

2026-2028

Fairfield County Community Health Improvement Plan

Coordinated by the Fairfield County Health Partners: Fairfield Medical Center, Fairfield County Department of Health and Fairfield Community Health Center.



Fairfield Medical Center: Community Health Improvement Plan (CHIP) 2026-2028

Fairfield Medical Center's Community Health Improvement Plan is based on the findings of the 2025 Fairfield County Health Assessment conducted by Fairfield Department of Health, Fairfield Community Health Center and Fairfield Medical Center. From the health needs identified in this assessment, FMC selected the following priorities that most closely aligned with its mission, goals, resources and strategic initiatives:

- 1) Access to Care
- 2) Cardiovascular Care
- 3) Cancer Care

By addressing access to care, cardiovascular care and cancer care together, FMC's 2026–2028 CHIP creates a comprehensive, equity-driven framework to improve health outcomes in Fairfield County.

Each of these areas contributes significantly to local morbidity and mortality, healthcare utilization, and health disparities. Through focused prevention, expanded access, coordinated care, and robust partnerships, FMC will support a healthier community—now and into the future.

Priority Area: Access to Care

Introduction

Access to timely, affordable, and continuous primary and specialty care is essential for preventing disease progression, managing chronic illness, and reducing avoidable emergency department utilization.

Through this CHIP priority area, Fairfield Medical Center (FMC) will strengthen its healthcare workforce, expand access to affordable services, and raise community awareness of available resources. These efforts will ensure that all residents of Fairfield County can access the right care, at the right time, in the right setting.

Vision Statement

All residents of Fairfield County have timely, affordable, and equitable access to high-quality primary and specialty care—supported by a strong healthcare workforce and effective community partnerships.

Goals, Objectives, Strategies, and Metrics (2026–2028)

Goal	Objectives (by End of 2028)	Key Strategies / Action Steps	Metrics / Indicators
Goal 1: Strengthen primary and specialty care access in our community.	1. Recruit and retain primary care providers. 2. Recruit and retain specialty care providers.	 Physician Relations and Human Resources will collaborate with FMC leadership to identify areas of provider need. Implement recruitment campaigns and retention initiatives to attract and support high-quality providers. Leadership will engage with providers to address workplace concerns and enhance professional satisfaction. 	 Reduction in provider vacancy rate. Number of new providers recruited. Provider retention rate. Average patient wait time for new appointments.
Goal 2: Expand access to affordable and	Increase availability of low- or no-cost care options	Partner with our foundation to provide financial assistance	Number of cardiac rehab scholarships provided.

preventive care services.	for uninsured and underinsured residents. 2. Expand community-based health services for priority populations.	and scholarships for cardiac rehabilitation and other medical services. • Collaborate with external organizations to provide free or low-cost mammograms and women's health visits. • Provide free health screenings and sports physicals in partnership with area schools and community organizations.	 Number of mammogram/women's health events hosted. Number of free screening events conducted. Number of student athletes receiving physicals. Number of community members served through affordability initiatives.
Goal 3: Increase community awareness and navigation of available healthcare services.	1. Improve public awareness of FMC services and how to access them. 2. Strengthen communication about FMC's role in community health.	 FMC will identify priority areas for community education and outreach. Develop and distribute educational materials in print, digital, and social media formats. Feature FMC services and programs in <i>The Monitor</i> and on social media platforms. 	 Number of educational articles and social posts published. Digital engagement metrics (impressions, clicks, shares). Community survey results indicating awareness of FMC services. Attendance at outreach and education events.

Evaluation and Reporting

Progress toward Access to Care goals will be reviewed annually. Metrics will be tracked through internal HR, community benefit, and marketing data, as well as partner organization reports. Findings will guide ongoing improvement and inform the next CHIP cycle.

Conclusion

By investing in workforce development, affordability, and community outreach, Fairfield Medical Center aims to make care more accessible for every resident of Fairfield County. These initiatives will strengthen the healthcare infrastructure, reduce barriers to access, and support a healthier, more connected community.

Priority Area: Cardiovascular Health

Introduction

Fairfield Medical Center's strengths in heart and vascular care, combined with demonstrated community need, create an opportunity to significantly reduce cardiovascular risk, improve outcomes, and narrow health disparities in Fairfield County. This CHIP outlines goals, objectives, strategies, and performance measures for prevention, early detection, management, and community engagement related to cardiovascular health for 2026–2028.

Vision

All residents of Fairfield County achieve healthier lives through reduced cardiovascular risk — supported by prevention, early detection, equitable access to high-quality care, and long-term disease management.

Goals, Objectives & Strategies (2026–2028)

Goal	Objectives (by end of 2028)	Key Strategies / Action Steps	Metrics / Indicators
Goal 1: Improve access to prevention and early detection of cardiovascular risk factors (e.g., diabetes mellitus, hypertension, hyperlipidemia, smoking, obesity).	Expand access to preventive cardiology services. Increase community participation in cardiovascular risk screenings.	 FMC will identify provider needs and recruit cardiology and preventive medicine specialists. Conduct regular community screenings for blood pressure, cholesterol, and BMI through primary care offices and health fairs. Launch education campaigns promoting heart-healthy diets, physical activity, and sodium reduction. 	Number of community screening events conducted. Number of individuals screened. Percentage of screened participants referred for follow-up care. Social media and community outreach impressions.

Goal 2: Improve access to specialty cardiovascular care.	1. Implement an outpatient heart monitor review and referral program. 2. Reduce wait times for cardiology appointments and procedures.	FMC will assess specialist demand and recruit additional cardiovascular providers. Expand cardiac rehabilitation access, including scholarship opportunities for underinsured patients. Develop referral pathways between primary care and cardiovascular specialists.	 Number of patients participating in cardiac rehab. Number of cardiac rehab scholarships provided. Average appointment wait time for new cardiology referrals. Patient satisfaction scores related to access.
Goal 3: Strengthen community engagement, education, and lifestyle support around cardiovascular health.	Increase public awareness of FMC's cardiovascular services. Promote healthy behaviors through community partnerships and outreach.	 FMC will create public education campaigns focused on cardiovascular health. Publish articles in <i>The Monitor</i> and on FMC's website and social media platforms. Collaborate with schools, employers, and community organizations to deliver lifestyle education and screenings. 	 Number of cardiovascular health articles published. Engagement metrics from digital and social media content. Number of community organizations engaged in cardiovascular health initiatives.

Evaluation and Reporting

Progress toward these objectives will be tracked annually. Performance will be reviewed using both quantitative data and qualitative input from community partners and participants. Annual reports will summarize progress and guide adjustments to strategies as needed.

Conclusion

By aligning clinical excellence with community outreach and prevention, Fairfield Medical Center aims to make measurable progress in reducing cardiovascular disease burden across Fairfield County. Through this CHIP, FMC reaffirms its commitment to building a healthier, more equitable community for all residents.

Priority Area: Cancer Care

Introduction

Over the 2026–2028 CHIP cycle, Fairfield Medical Center (FMC) aims to reduce the cancer burden in Fairfield County by enhancing prevention and early detection, improving the timeliness and quality of treatment, addressing disparities in care, and strengthening survivorship and quality of life support.

Through coordinated efforts across service lines, community partnerships, and patient engagement, FMC will ensure that every individual has equitable access to high-quality cancer care— from prevention through survivorship.

Vision

All residents of Fairfield County have equitable access to comprehensive, high-quality cancer prevention, detection, treatment, and survivorship care—resulting in earlier diagnoses, better outcomes, and improved quality of life.

Goals, Objectives, Strategies, and Metrics (2026–2028)

Goal	Objectives (by End of 2028)	Key Strategies / Action Steps	Metrics / Indicators
Goal 1: Increase early detection of common cancers.	1. Raise rates of screening for breast, colorectal, lung, and cervical cancers among eligible populations.	 Develop targeted outreach campaigns to raise awareness of recommended cancer screenings. Partner with primary care practices to strengthen screening reminders and navigation 	 Screening rates by cancer type and demographic subgroup. Stage at diagnosis data. Number of screening events
		support.	conducted.
Goal 2: Improve treatment access, timeliness, and continuity of care.	1. Ensure newly diagnosed cancer patients begin treatment within recommended timeframes (e.g., within 30 days of diagnosis). 2. Ensure 100% of complex cancer cases receive multidisciplinary care planning.	 Assess barriers to care and implement targeted solutions. Maintain program accreditation and continuous quality improvement in cancer treatment. 	 Median time from diagnosis to treatment initiation. Percent of patients with documented multidisciplinary care plan.

			Patient satisfaction and access metrics.
Goal 3: Enhance survivorship support and quality of life.	 Implement survivorship care plans for all cancer survivors by end of 2028. Establish support programs and achieve active participation among interested survivors. 	 Develop and expand survivorship programs (support groups, rehabilitation, nutrition, exercise, counseling). Ensure each patient discharged from active treatment receives a personalized survivorship care plan, including follow-up schedule and resources. 	 Number of survivorship care plans delivered. Participation rates in survivorship and support programs.

Evaluation and Reporting

Progress toward cancer care goals will be reviewed annually. Data will be collected from internal clinical systems, cancer registry metrics, and community partners. Evaluation will include both quantitative and qualitative measures to assess impact, equity, and sustainability.

Conclusion

By prioritizing prevention, early detection, equitable access, and comprehensive survivorship support, Fairfield Medical Center will continue advancing high-quality, person-centered cancer care for all residents of Fairfield County. These initiatives strengthen FMC's mission to provide excellence in care while reducing disparities and improving community well-being.



Adoption of Community Health Improvement Plan

On December 3, 2025, the Board of Directors for Fairfield Medical Center met to discuss the 2026-2028 Community Health Improvement Plan. Upon review, the Board approved the 2026-2028 Community Health Improvement Plan.

Matthew Wideman

Fairfield Medical Center Board of Directors