Morton Hospital Community Health Improvement Plan

October 1, 2025 – September 30, 2028

As a result of the Community Health Needs Assessment (CHNA) prepared for Morton Hospital (MH) as of September 30, 2025, MH's leadership team, executive management, and other individuals critical to the organizational planning process have created an implementation strategy detailing action item plans covering the period from October 1, 2025 through September 30, 2026 to address the significant needs identified in MH's CHNA report. Based on the complex health issues in the community, MH has strategically planned ways to address these significant needs in order to maximize the improvement of the overall health and wellness of residents within its community. As discussed in the 2025 CHNA, available online at https://www.brownhealth.org/sites/default/files/2025-10/Brown-University-Health-Morton-Hospital-2025-CHNA-Final.pdf, the following issues were identified as the significant health needs currently facing our community*:

1. Access to Care and Services
2. Behavioral Health
3. Chronic Disease Prevention and Management
4. Housing
5. Maternal and Child Health
6. Older Adult Health and Wellbeing

*Note: while 1-3 above were identified as the top 3 health-related needs, additional social factors (4-6) were identified as areas of concern that affect individuals' health and wellbeing. Morton Hospital has also identified some actions we can take to directly or indirectly help address these identified needs as noted below.

Significant Health Need #1: Access to Care and Services				
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on MH Community	Outside Groups Collaboration	Timeframe for Implementation
1.1 Expand access points for primary and preventive care by recruiting and building our primary care network.	• Executive leadership team • Provider recruitment team	• Increased ability for residents to obtain timely preventive and routine care	• N/A	FY 2026-27

	• Marketing team			
1.2 Continue universal screening of patients for socioeconomic needs that may delay care (food insecurity, transportation, etc.) and generate referrals to community-based supports.	• Patient Access staff • ED staff, including social workers • Community partners • Patient Advocate • Resource guides and collateral	• Enhance access to support and wraparound services for patients in need • Reduced avoidable ED reliance for non-emergent needs by improving navigation and outpatient linkage	• Community Counseling of Bristol County (CCBC) • Local health and human service organizations	FY 2026-28
1.3 Continue to offer financial counseling services to help patients obtain health insurance coverage and navigate financial barriers	• Financial counselors • Patient Access staff • Care Management/Social Workers • Financial Assistance Plan signage and handouts • Other financial resource collateral	• Increase percentage of residents in our service area with health insurance coverage • Increase patient satisfaction and reduce stresses associated with financial burdens • Increase the number of patients seeking essential and preventative health care services	• Insurance carriers	FY 2026-28
1.4 Monitor capacity and access issues for key service lines including preventative screenings; work with provider offices to remove any barriers to accessing care; identify solutions when barriers and access issues are identified to ensure access to timely care.	• Executive leaders and department managers • Practice Administrator Luncheons • Marketing staff; communication between hospital and practices	• Improved access to care by reducing barriers, improving coordination, and reducing cancellations • Increased patient satisfaction • Increased number of residents receiving preventative screenings and care	• Brown Health Medical Group • Manet Community Health Center	FY 2026-28
1.5 Partner with Revere Health and other non-Brown University Health primary care practices to facilitate referrals between primary care and Morton services	• MH staff support • Provider liaison • Practice leadership • MH brochures and provider profile cards • Referral guides	• Improved access to care by reducing barriers, improving coordination, and reducing cancellations • Increased patient satisfaction	• Revere Health	FY 2026-28

		• Increased number of residents receiving preventative screenings and care		
1.6 Continue community outreach efforts such as health fair participation, community blood pressure screenings, and community health education programming that may serve as a gateway to essential care needs.	• MH staff support • Educational materials	• Raise awareness of health risks • Education to help patients understand the resources and services available at Morton and within the community • Assistance with referrals to primary care and other services	• Community organizations that host screening events and health fairs	FY 2026-28
1.7 Improve collection and analysis of race, ethnicity and language data in LifeChart to ensure we are meeting patient needs	• MH Quality team • MH staff support • Health Equity Council	• Patient demographic data in health records match the patients' self-described demographics • Improved data collection for analysis and planning purposes • Ability to accurately measure and target racial and ethnic health disparities	• Partner organizations represented on our Health Equity Council	FY 2026
Significant Health Need #2: Behavioral Health				
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on MH Community	Outside Groups Collaboration	Timeframe for Implementation
2.1 Maintain and strengthen ED-based crisis response and daily case review to connect patients to follow-up services and reduce discharge barriers	• ED Behavioral Health Crisis Team • Community partners • ED staff, including social workers	• Increased navigation and access to mental and behavioral health services	• Community Counseling of Bristol County (CCBC) • Community Crisis Intervention Team (CCIT) • RAP	FY 2026-28

2.2 Partner with the City of Taunton to discuss the feasibility of implementing a Recovery Coach program in our Emergency Department.	• Recovery coaches • ED staff, including behavioral health staff and social workers • Program leaders • Support resources and collateral	• Increased support and navigation for patients experiencing addiction or in recovery • Reduced rate of SUD related visits to the Emergency Department	• City of Taunton	FY 2026
2.3 Continue our DPH Healthcare Quality & Equity Improvement Project goal of ensuring patients who come to our Emergency Department seeking crisis intervention have a follow-up appointment with an outpatient psychiatry provider within 7 days of discharge	• MH Quality team • ED Behavioral Health team • ED staff support, including social workers	• Enhanced follow up care • Reduced readmissions to the ED	• DPH	FY 2026
2.4 Grow our behavioral health team and increase appointment capacity in our Outpatient Psychiatry Clinic	• Hospital leadership • Provider recruitment team • Psychiatry staff support	• High risk population will have greater access to outpatient behavioral health services	• N/A	FY 2026
2.5 Explore behavioral health telehealth opportunities to enhance access to care	• Hospital and system leadership • Behavioral health leadership and staff support • IS staff support	• Increased access to behavioral health services including expanded appointment times	• N/A	FY 2026-27
2.6 Participate in community coalitions addressing behavioral health, opioid/substance use, and coordinated crisis response	• MH staff support	• Better coordination among community resources • Reduction in ED visits by high utilizers due to increased wraparound support	• CCIT • Taunton Opioid Advisory Committee • CCBC	FY 2026-28
Significant Health Need #3: Chronic Disease Prevention and Management				
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on MH Community	Outside Groups Collaboration	Timeframe for Implementation
3.1 Improve access to preventive cancer screenings by adding new specialists to support demand (in areas such as breast care, GI, and surgery), and addressing any access	• Hospital leadership • Provider recruitment team	• Improved access to preventative screenings	• N/A	FY 2026-27

barriers for our diagnostic imaging services	• Patient Access team • Practice Administrator Luncheons • Marketing staff; communication between hospital and practices			
3.2 Integrate chronic disease management support with SDoH navigation by utilizing and promoting support services available within the Brown University Health network	• ED staff, including social workers • Care management/social worker support • Community partners • Patient Advocate • Resource guides and collateral	• Increased utilization of available support services and programs	• N/A	FY 2026-28
3.3 Offer community education programming on various chronic disease related topics	• Provider and clinical staff support • Marketing support • Educational collateral and resources • Dinner/lunch and learn programs • Health fairs/events	• Increased awareness and education around chronic diseases and risk factors	• Organizations that host health fairs and other relevant events	FY 2026-28
3.4 Strengthen tobacco cessation pathways given higher smoking prevalence in Taunton/Bristol County	• Respiratory staff support • MH clinical staff support • MH Quality team • Quitworks collateral and resources	• Increased utilization of smoking cessation resources • Decreased incidence rate of smoking and smoking-related disease	• DPH QuitWorks	FY 2026
3.5 Address co-morbidities related to obesity through our weight loss program and support groups	• Weight loss program staff • Weight loss support groups • Marketing staff support • Educational collateral	• Reduction in chronic disease tied to lower obesity rates	• N/A	FY 2026-28

Significant Health Need #4: Housing				
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on MH Community	Outside Groups Collaboration	Timeframe for Implementation
4.1 Continue universal screening of patients to identify potential housing needs and opportunities to refer to community services	• Patient Access staff • ED staff • Care management/social workers	• Improved health outcomes among patients experiencing homelessness	• CCBC • Our Daily Bread Food & Resource Center • Taunton Housing Authority • Taunton Human Services • Local homeless shelters	FY 2026-28
4.2 Collaborate on discharge planning solutions for patients experiencing homelessness to reduce avoidable readmissions and ED revisits	• Care management/social workers • Hospital clinical leadership	• Reduction in readmissions among patients experiencing homelessness • Reduction in length of stay among patients experiencing homelessness	• N/A	FY 2026-28
4.3 Partner with Our Daily Bread on educational and screening programming for Our Daily Bread clients; support Our Daily Bread through charitable donations	• MH staff support	• Capacity building for Our Daily Bread • In-kind services for homeless individuals	• Our Daily Bread Meal & Resource Center	FY 2026-28
Significant Health Need #5: Maternal and Child Health				
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on MH Community	Outside Groups Collaboration	Timeframe for Implementation
5.1 Ensure hospital services/staff are familiar with community support services, including WIC and local birthing centers, and aware of how to connect families to these services; partner with our Brown Health Medical Group GYN practice to ensure up-to-date resources and referral lists are available for new and expecting moms	• MH staff support • Resource guides and collateral • Referral lists	• Increased utilization of support services available within the community	• WIC • Manet Community Health Center • Local organizations offering resources for families and	FY 2026

			early childhood services • Nearby birthing centers and OB providers	
5.2 Continue to link eligible low-income families to the Department of Transitional Assistance for SNAP benefits access during the MassHealth application process through Patient Access.	• Patient Access staff • Financial counselors	• Facilitate applications for SNAP benefits as well as health insurance coverage	• Department of Transitional Assistance/SNAP	FY 2026-28
5.3 Continue to provide mandatory training for Emergency Department staff on emergency deliveries to ensure staff competency and safe birthing practices within the department	• MH staff support • ED staff and clinical leadership • Training resources	• Availability of facility for emergency births	• Local EMS partners	FY 2026-28
5.4 Maintain and/or enhance current specialty pediatric services provided by the hospital, including surgical care; plan to welcome a new pediatric surgeon in March of 2026	• Specialty providers	• Access to specialty pediatric care in community	• N/A	FY 2026-28
Significant Health Need #6: Older Adult Health and Wellbeing				
Actions Planned for Implementation	Resources Planned to Address Significant Health Need	Anticipated Impact on MH Community	Outside Groups Collaboration	Timeframe for Implementation
6.1 Continue to offer navigation supports for older adults facing managed care literacy challenges, medication costs, transportation barriers, etc.	• Financial counselors • Physician, nursing and professional staff support • Educational resources • Care management/social worker support	• Reduce barriers to care for older adults in our community	• Organizations offering resources for seniors	FY 2026-28
6.2 Partner with senior services organizations to provide health education to senior population	• Physician, nursing and professional staff support • Marketing team support • Educational collateral	• Increased awareness among senior population of health risks and common chronic diseases	• Local senior centers and councils on aging	FY 2026-28

Additional Areas of Focus

1. In addition to the above outlined strategies, Morton Hospital plans to continue its focus on other relevant social factors such as **education** and **employment**. The hospital

maintains several initiatives related to these important areas to help address the higher than state average unemployment and poverty rates in our community.

2. We will also continue to focus on ensuring we are providing **culturally and linguistically appropriate care and services** by offering a robust language access program, which will assess periodically, and educating our staff on these topics.

Conclusion

This Morton Hospital Implementation Strategy report was authorized and approved by the Brown University Health Board of Trustees on [DATE].

MH will document progress on the implementation strategies presented as part of its commitment to the community it serves each year in its annual Community Benefits Report to the Massachusetts Attorney General's Office. MH appreciates the continued support of its partners which help it meet the health care needs of patients in Southeastern Massachusetts. Questions or comments on the MH CHNA or Implementation Plan may be submitted to:

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