Fort HealthCare

Community Health Improvement Plan (CHIP)

2026-2028

Paper copies of this document may be obtained at Fort Healthcare, 611 Sherman Ave E, Fort Atkinson, WI 53538.

This document is also available electronically
via the hospital website https://www.forthealthcare.com/community-health-needs-assessment/.

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Fort HealthCare Overview

Fort HealthCare (FHC) is a rural, independent, health system consisting of a 49-bed acute care hospital in Fort Atkinson, Wisconsin and 18 clinics in 6 communities across Jefferson County. Fort HealthCare's mission is "***to improve the health and wellbeing of the community***" and the vision is "***to be the healthiest community in Wisconsin".*** FHC seeks to achieve their mission by favorably impacting health behaviors, clinical care, social drivers of health and the physical environment. Partnerships with area organizations and stakeholders that share similar goals will continue to assure that all residents lead healthy and productive lives.

In 2025, FHC conducted a comprehensive Community Health Needs Assessment (CHNA 2025) in collaboration with the Dodge Jefferson Healthier Community Partnership (DJHCP). In addition to this assessment, FHC collects and monitors multiple sources of qualitative and quantitative data to measure the impact of work implemented across the service area, and to ensure that FHC's strategic plan continues to be aligned with the organizational Mission and Vision.

Sources used in establishing this Community Health Improvement Plan (CHIP) includes:

- Community Health Needs Assessment (CHNA 2025)
- County Health Rankings & Roadmaps – Jefferson Wisconsin
- Jefferson & Dodge County Health Department Health Survey
- Oracle Health Data Intelligence: Oracle Population Health Analytics – data utilized from October-November 2025

CHNA Overview

The 2025 Community Health Needs Assessment (CHNA) builds on a systematic and comprehensive approach to understanding the health and wellbeing of Dodge and Jefferson Counties. Through robust data collection, deep community engagement, and collaboration across sectors, this CHNA serves as a shared blueprint for identifying regional priorities and guiding action over the next three years.

For 2025, the Dodge-Jefferson Healthier Community Partnership (DJHCP) placed an even stronger emphasis on mental health and wellbeing, using the Vital Conditions for Health Framework[1] to understand the upstream factors that shape community outcomes. This model highlighted four essential conditions—Belonging & Connection, Basic Needs, Housing, and Financial Stability—each serving as a core driver of long-term wellbeing and health equity.

The 2025 CHNA also intentionally centers equity and lived experience. Community voices were elevated through youth-led interviews, parent surveys, focus groups, data walks, and broad stakeholder engagement. These perspectives ensured that the assessment not only reflects

data, but also the real challenges, hopes, and experiences of residents, particularly in areas related to financial strain, access to housing, care navigation, discrimination, and other social drivers of health.

As part of the CHNA process, regional partners convened to review both quantitative and qualitative data and to identify the most pressing and actionable needs. Across all sources, stakeholders reaffirmed that mental health and wellbeing remains the region's most urgent and cross-cutting challenge. The partners therefore elevated the four Vital Conditions listed above as the foundational levers for advancing overall community wellness.

While all Vital Conditions identified through the CHNA are important—and Fort HealthCare remains committed to supporting progress across each—Fort HealthCare will additionally focus its organizational Community Health Improvement Plan (CHIP) priorities on two critical health-driving areas: **Prevention** and **Chronic Disease Management**. These priorities were identified through internal clinical data, community need, and alignment with our mission to improve long-term health outcomes, reduce preventable disease, and enhance the quality of life for our patients and communities. This focus also directly supports Fort HealthCare's Mission and Vision, advances the goals outlined in our Strategic Plan, and reinforces the organization's ongoing Performance Improvement Plans (PIPs). Together, these priorities create a cohesive, data-driven foundation for improving health, advancing equity, and ensuring sustained organizational impact.

Together, these regional and organizational priorities ensure a balanced approach: grounding our work in the broad upstream factors identified through the CHNA, while also advancing targeted strategies that leverage Fort HealthCare's clinical strengths to address preventive nutrition and physical activity, as well as primary and secondary chronic disease interventions related to conditions such as diabetes, hypertension, and cancer.

Fort HealthCare CHIP Implementation Strategy

Fort HealthCare's implementation strategy is designed to translate the findings of the Community Health Assessment into focused, measurable action. Guided by the organization's Mission to improve the health and well-being of our community and our Vision to be the healthiest community in Wisconsin, Fort HealthCare utilizes a structured, data-driven approach to prioritize initiatives that address both upstream drivers of health and organizational performance goals. Our strategy aligns with the Fort HealthCare Strategic Plan, organizational and departmental Performance Improvement Plans (PIPs), and priority areas identified through the Community Health Needs Assessment and countywide engagement process. Each initiative is supported by clearly defined goals, evidence-informed interventions, cross-department collaboration, and timelines that ensure accountability. Progress is monitored through ongoing

data collection, evaluation, and stakeholder communication, allowing Fort HealthCare to adapt strategies as needed, sustain improvements, and achieve measurable community health impact.

A core component of Fort HealthCare's CHIP implementation strategy is the use of clinical registry data to inform planning, identify gaps in care, and guide targeted improvement efforts. These insights inform ongoing discussions within clinical leadership and population health teams to prioritize opportunities for improvement. In response to these discussions, Fort HealthCare is developing targeted digital outreach campaigns, planned for early 2026, to engage patients who are not meeting these measures. These campaigns will combine digital outreach with defined clinic-based workflows, including nurse visits for blood pressure checks and staff-supported follow-up for colorectal cancer screening education and scheduling. This approach reflects Fort HealthCare's commitment to pairing digital engagement strategies with thoughtful clinical processes to ensure effectiveness and patient-centered care.

Pediatric registry data also drives our initiatives. Fort HealthCare identified well-child visit completion as a priority area and established plans to convene a focused workgroup to improve performance across pediatric age groups. This workgroup will review current workflows, access, and engagement strategies to support timely well-child visits and align with Fort HealthCare's broader preventive care goals outlined in the CHIP.

Fort HealthCare's implementation strategy is intentionally aligned with the **Wisconsin State Health Improvement Plan (SHIP) 2023–2027**[2], which provides a statewide framework for advancing health equity and addressing the conditions that influence health beyond clinical care. The SHIP emphasizes safe and supportive communities, equitable access to care, mental and emotional well-being, social connectedness, and systems that promote fair opportunities. By incorporating SHIP priorities and recommendations into its CHIP, Fort HealthCare ensures alignment with statewide goals, leverages shared data and best practices, and contributes to coordinated, long-term population health improvement across Wisconsin.

In addition, Fort HealthCare's CHIP implementation strategy is informed by **Healthy People 2030**[3], the national framework outlining evidence-based objectives to improve health and well-being for all. Healthy People 2030's focus on eliminating health disparities, addressing social determinants of health, and promoting cross-sector collaboration reinforces Fort HealthCare's community health approach. Its measurable objectives and evidence-based action models serve as reference points for designing community programs, preventive screenings, health education initiatives, and chronic disease management strategies.

Together, these guiding frameworks—Fort HealthCare's internal strategic direction, clinical registry insights, the Wisconsin SHIP, Healthy People 2030, and findings from the local CHNA—create a cohesive and actionable roadmap for community health improvement. This integrated

approach ensures that Fort HealthCare's CHIP is locally responsive, data-informed, and aligned with state and national priorities. Through this strategy, Fort HealthCare is positioned to drive sustainable improvements in mental health and well-being, preventive care, nutrition and physical activity, and chronic disease prevention and management, advancing our shared vision of a healthier Jefferson County.

CHIP Health Priority: Behavior Health				
Community Health Goal 1: Increase Access to Behavioral Health care for FHC patients and our community				
Strategy	Actions	Outcomes	Resources	Partnerships
Identify need to improve BH access.	Conduct needs assessment with Primary Care Providers, Behavioral Health Providers, Specialty Care providers and the ED, IPS and other FHC Departments	A clear picture of what patients, providers, and departments need to improve access to Behavioral Health services.	FHC Staff	Internal clinical partners: Primary Care, Behavioral Health, ED, IPS
	Identify gaps in behavioral health access and care coordination using assessment data, utilization trends, and provider feedback.	A clear understanding of how often Behavioral Health services are used, where patients are being referred, and where bottlenecks or gaps exist in the care process.	Access to internal EHR data and reporting tools (Oracle, dashboards, internal datasets).	Quality & Integrated Care team (data support) and clinic leadership
	Compile an inventory of existing behavioral health services and referral pathways to identify current capacity and unmet needs for future planning.	A clear understanding of existing internal & external behavioral health services, referral pathways, and resource gaps to improve access to care.	Inventory template and tracking spreadsheet, survey tools, EHR service listings.	Primary Care, Behavioral Health providers, Specialty Care clinicians, Key strategic partners

Community Health Goal 2: Collaboration with DJHCP				
Strategy	Actions	Outcomes	Resources	Partnerships
Fort HealthCare will collaborate with the Dodge-Jefferson Community Health Partnership to align on a shared, bi-county strategy informed by community health assessment findings and regional priorities. Strategy development will focus on coordinated, systems-level approaches that build upon existing strengths and initiatives across Dodge and Jefferson counties.	Specific actions will be identified through ongoing DJHCP planning efforts and will reflect agency-specific roles within the broader regional strategy. Fort HealthCare will implement actions that align with its mission, capacity, and community health priorities once finalized.	Measurable outcomes and evaluation metrics will be established as part of the finalized regional strategy to ensure progress can be tracked over time. Outcomes will focus on improving community-identified priority areas and strengthening cross-county collaboration and impact.	Resources to support this goal will be identified through DJHCP partners and may include shared data, existing programs, funding opportunities, and staff expertise. Fort HealthCare will leverage internal and external resources to support implementation as strategies are finalized.	This goal will be implemented in partnership with the Dodge-Jefferson Community Health Partnership and its member organizations, including local health departments, healthcare systems, and community-based partners. Collaboration will emphasize shared accountability, coordinated action, and alignment across agencies and counties.

Community Health Goal #2 will be addressed in collaboration with the Dodge-Jefferson Community Health Partnership (DJHCP) as part of a shared, bi-county approach to community health improvement. This goal is informed by recent community health assessment findings and ongoing regional discussions identifying shared priority areas across Dodge and Jefferson counties, including basic needs, housing, meaningful work and wealth, and social connectedness.

At the time of this CHIP submission, Fort HealthCare and DJHCP partners are actively engaged in a planning and alignment phase, working to define a coordinated strategy, specific actions, measurable outcomes, resources, and partnership roles. This work is occurring alongside county and organizational approval timelines and is expected to continue into early 2026.

Once the regional strategy and agency-specific action plans are finalized, Fort HealthCare will formally incorporate defined strategies, actions, outcomes, and evaluation measures into this Community Health Improvement Plan and support implementation through existing and emerging partnerships. Progress and updates related to this goal will be documented and shared as part of ongoing CHIP reporting and community communication efforts.

CHIP Health Priority: Prevention				
Community Health Goal 1: Achieve at least an 80% colorectal cancer screening completion rate among eligible adults ages 45–64 by September 30, 2026				
Strategy	Actions	Outcomes	Resources	Partnerships
Expand access, awareness, and navigation support for evidence-based colorectal cancer screening options through community partnerships, clinical engagement, and targeted health education	• Develop and promote a March 2026 colorectal cancer screening campaign aligned with National Colorectal Cancer Awareness Month. • Create a detailed implementation plan to guide colorectal cancer screening outreach, patient follow-up, and clinic workflows. • Prioritize first-time colorectal cancer screenings for adults ages 45–64. • Develop and implement a targeted digital outreach campaign to engage eligible adults ages 45–64 who have not completed a colorectal cancer screening.	• Increase in first-time colorectal screenings for eligible adults. • Progress toward 80% screening completion by 9/30/26, measured monthly through Adult Oracle Population Health Analytics Scorecard reports. .	• Marketing & Communications support for campaign materials • Clinical staff time for education & follow-up • Data analytics assistance for outreach lists • Technical support for digital outreach development and bilingual patient communication. • Educational & promotional materials • Patient navigation support through clinics, and Community Health & Wellness • Funding support for the voucher program (grants, donors, foundation support)	• Fort HealthCare Primary Care Clinics • Fort HealthCare Marketing & Communications • Rock River Community Clinic • Jefferson County Health Department • Tomorrow's Hope • American Cancer Society • FHC Foundation (voucher program funding support) • Local employers promoting preventive screening as part of wellness benefit • Fort HealthCare technology partners

CHIP Health Priority: Prevention				
Community Health Goal 2: Increase colorectal cancer screening rates among Spanish-speaking adults ages 45–64 and older-adults ages 65-75 to 80% by September 30, 2026.				
Strategy	Actions	Outcomes	Resources	Partnerships
Expand access, awareness, and navigation support for evidence-based colorectal cancer screening options through community partnerships, clinical engagement, and targeted health education	• Explore and design a Colonoscopy Voucher Program for uninsured or underinsured adults by 9/30/26. • Provide language-appropriate and culturally relevant outreach, including translated materials, interpreter-led Q&A sessions, and community-based education. • Partner with bilingual community advocates to assist with education and screening navigation. • Offer clinic-based and community-based "Screening Sign-Up Days" at locations frequented by Spanish-speaking community members.	• Spanish-language educational campaign launched by March 2026. • Increased screening completion among Spanish-speaking populations in both age groups. • Development of a colonoscopy voucher program blueprint, including eligibility, funding, and implementation steps, by 9/30/26	• Bilingual patient navigators/interpreters • Culturally adapted educational materials (print & digital) • Partnerships with local media outlets serving Spanish-speaking audiences • Outreach events hosted at community-trusted locations (churches, community centers, schools)	• Fort HealthCare Clinics • Rock River Community Clinic • Jefferson County Health Department • Tomorrow's Hope • Local Spanish-speaking churches & faith leaders • Community Action Coalition • Local media

CHIP Health Priority: Chronic Disease Management – Hypertension				
Community Health Goal: By September 30, 2026, achieve an 80% hypertension control rate (blood pressure <140/90 mmHg) among Fort HealthCare patients.				
Strategy	Actions	Outcomes	Resources	Partnerships
Implement targeted community and clinical screening and referral programs for Hypertension	• Use digital outreach to send automated reminders, education messages, and follow-up prompts for patients with elevated readings or overdue visits. • Consider use of Self-Monitoring Blood Pressure (SMBP) machines and include instructions for accurate self-monitoring and options for borrow/loaner cuffs. • Expand blood pressure screening opportunities across clinics and community locations (senior centers, community events, employer wellness days). • Utilize hypertension education promoting BP checks, education, and lifestyle guidance (digital + print).	Monthly improvements in the percentage of hypertensive patients with BP <140/90 as reported in Oracle dashboards.	• Health screeners for community events • Bilingual educational materials on hypertension, sodium reduction, medication adherence, and lifestyle changes • Clinical workflow tools (smartphrases, digital outreach/Oracle alerts, tracking dashboards) • Staff time for screenings, follow-up visits, and community outreach • Marketing & Communications support for campaign development • Clinic nurse visits for blood pressure measurement	• Fort HealthCare Primary Care Clinics & Care Coordination • FHC Cardiac Rehab & Diabetes/Nutrition Services • Jefferson County Health Department • Rock River Community Clinic • Senior Centers (Jefferson, Fort Atkinson, Lake Mills, Whitewater) • Local employers participating in wellness screenings • American Heart Association (toolkits, patient education)

CHIP Health Priority: Well Child Visits				
Community Health Goal 1: Increase well-child visit completion rates in the 2nd, 3rd, 4th, 5th and 6th years of life groups to at least 70% by September 30, 2026.				
Strategy	Actions	Outcomes	Resources	Partnerships
Strengthen early identification, outreach, and scheduling of overdue and upcoming well-child visits.	• Leverage the Pediatric HealtheRegistry to correctly capture all data, and to identify overdue and upcoming well-child visits monthly. • Maximize digital tools and resources to enhance the patient experience and support completion of well-child visits. • Integrate a "Back on Track" campaign each spring and fall to encourage visit completion. • Ensure adequate appointment availability to support timely completion of well-child visits. • Provide education to families about the importance of annual wellness visits for developmental milestones, vaccinations, and school readiness.	• Achieve well-child visit rates of **≥70%** across pediatric age groups by September 30, 2026. • Increase in completed well-child visits. • Quarterly improvements in registry metrics (numerators/denominators) as seen in the Pediatric HealtheRegistry Scorecard.	• Pediatric HealtheRegistry data analytics support (monthly lists, trend monitoring). • Marketing and Communication support for campaign creation and distribution. • Digital outreach tools for automated reach outs and recalls. • Printing supplies for reminder cards, posters, and parent education materials	• Fort HealthCare Pediatric & Family Practice Clinics (primary partners). • Pediatric Committee & Primary Care Council for operational alignment. • Jefferson County Health Department • Local school districts, Head Start, daycare centers, and preschools for distributing reminders. • Rock River Community Clinic for coordinated referrals and supportive care. • FHC Marketing & Communications for campaign visibility. • Local libraries and community centers for hosting educational materials and pop-up scheduling events

Next Steps

This Community Health Improvement Plan outlines Fort HealthCare's priorities and strategies for the next three years. Fort HealthCare's Community Health & Wellness department, under the guidance of the Executive Director of Population Health, will lead implementation efforts and monitor progress across all priority areas. Ongoing collaboration with internal departments and external community partners will ensure that strategies remain aligned with emerging needs and organizational goals. Progress will be reviewed regularly, reported annually to Fort HealthCare leadership and the Board of Directors, and shared transparently with the community to demonstrate impact, accountability, and continued commitment to improving the health and well-being of the region.

References, Resources, Appendices

- Dodge Jefferson Healthier Community Partnership. (2025, October). Community Health Needs Assessment – Dodge & Jefferson County, WI. https://www.forthealthcare.com/wp-content/uploads/2025/11/CHA_2025_JeffersonCountyData_FinalEdits-Complete-II.pdf
- Dodge–Jefferson Community Health Assessment Community Survey (October – December 2025). https://reporting.alchemer.com/r/699684_68da9c5fa49b02.87147599
- [1]Vital Conditions Framework: https://rippel.org/vital-conditions/
- [2]Wisconsin State Health Improvement Plan (SHIP). https://www.dhs.wisconsin.gov/statehealthplan/index.htm
- [3]Healthy People 2030 Resources. https://odphp.health.gov/healthypeople
- Fort HealthCare Strategic Plan 2025-2028. https://www.forthealthcare.com/wp-content/uploads/2025/05/2025-2028-Strategic-Plan-May-2025.pdf