



2026-2028 IMPLEMENTATION STRATEGY

Created in alignment with the Community Health Needs Assessment

Introduction

This implementation plan describes how Williamson Memorial, Inc. will address priority community health needs identified through the Community Health Needs Assessment process over the three-year period 2026–2028. The focus is on improving access to inpatient and outpatient services, supporting early detection and prevention of chronic conditions, strengthening coordinated care, and contributing to local economic vitality and workforce participation in the rural service area. Strategies were developed with input from providers, community stakeholders, and partners. All actions are scheduled for 2026-2028 implementation. All actions align with the current CHNA cycle and will be evaluated annually, with a new CHNA and updated strategy planned for the next three-year cycle.

Williamson Memorial, Inc. identified three key priorities including Hospital Access, Early Detection and building the Continuum of Care in the community. This document provides a summary of the implementation strategies that were adopted.

Implementation Strategies

- 1. Improving Access to Diagnostic and Preventive Services**
- 2. Early Detection of Chronic Conditions**
- 3. Strengthening the Continuum of Care**

1. Improving Access to Diagnostic and Preventive Services

Actions: Establish in-house radiology, laboratory, nutrition, and physical therapy services to support inpatient care and community prevention efforts.

Timeline: Initial launch in 2026 with full operations by end of 2027; continued expansion and optimization through 2028.

Anticipated Impact: Greater local access to care, reduced travel burdens for patients and families, and support for early detection of chronic conditions.

Measurement: Year-over-year revenue growth for each service line (compared to baseline), increased service utilization, and positive community feedback on access.

2. Early Detection of Chronic Conditions

Actions: Position the hospital as a diagnostic hub through provider outreach, streamlined referral pathways, and educational programs on lifestyle interventions for conditions such as pre-diabetes, liver disease, and cancer.

Timeline: Ongoing rollout beginning 2026, with sustained outreach and program delivery through 2028.

Anticipated Impact: Higher rates of early-stage diagnosis and treatment, lower chronic-disease costs, and fewer hospitalizations.

Measurement: Claims-data trends showing reduced chronic-condition costs and hospitalization rates, plus increased early-intervention volume.

3. Strengthening the Continuum of Care

Actions: Build referral networks, hub-and-spoke service models, and integrated workflows across primary/specialty care, inpatient treatment, and preventive programs. Incorporate telehealth, remote patient monitoring (starting with discharge planning), and cost-reducing technologies for radiology, laboratory, and inpatient operations.

Timeline: Phased rollout concurrent with service-line launches in 2026; full integration and refinement through 2028.

Anticipated Impact: Seamless patient journeys, improved care coordination, higher patient loyalty, and more efficient hospital operations.

Measurement: Increased referral volume; reduced unnecessary transfers; community feedback on care coordination.

Resources, Partnerships, and Collaboration

Implementation will be supported by operational funding, grant resources, and technology investments. Key partners include the local provider network, academic institutions, community organizations, and workforce development groups. The hospital will continue coordinating with regional health partners to maximize impact and avoid duplication.

Evaluation and Monitoring

Progress will be reviewed quarterly using the metrics listed above, with annual updates reported to the board and community stakeholders. A comprehensive evaluation will occur in 2028 to inform the next CHNA cycle and any plan adjustments needed to ensure measurable community benefit.

This document provides a roadmap for a three-year implementation strategy that positions Williamson Memorial, Inc. as a sustainable community resource that delivers measurable improvements in health access, prevention, and care coordination.