

Strategy	Board-level measure	Responsible areas	Timing
Participate in appropriate regional behavioral health workgroups and initiatives.	Participation and contributions summarized quarterly.	Executive sponsor; Community Engagement; assigned clinical leaders	Quarterly
Strengthen partnerships with local behavioral health, public safety, and community service organizations.	Partnership activities and outcomes documented.	Community Engagement; Social Services; Emergency Department	Ongoing
Explore partnerships and resources for caregivers, grief, dementia, and other community support needs.	Available resources and partnership options evaluated.	Social Services; Senior Life Solutions; Community Engagement	By Q4 2027

5. Priority 2: Access to Care and Care Navigation

Community Need

Cost was the leading health worry. Approximately 23% of district residents and 19.1% of Washington County respondents reported skipping care, medication, or appointments because of cost. Other barriers included rural distance, transportation, provider shortages, insurance complexity, health literacy, and determining the right level of care.

Goal

Improve access to timely, affordable, and appropriate care by strengthening navigation, preventive services, financial-assistance awareness, and access to primary and specialty care.

Objective 2.1 | Improve navigation and connection to services

Strategy	Board-level measure	Responsible areas	Timing
Maintain an internal inventory of available health and community resources.	Inventory established and reviewed at least annually.	Social Services; Revenue Cycle; Clinics	By Q2 2027; annually
Maintain accurate resource information for patients and the community through MCH's website and appropriate materials.	Website and resource materials reviewed and updated.	Social Services; Marketing; Revenue Cycle	By Q2 2027; annually
Improve MCH's presence and participation in shared community-resource platforms such as Find Help.	MCH service listings reviewed, corrected, and expanded as appropriate.	Community Engagement; Marketing; Information Technology; departments	By Q3 2027
Promote financial assistance, cost estimates, MDsave, and enrollment resources.	Materials reviewed; available utilization measures reported.	Revenue Cycle; Marketing; Social Services	Annually
Incorporate the Community Health Worker role into care navigation as the position becomes available.	Role in navigation defined and implemented.	Social Services; Administration	Upon hire

Objective 2.2 | Improve preventive care

Strategy	Board-level measure	Responsible areas	Timing
Use registry, payer, and care-gap data to identify preventive-care opportunities.	Baseline and selected measures reviewed quarterly.	Clinics; Quality; Population Health	Beginning Q1 2027
Conduct targeted outreach for preventive screenings and annual wellness visits.	Outreach and completed services summarized quarterly.	Clinics; Care Navigation; Population Health	Quarterly
Review differences in preventive-care completion by available demographic, geographic, and coverage factors.	Annual review completed and opportunities identified. (Mammography, Colon Cancer Screening, Pap)	Quality; Clinics; Population Health	Annually
Promote preventive health through education, community events, and awareness campaigns.	Activities, participation, and available referrals documented.	Community Engagement; Clinics; Marketing	Annually

Initial measures may include annual wellness visits; colorectal, breast, and cervical cancer screening; kidney health evaluation for patients with diabetes; glycemic control; blood pressure control; and depression screening with follow-up. The internal action plan will identify the final measures, baselines, and targets used for quarterly reporting.

Objective 2.3 | Improve access to primary and specialty care

Strategy	Board-level measure	Responsible areas	Timing
Monitor and address patient access to primary care, including appointment availability, no-shows, and other identifiable barriers.	Access indicators and improvement opportunities reviewed.	Administration; Clinics; Quality	Quarterly
Evaluate specialty-service needs using referral patterns, patient demand, and available utilization data.	Needs review completed and recommendations documented.	Administration; Medical Staff; Clinics; Finance	Annually
Pursue provider recruitment, visiting specialty services, and telehealth opportunities when supported by community need and organizational feasibility.	Recruitment and service-development activity summarized.	Administration; Human Resources; Medical Staff	Ongoing
Facilitate connection to primary care and appropriate follow-up when patients present with ongoing healthcare needs.	Internal process reviewed; trackable results included when available.	Emergency Department; Clinics; Care Navigation	Beginning 2027

6. Other Significant Health Needs

Chronic Disease and Obesity

MCH will address chronic disease through preventive screening, diabetes care, blood-pressure control, wellness visits, nutrition education, rehabilitation, and early identification of care gaps. Approximately 40.1% of adults in the Three Rivers district have obesity and 34.6% have high blood pressure.

Youth Wellbeing

Youth wellbeing is incorporated into the Mental Health priority through education, partnership development, referral coordination, and exploration of youth-specific behavioral health initiatives.

Housing and Broader Social Needs

MCH cannot independently resolve affordable housing, transportation or other broad social needs. MCH will respond through screening, navigation, referral, community collaboration, shared resource platforms, and regional workgroups. These needs will be addressed as factors affecting health and access rather than as separate hospital-led priorities.

7. Governance, Monitoring and Public Reporting

Board and Operational Oversight

The MCH Board of Directors will approve this plan and receive an annual progress report. An MCH Community Health Improvement Team will provide operational oversight and may include executive leadership, Community Engagement, Quality, Nursing, Rural Health Clinics, Emergency Department, Social Services or Care Navigation, Finance or Revenue Cycle, Marketing, Human Resources, and other subject-matter leaders as needed.

Internal Action Plan and Quarterly Progress Tracker

MCH will maintain a separate internal action plan and quarterly progress tracker. The tracker will identify the specific action, owner, supporting departments, measure, data source, baseline, target, due date, quarterly status, barriers, next steps, and supporting evidence. This working document may be updated as data availability and operational needs change without requiring Board approval, provided the priorities and goals in this plan remain unchanged.

Quarterly Review

- Strategies and milestones completed
- Performance measures and available results
- Barriers, delays, and corrective actions
- Community partnerships and resources contributed
- Needed changes and next-quarter priorities
- Success stories and unanticipated outcomes

Annual Public Reporting

MCH will publish an annual progress update describing progress on the goals and strategies, available results, community-benefit activities, partnerships, barriers, changes, and priorities for the following year.

Website Availability

- Current Community Health Needs Assessment
- Current MCH Community Health Improvement Plan and Implementation Strategy
- Related Three Rivers regional plan
- Annual progress summaries
- Instructions for requesting a printed copy

8. Implementation Calendar

Period	Primary deliverables
Q4 2026	Board approval; website publication; confirm implementation team and strategy owners; develop the internal action plan and measurement framework.
Q1 2027	Establish baselines; confirm data sources; finalize the resource inventory and priority referral workflows; begin quarterly reporting.
Q2 2027	Review first-quarter results; initiate priority education, partnership, navigation, and preventive-care activities. Adjust interventions; prepare for the next CHNA cycle and implementation strategy.
Q3 2027	Review progress; adjust strategies as needed; improve MCH information on community-resource platforms; evaluate partnership opportunities.
Q4 2027	Complete annual review; publish a progress summary.

9. References and Source Documents

3. Three Rivers Public Health Department. 2026 Regional Community Health Assessment: Dodge, Saunders, and Washington Counties, Nebraska.
4. Three Rivers Public Health Department. Community Health Improvement Plan 2026–2030.
5. Memorial Community Hospital. Community Health Improvement Plan 2023–2025, developed from the 2022 assessment cycle.
6. Three Rivers Public Health Department CHA/CHIP live dashboard.
7. Healthy People 2030, U.S. Department of Health and Human Services.
8. Internal MCH quality, clinic, Emergency Department, recruitment, community-benefit, and financial-assistance data, as available and appropriate.

Plan Maintenance

This plan may be updated annually to add validated baselines, measurable targets, responsible leads, and revised strategies. Material changes to priorities or goals will be presented to the MCH Board. Nonmaterial implementation updates may be approved administratively and reflected in the internal action plan and annual public progress report.