



# SOUTH COUNTY HEALTH

## 2026-2028 Community Health Improvement Plan



## About South County Health

At South County Health, our mission is clear: to be Rhode Island's Most Trusted Health Partner, delivering the highest quality, accessible, and sustainable healthcare to our community. We are deeply committed to the health and wellbeing of our community. Our focus remains on expanding access, driving medical innovation, and delivering exceptional experiences to our patients through personalized, high-quality, and safe care—all close to home.

What began as a cottage hospital on Kenyon Avenue in 1919 has evolved into a technologically advanced healthcare system whose innovations and expertise has enabled South County Health to gain national and international recognition for excellence in patient care and positive outcomes.

We look forward to providing care to this and future generations of patients and continually advancing the medical capabilities we offer and the health of those we serve.

South County Health is a leader in medical quality, service, and innovation, providing care to patients across Rhode Island in acute and outpatient settings. South County Health is comprised of South County Hospital, South County Medical Group, and South County Home Health. South County Hospital is a 100-bed acute care hospital located in Wakefield, RI. It is one of only two hospitals in Rhode Island currently with a 5-Star rating.

South County Health is dedicated to understanding and addressing the most pressing health and wellness concerns for the communities we serve. In collaboration with the Hospital Association of Rhode Island (HARI) and its member hospitals, South County Health undertook a Community Health Needs Assessment (CHNA) for its service area. The goal of the CHNA is to monitor the health of community members and to identify common and unique challenges across the region. The CHNA informs the development of a Community Health Improvement Plan (CHIP) to address identified priority needs and align community investments with the highest needs.

### South County Health 2025 CHNA and CHIP Leadership

**Holly Fuscaldo**, LICSW, QMHP, CCISM

*Clinical Team Lead, Case Management & Behavioral Health*

**Nina Laing**, RN, BSN, CCM

*Director, Case Management Department*

## 2026-28 Community Health Improvement Plan

### What is a Community Health Improvement Plan (CHIP)?

A CHIP helps organizations move from data to action to address priority health needs identified in the Community Health Needs Assessment (CHNA). The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, strategies, and action steps over the three-year reporting timeframe. Anchoring initiatives and community benefit activities to measurable objectives, the CHIP creates a framework for measuring the impact of our work.

### Determining Community Health Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining health priorities on which to focus its efforts over the next three-year cycle, South County Health leadership reviewed findings from the CHNA and sought to align with its health improvement programs and population health management strategies.

South County Health applied the following rationale and criteria to define community health priorities:

- Prevalence of disease and number of community members affected
- Rate of disease compared to state and national benchmarks
- Health differences between community members
- Existing programs, resources and expertise to address issues
- Input from community partners and representatives
- Alignment with concurrent public health and social service organization initiatives

Based on the CHNA findings, South County Health will focus on the following priority areas, addressing underlying Social Drivers of Health and the needs of distinct population groups as cross-cutting strategies:



## Community Input and Alignment

Like the CHNA, the CHIP reflects input from diverse stakeholders and helps to foster collaboration among community-based organizations. Community health priorities and health improvement strategies for South County Health are aligned with the work of other HARI member hospitals and the Rhode Island Department of Health's Health Equity Initiatives.

The CHIP also continues to advance the work of Healthy Bodies, Healthy Minds, Washington County's Health Equity Zone (HEZ). Healthy Bodies, Healthy Minds is one of 14 HEZs in Rhode Island created in 2015 by the Rhode Island Department of Health to remove obstacles to improve community health and wellbeing. South County Health serves on the Steering Committee for the HEZ and provides administrative support.

Health and human service experts and community members alike provided input to define and recommend solutions to the historical and day-to-day challenges in our community. Together this input provided diverse perspectives on health trends, helped us better understand lived experiences among historically disenfranchised and underserved populations, and provided insights into service delivery gaps that contribute to health disparities and inequities.

## Developing a Plan for Health Improvement

Community health improvement requires collaboration among community-based organizations, policy makers, funders, and many other partners. The CHIP outlines goals and strategies to address our community’s most pressing health needs and is supported by specific action steps to be taken by South County Health. We will continue to monitor and share our progress toward these efforts during the 2026-2028 reporting cycle.

Access to Care			
<b>Goal:</b>	<b>Increase timely, affordable, and culturally responsive access to primary, preventive, and specialty care.</b>		
<b>CHNA Identified Needs:</b>	<ul style="list-style-type: none"> <li>• Rising cost of living and affordability concerns; federal funding cuts</li> <li>• Declining/Limited primary care availability</li> <li>• Limited services for aging population</li> <li>• Uninsured or underinsured residents</li> <li>• Transportation and geographic barriers</li> <li>• Language, cultural, and digital barriers</li> </ul>		
<b>Healthy Bodies Healthy Minds Alignment:</b>	Health advocacy; housing workgroup; aging services		
<b>CHIP Strategies:</b>	<table border="1"> <tr> <td> <ul style="list-style-type: none"> <li>• Recruit and retain primary care providers</li> <li>• Support statewide advocacy efforts for primary care reimbursement</li> <li>• Optimize scheduling and referral processes for improved continuity of care</li> <li>• Strengthen patient care coordination and navigation for more proactive healthcare</li> <li>• Collaborate with health and social service partners to provide community-based case management for patients with complex health needs</li> <li>• Conduct universal screening for health-related social needs (HRSNs) across inpatient and ambulatory settings</li> <li>• Improve transportation options (Uber, vouchers, ride partnerships, etc.)</li> <li>• Reduce disparities related to insurance status, language, race/ethnicity, and geography</li> </ul> </td> <td> <b>CHIP Measures:</b> <ul style="list-style-type: none"> <li>• Percentage of residents with a usual source of care</li> <li>• Utilization of preventive services</li> <li>• Primary care access rate</li> <li>• HRSN screening and referral completion</li> <li>• Average wait time for appointments</li> <li>• Community Care Team interventions</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>• Recruit and retain primary care providers</li> <li>• Support statewide advocacy efforts for primary care reimbursement</li> <li>• Optimize scheduling and referral processes for improved continuity of care</li> <li>• Strengthen patient care coordination and navigation for more proactive healthcare</li> <li>• Collaborate with health and social service partners to provide community-based case management for patients with complex health needs</li> <li>• Conduct universal screening for health-related social needs (HRSNs) across inpatient and ambulatory settings</li> <li>• Improve transportation options (Uber, vouchers, ride partnerships, etc.)</li> <li>• Reduce disparities related to insurance status, language, race/ethnicity, and geography</li> </ul>	<b>CHIP Measures:</b> <ul style="list-style-type: none"> <li>• Percentage of residents with a usual source of care</li> <li>• Utilization of preventive services</li> <li>• Primary care access rate</li> <li>• HRSN screening and referral completion</li> <li>• Average wait time for appointments</li> <li>• Community Care Team interventions</li> </ul>
<ul style="list-style-type: none"> <li>• Recruit and retain primary care providers</li> <li>• Support statewide advocacy efforts for primary care reimbursement</li> <li>• Optimize scheduling and referral processes for improved continuity of care</li> <li>• Strengthen patient care coordination and navigation for more proactive healthcare</li> <li>• Collaborate with health and social service partners to provide community-based case management for patients with complex health needs</li> <li>• Conduct universal screening for health-related social needs (HRSNs) across inpatient and ambulatory settings</li> <li>• Improve transportation options (Uber, vouchers, ride partnerships, etc.)</li> <li>• Reduce disparities related to insurance status, language, race/ethnicity, and geography</li> </ul>	<b>CHIP Measures:</b> <ul style="list-style-type: none"> <li>• Percentage of residents with a usual source of care</li> <li>• Utilization of preventive services</li> <li>• Primary care access rate</li> <li>• HRSN screening and referral completion</li> <li>• Average wait time for appointments</li> <li>• Community Care Team interventions</li> </ul>		

Behavioral Health			
<b>Goal:</b>	<b>Improve access to high-quality mental health and substance use services and reduce stigma.</b>		
<b>CHNA Identified Needs:</b>	<ul style="list-style-type: none"> <li>Shortage of behavioral health providers</li> <li>Insurance barriers for behavioral health services (reimbursement, health insurance coverage)</li> <li>Rising rates of anxiety, depression, and substance use</li> <li>Limited crisis and follow-up services</li> <li>Stigma and lack of awareness</li> </ul>		
<b>Healthy Bodies Healthy Minds Alignment:</b>	Statewide advocacy for care access and support; Mental Health First Aid; Crisis Intervention Team and training; youth programming; etc.		
<b>CHIP Strategies:</b>	<table border="0" style="width: 100%;"> <tr> <td style="vertical-align: top; width: 60%;"> <ul style="list-style-type: none"> <li>Advance Healthy Bodies Healthy Minds county-wide strategic effort to transform behavioral health services</li> <li>Support advocacy efforts for insurance parity for behavioral health services</li> <li>Implement universal patient screening for depression and suicide risk in the ED</li> <li>Support warm handoff referrals and earlier access to treatment for patients seen in the ED with behavioral health concerns</li> <li>Provide staff training in suicide prevention and crisis intervention</li> <li>Expand crisis intervention and mobile response teams</li> <li>Increase access to peer support and recovery services</li> <li>Provide community education on mental health and substance use</li> <li>Enhance school-based mental health support</li> <li>Provide hospital-based support for patients with dementia and Alzheimer's disease</li> </ul> </td> <td style="vertical-align: top; width: 40%;"> <p><b>CHIP Measures:</b></p> <ul style="list-style-type: none"> <li>Behavioral health provider-to-population ratio</li> <li>Staff training rates</li> <li>Patient screening rates</li> <li>ED visits for mental health crises and treatment access</li> <li>Community self-reported mental health status</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>Advance Healthy Bodies Healthy Minds county-wide strategic effort to transform behavioral health services</li> <li>Support advocacy efforts for insurance parity for behavioral health services</li> <li>Implement universal patient screening for depression and suicide risk in the ED</li> <li>Support warm handoff referrals and earlier access to treatment for patients seen in the ED with behavioral health concerns</li> <li>Provide staff training in suicide prevention and crisis intervention</li> <li>Expand crisis intervention and mobile response teams</li> <li>Increase access to peer support and recovery services</li> <li>Provide community education on mental health and substance use</li> <li>Enhance school-based mental health support</li> <li>Provide hospital-based support for patients with dementia and Alzheimer's disease</li> </ul>	<p><b>CHIP Measures:</b></p> <ul style="list-style-type: none"> <li>Behavioral health provider-to-population ratio</li> <li>Staff training rates</li> <li>Patient screening rates</li> <li>ED visits for mental health crises and treatment access</li> <li>Community self-reported mental health status</li> </ul>
<ul style="list-style-type: none"> <li>Advance Healthy Bodies Healthy Minds county-wide strategic effort to transform behavioral health services</li> <li>Support advocacy efforts for insurance parity for behavioral health services</li> <li>Implement universal patient screening for depression and suicide risk in the ED</li> <li>Support warm handoff referrals and earlier access to treatment for patients seen in the ED with behavioral health concerns</li> <li>Provide staff training in suicide prevention and crisis intervention</li> <li>Expand crisis intervention and mobile response teams</li> <li>Increase access to peer support and recovery services</li> <li>Provide community education on mental health and substance use</li> <li>Enhance school-based mental health support</li> <li>Provide hospital-based support for patients with dementia and Alzheimer's disease</li> </ul>	<p><b>CHIP Measures:</b></p> <ul style="list-style-type: none"> <li>Behavioral health provider-to-population ratio</li> <li>Staff training rates</li> <li>Patient screening rates</li> <li>ED visits for mental health crises and treatment access</li> <li>Community self-reported mental health status</li> </ul>		

Chronic Disease			
<b>Goal:</b>	<b>Reduce chronic disease incidence and mortality through prevention, early detection, and management support.</b>		
<b>CHNA Identified Needs:</b>	<ul style="list-style-type: none"> <li>• Rising cost of living and affordability concerns; federal funding cuts</li> <li>• Primary and specialty care access barriers</li> <li>• Disparities in health literacy</li> <li>• Disparities in disease prevalence and outcomes</li> <li>• Declining health and social wellbeing for aging population</li> <li>• Limited support for disease management and care navigation</li> </ul>		
<b>Healthy Bodies Healthy Minds Alignment:</b>	Health advocacy; housing workgroup; aging services		
<b>CHIP Strategies:</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Implement Mobile Integrated Health Program for community-based care and navigation support</li> <li>• Strengthen community partnerships and build capacity for initiating supportive services for older adults</li> <li>• Partner with skilled nursing facilities to improve transitions of care</li> <li>• Strengthen patient care coordination and navigation for more proactive healthcare</li> <li>• Collaborate with health and social service partners to provide community-based case management for patients with complex health needs</li> <li>• Provide point-of-care support to address health-related social needs</li> <li>• Provide evidence-based nutrition education and programming</li> <li>• Expand community-based and mobile screening, health education, and vaccination</li> </ul> </td> <td style="width: 40%; vertical-align: top;"> <p><b>CHIP Measures:</b></p> <ul style="list-style-type: none"> <li>• Utilization of preventive services</li> <li>• Readmission rates</li> <li>• Provision of financial support</li> <li>• Outcomes by insurance status, language, race/ethnicity, and geography</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>• Implement Mobile Integrated Health Program for community-based care and navigation support</li> <li>• Strengthen community partnerships and build capacity for initiating supportive services for older adults</li> <li>• Partner with skilled nursing facilities to improve transitions of care</li> <li>• Strengthen patient care coordination and navigation for more proactive healthcare</li> <li>• Collaborate with health and social service partners to provide community-based case management for patients with complex health needs</li> <li>• Provide point-of-care support to address health-related social needs</li> <li>• Provide evidence-based nutrition education and programming</li> <li>• Expand community-based and mobile screening, health education, and vaccination</li> </ul>	<p><b>CHIP Measures:</b></p> <ul style="list-style-type: none"> <li>• Utilization of preventive services</li> <li>• Readmission rates</li> <li>• Provision of financial support</li> <li>• Outcomes by insurance status, language, race/ethnicity, and geography</li> </ul>
<ul style="list-style-type: none"> <li>• Implement Mobile Integrated Health Program for community-based care and navigation support</li> <li>• Strengthen community partnerships and build capacity for initiating supportive services for older adults</li> <li>• Partner with skilled nursing facilities to improve transitions of care</li> <li>• Strengthen patient care coordination and navigation for more proactive healthcare</li> <li>• Collaborate with health and social service partners to provide community-based case management for patients with complex health needs</li> <li>• Provide point-of-care support to address health-related social needs</li> <li>• Provide evidence-based nutrition education and programming</li> <li>• Expand community-based and mobile screening, health education, and vaccination</li> </ul>	<p><b>CHIP Measures:</b></p> <ul style="list-style-type: none"> <li>• Utilization of preventive services</li> <li>• Readmission rates</li> <li>• Provision of financial support</li> <li>• Outcomes by insurance status, language, race/ethnicity, and geography</li> </ul>		

## Community Commitment and Collaboration

The 2025 CHNA report was presented to the South County Health Board of Directors and approved in September 2025. The corresponding three-year CHIP was presented to the Board of Directors and approved in January 2026.

South County Health is committed to advancing initiatives and community collaboration to address the needs identified through the CHNA. We welcome your partnership to meet the health and medical needs of our community. We know we cannot do this work alone and that sustained, meaningful health improvement will require collaboration to bring the best that each of our community organizations has to offer.

To contact us, please visit [southcountyhealth.org](https://southcountyhealth.org) or contact Nina Laing at [nlaing@southcountyhealth.org](mailto:nlaing@southcountyhealth.org).

Together, we can make our communities better places to live, work, learn, and play.