Memorial Healthcare System

2021 - 2024
Community Health Needs Assessment
Annual Update

2021- 2024 Prioritizing the Needs

Data Source

Data Source		
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ US Bureau of the Census ✓ BRHPC Health Data Warehouse ✓ Florida Charts	Access to Care	•Re-engage community to resume control of their health for routine care and preventative screening •Expand Memorial healthcare services & increase Community Awareness •Continue to expand telehealth and digital services •Increase access to legal and navigation services
Qualitative: ✓ *Focus Groups* ✓ *Key Informants* ***Quantitative:*** ✓ *BRHPC Health Data Warehouse* ✓ *Florida Charts*	Preventive Care	•Reduce the use of vaping focus on vulnerable, and at-risk populations including adolescents •Increase Community Awareness of Mental Health and Substance Abuse Program service options
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	Community Health Education	• Improve Quality of life, promote self-care management, and increase preventative screenings • Reduce the incidence of low birthweight and negative birth outcomes
Qualitative: ✓ Focus Groups **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	Quality of Care	• Address health access as it relates to serving vulnerable communities • Specific focus on health equity by addressing health related needs • Implement strategies identified as part of MHS community initiatives

Memorial Healthcare System

Access to Care

1. Re-engage community members to resume control of their health for routine care and preventative screening

2. Expand MHS services and increase community awareness

3. Continue to expand telehealth and digital services

4. Increase access to legal and navigation services

Access To Care Goals

Priority #1 - Access Goals			
1. Re-engage community to resume control of their health for routine care and preventative screenings	**2. Expand Memorial Healthcare services & increase community awareness**	**3. Continue to expand telehealth and digital services**	**4. Increase access to legal & navigation Services**
To be a leader for environmental safety in healthcare	Open 2 new specialty services within primary care	Provide access to mobile devices including Wi-Fi	Continue legal aid partnership
Digital engagement- personal touch approach	Invite community to grand openings & open houses	Provide education on telehealth technology	Partner with community stakeholders to provide Health Literacy workshops
Encourage the use and expand digital platforms	Create marketing strategies to communicate new service lines	Continue to develop telehealth platforms for remote patient monitoring	Expand navigation services to other service lines (i.e., Sickle Cell Clinic
Create virtual tours of MPC locations to increase patient confidence			Provide care coordination focusing on SDOH needs with community partners

Re-engage community to resume control of their health for routine care and preventative screening

YOUR SAFETY FIRST

All staff members are required to wear masks at all times.

It must cover your NOSE and MOUTH.

Memorial Primary Care | **Thank You** for your understanding and cooperation.

Live Your Best Year!

Schedule your wellness visit with us today.

At **Memorial Primary Care**, helping you live your healthiest life is our priority. With your Medicare covered yearly Wellness Visit we can help you get the quality of care you deserve and desire in your golden years.

At the yearly wellness visit we will:

- **Review your current health, medical history and risk factors**
- **Develop a personalized plan to stay healthy**
- **Discuss your wishes for your health, now and in the future**
- **Focus on your social and mental well-being**

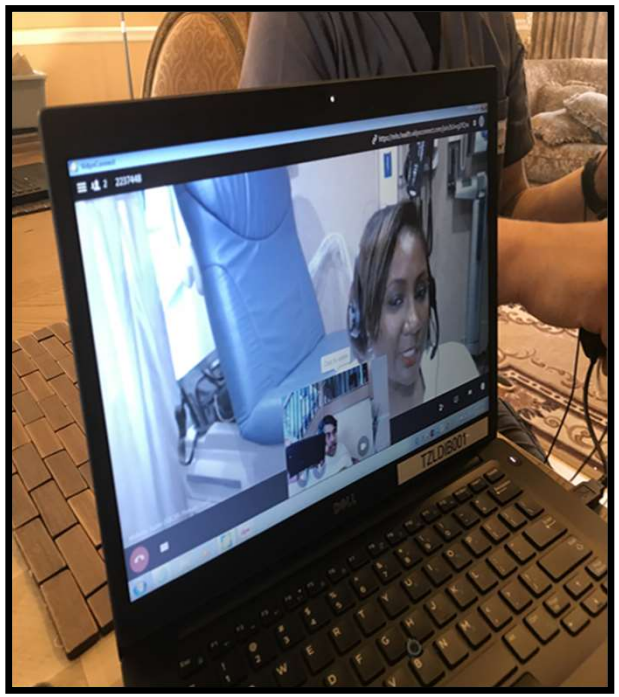
*The wellness visit is not the same as a routine office visit or physical exam. Please mention **yearly wellness visit** when scheduling.*

Memorial Primary Care

Call us today to schedule your appointment:

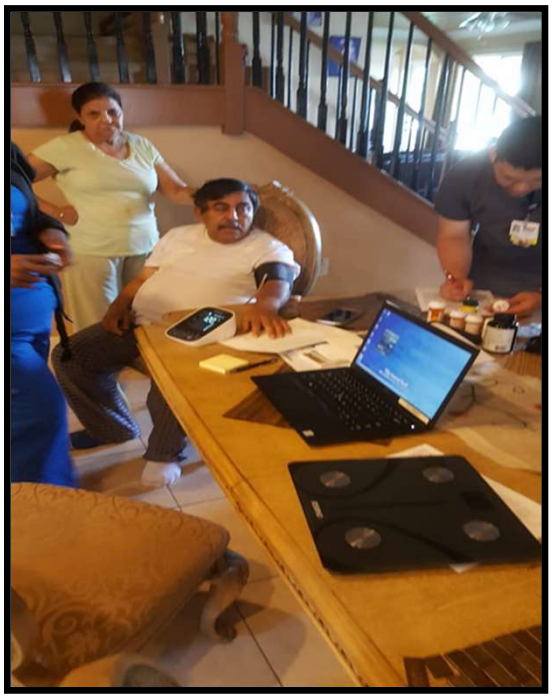
954-276-5552

Digital engagement personal touch



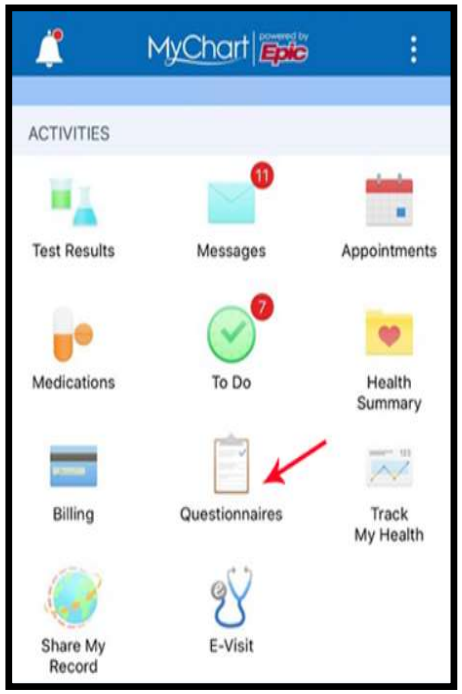
MPC telehealth visits:

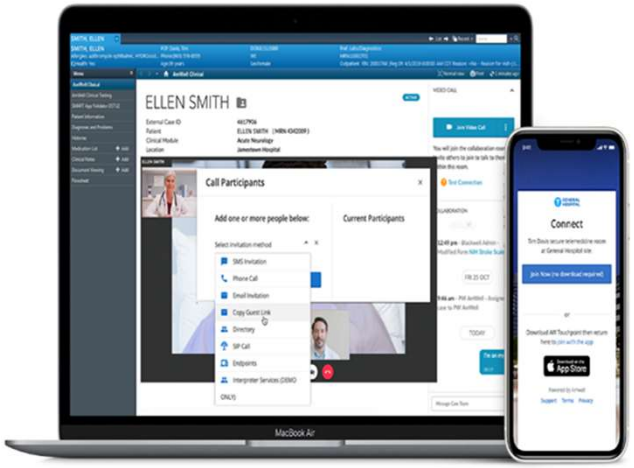
- FY2022 – 48,394
- FY2023 – 30,309
- FY2024 – 35,295



Digital platforms

84% Active MyChart





Simple Video Connection

Connect with patients or care teams for virtual visits with just one click in Millennium. Amwell Connect EHR generates a simple invitation via SMS or email so that recipients can connect without needing to log in.

Link

Expand Memorial healthcare services & increase community awareness

Aventura
20801 Biscayne Blvd. Suite 201
Aventura, FL 33180

Dania Beach
140-A South Federal Highway
Dania Beach, FL 33004

East Hollywood
3700 Johnson Street
Hollywood, FL 33021

Hallandale Beach
1750 East Hallandale Beach Blvd.
Hallandale Beach, FL 33009

Hollywood
4105 Pembroke Road
Hollywood, FL 33021

Miramar
6730 Miramar Parkway
Miramar, FL 33023

Miramar Medical Office Building
1951 SW 172 Avenue Suite 210
Miramar, FL 33029

Monarch Lakes
12781 Miramar Parkway Suite 1-202
Miramar, FL 33027

Palm Springs North/ Country Club of Miami
8649 NW 186th Street
Hialeah, FL 33015

Pembroke Pines
2217 N University Drive
Pembroke Pines, FL 33024

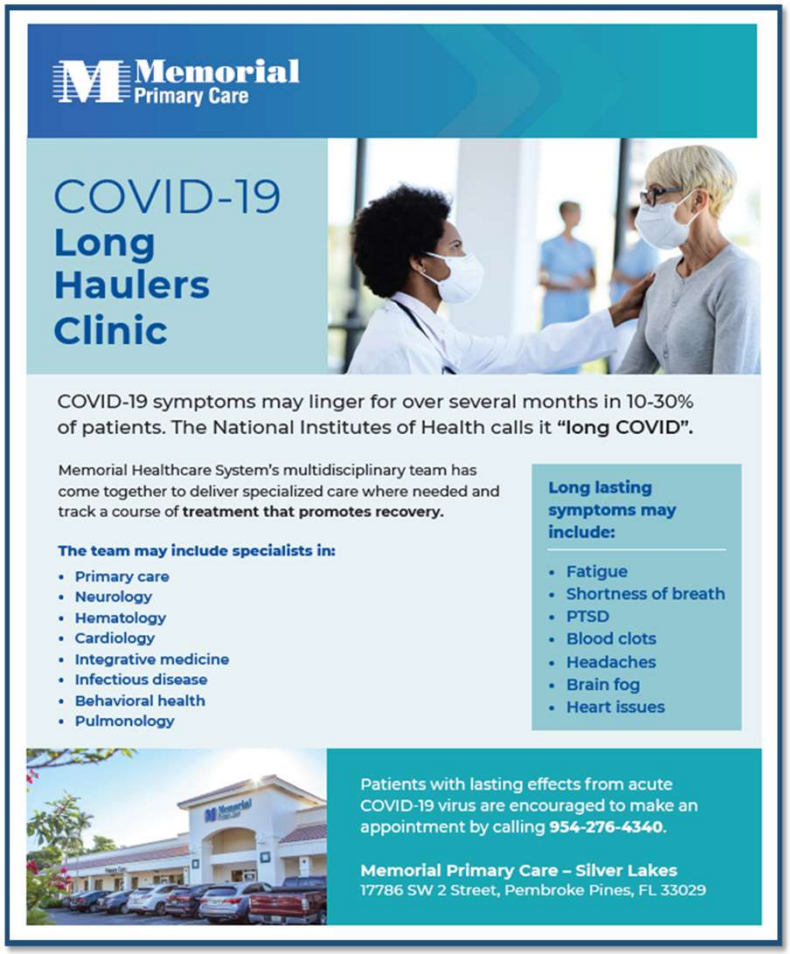
Plantation (Opening 2024)
1000 S. Pines Island Road Suite A-180
Plantation, FL 33324

Silver Lakes
17786 SW 2 Street
Pembroke Pines, FL 33029

West Miramar
10910 Pembroke Road
Miramar, FL 33025

Weston
17130 Royal Palm Blvd Suite 1 & 2
Weston, FL 33326

COVID-19 Long Haulers Program



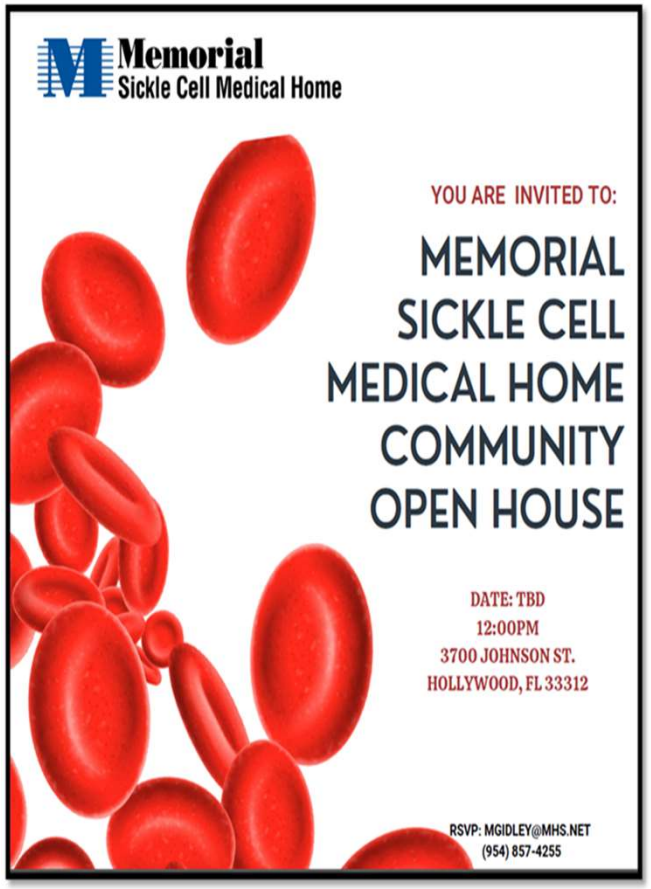
May 1, 2021 – Sept. 30, 2022	Total
Number of Completed Visits	1,235
Number of New Patients	600

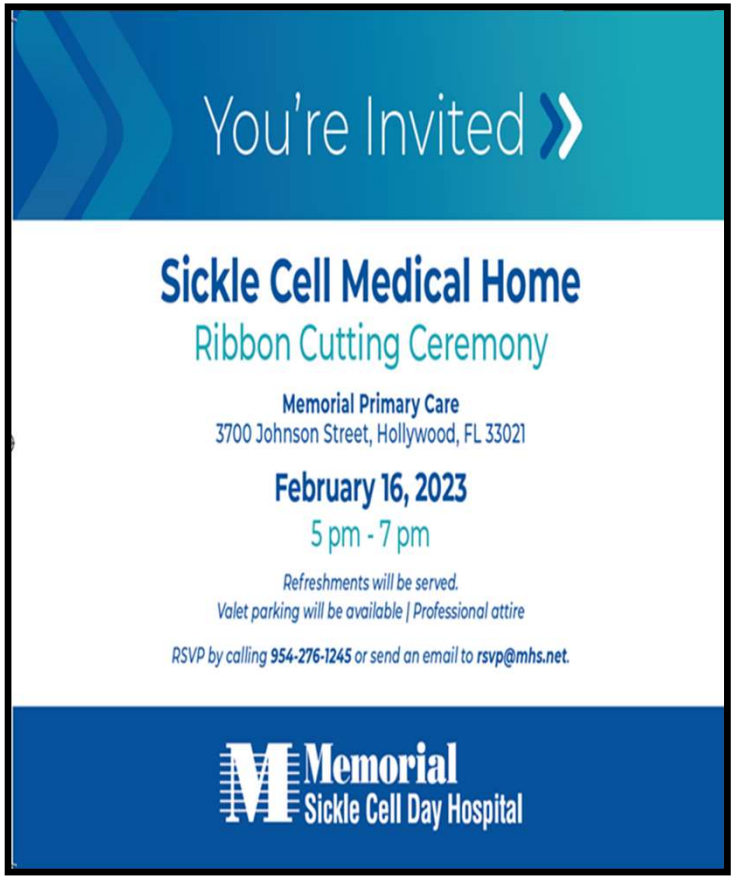
October 1, 2022 - Program has now transitioned back to the Primary Care setting for supportive care.

CBS EYE ON HEALTHCARE CHAMPIONS

Video

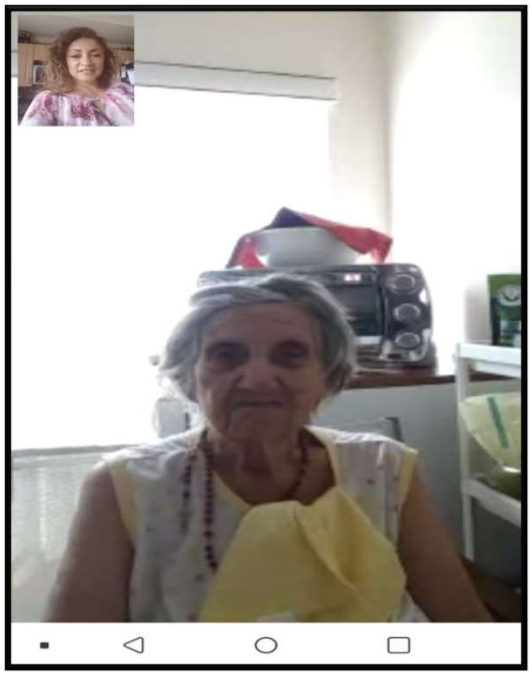
Sickle Cell Medical Home





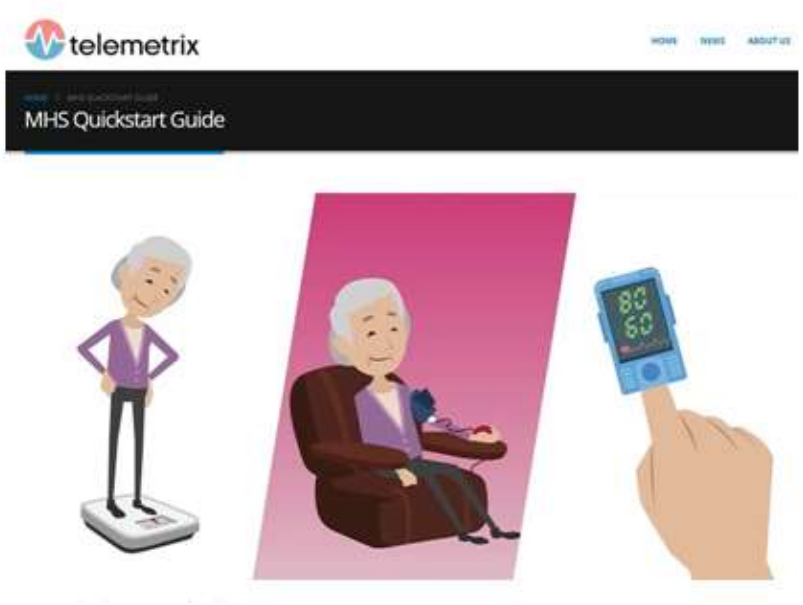
Continue to expand telehealth and digital services

Provide access to mobile devices and education on mobile devices



- Linked 67 families to Comcast $10/month special
- Provided 273 mobile devices (smart phones, tablets, laptops)
- Provided education on technology to 237 individuals in underserved communities

Remote Patient Monitoring (RPM)



- Program implemented in April 2022
- 220 patients have been enrolled for BP and CHF Monitoring as of July 2024
- Average length of monitoring is 3 months

Increased access to legal and navigation services

Medical Legal Aid Partnership

2021-2024			
SDOH	**Total cases handled by MLP by health-related social need**	**Legal Matter**	***TOTAL***
Income	**227**	Cash Assistance	**16**
		Clothing	**3**
		Consumer/Debt	**22**
		Food Assistance	**21**
		Health Insurance	**48**
		Social Security Disability (SSI/SSDI)	**117**
Housing & Utilities	**187**	Homelessness	**59**
		Housing (Tenant issues /Evictions, Mortgage, Conditions)	**122**
		Utilities	**6**
Education & Employment	**25**	Education	**8**
		Employment/Unemployment	**17**
Legal Status	**29**	Immigration	**29**
		Veteran Issues	**0**
Personal & Family Stability	**69**	Family Law	**45**
		HIV/AIDS	**0**
		Safety/Domestic Violence	**14**
		Transportation	**10**
Natural Disaster	**61**	*COVID-19 Related Issues	**61**

- 598- total referrals
  - 41 - retained/accepted
  - 35 out of 41- resolved/closed
- 375 - Advise given/referred outside recourses for non-legal medical matters
- 173- Other legal advice given or facts in case did not rise to the level of a legal matter.

Advancing health literacy to enhance equitable community responses to COVID-19 outcomes

December 2021- December 2022

Outcomes	Count
Community Members Educated	3,566
Resources /Referrals	3,727
Community Education Events	93
Surveys Completed	815
Education Resulting in Vaccine	782

* some given more than one resource/referral
* no surveys completed during community events

Survey Question	% Percent on Post Testing
Increase confidence related to covid 19 vaccines	34 % increase
Increase knowledge of testing locations and vaccination's locations	32% increase
Increase knowledge & Understanding of Covid-19 Resources	43% increase

Preventative Care

1. Reduce the use of vaping focus on vulnerable, and at-risk populations including adolescents

2. Increase community awareness of mental health and substance abuse program service options

Preventative Care Goals

Priority #2 - Preventative Care Coals	
1. Reduce the use of vaping focus on vulnerable, at-risk populations including adolescents	**2. Increase community awareness of Mental Health and Substance Abuse Program service options**
Coordinate with United Way for County wide vaping marketing campaign	Expand care coordination to ensure warm patient hand-off from MPC to Behavioral Health
Provide vaping prevention education to adolescents and venerable populations	Expand Telehealth for Substance Abuse (SA) and Mental Health (MH) Services
Utilize remote vaping and tobacco prevention education for patient access on demand	Develop Mental Health Model for adolescents and young adults
	Create ED Care Coordination for patients and families in crisis due to SA/MH episodes

Reduce the use of vaping focus on vulnerable, and at-risk populations including adolescents

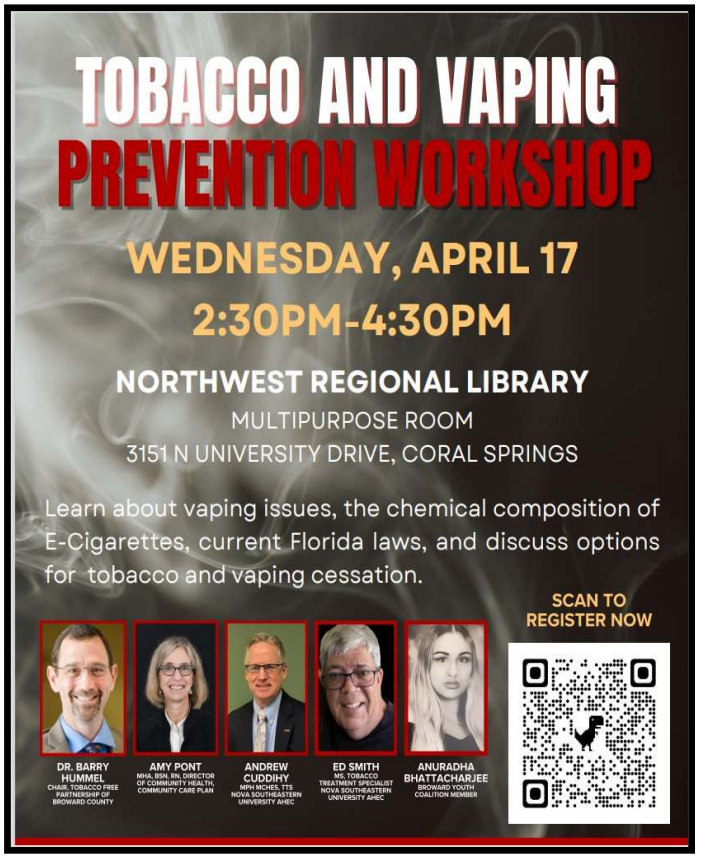
Mist Busters: Facts and Fiction Around Vaping

- Memorial Cancer Institute partnered with American Lung Association to host *Mist Busters: Facts and Fiction around Vaping* via Facebook Live
- **Dr. Mark Block**, Chief of Thoracic Surgery Division, went over 4 myths regarding vaping as well as vaping statistics and facts
- Staff from the State of Florida, Virginia, Texas, and Ohio Health Departments joined the live session

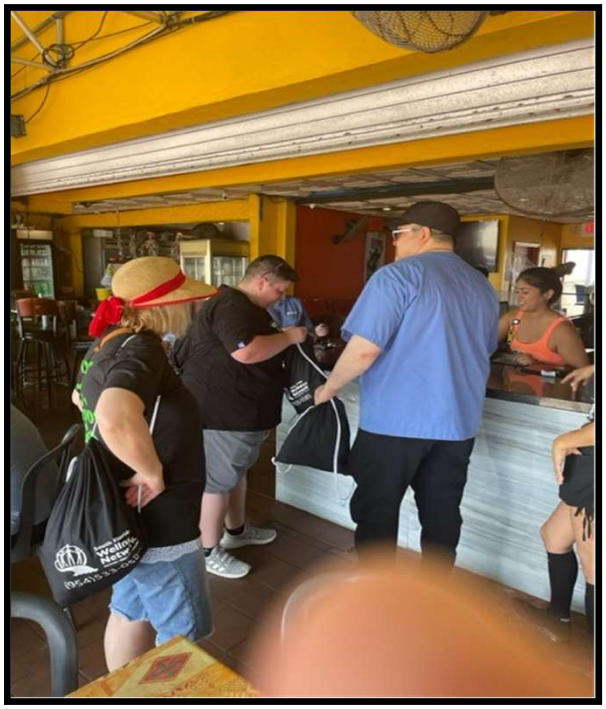
Vaping outreach and activities

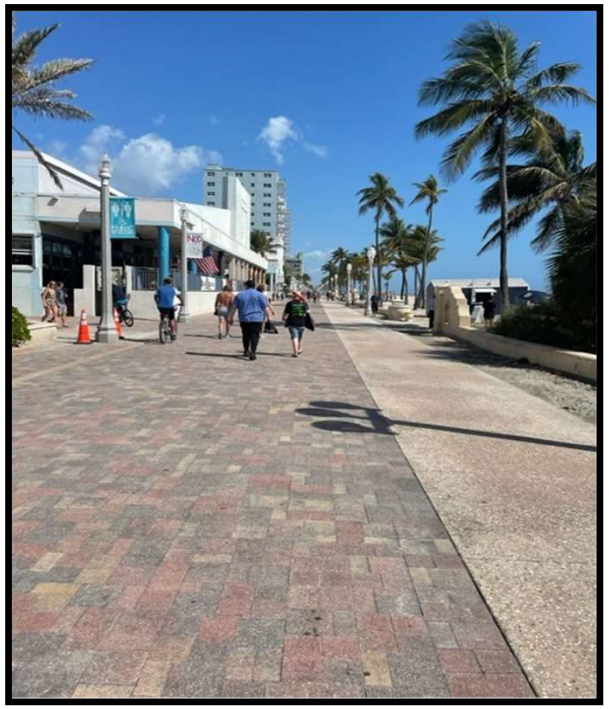
Educational Workshops

- Provided 261 sessions, classes and workshops.
  - 3,447 youth attended
  - 386 caregivers attended



Increase community awareness of Mental Health and Substance Abuse Program service options





Hollywood Beach- Narcan Education & Kit Distribution

Community Action Treatment (CAT)

The Community Action Treatment (CAT) Team provides intensive, integrated, individually tailored community-based behavioral health treatment and family-focused support services. The CAT team serves young people ages 11 through 21 who struggle with severe mental health and co-occurring substance misuse. The multidimensional Team of professionals will support clients and their families to improve the psychosocial functioning of young people across settings, to increase the ability of the family to manage and help their child with challenges related to severe emotional disturbance, and to strengthen family functioning. These improvements will reduce the occurrences of mental health crisis necessitating hospitalization, out of home placement or other highly restrictive interventions and increase health and wellness.

In order to qualify:

- Young Person must be between the ages of 11-21 with a mental health diagnosis or co-occurring substance abuse diagnosis with one or more of the following:
- being at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care
- Two or more periods of hospitalization or repeated failures
- Involvement with Department of Juvenile Justice or multiple episodes involving law enforcement.

Services include:

Individual/family Counseling

Intensive Case Management

Peer Support

Med Management/education

Risk Factors Addressed:

- Substance Abuse Issues
- Low Academic Performance
- Behavior Problems/Frequent Suspensions
- Truancy/Unexcused Absences
- Known Family Difficulties
- Family Management Problems

Program Goals:

- Strengthen the family and support systems for youth and young adults to assist them to live successfully in the community
- Improve school related outcomes such as attendance, grades, and graduation rates
- Decrease out-of-home placements
- Transition into age appropriate services
- Increase health and wellness.

Care Coordination Team in the Emergency Department

The Memorial Regional Hospital Care Coordination Team - Emergency Department (CCT-ED) Program is designed to prevent unintentional drug overdoses and escalating behavioral health concerns through interventions originating in the ED.

CCT-ED works to identify, engage and effectively link individuals and families with substance abuse and/or behavioral health disorders to immediate care including medication, medication assisted treatment and ambulatory detoxification.

Community Health Education

1. Improve quality of life, promote self-care management, and increase preventative screenings

2. Reduce the incidence of low birthweight and negative birth outcomes

Community Health Education Goals

Priority #3 - Community Health Education	
1. Improve quality of life, promote self-care management, and increase preventative screenings	**2. Reduce the incidences of low birthweight and negative birth outcomes**
Provide virtual disease management programs	Increase pre-natal compliance, low birth weight, maternal and infant mortality
Develop support groups with community partners specific to chronic diseases	Develop program focusing on teen pregnancy, teen mothers and medical compliance with pre & post-natal care
Continue community based chronic disease navigation programs	Develop a community outreach team to focus on vulnerable neighborhoods to increase health access

Improve quality of life, promote self-care management, and increase preventative screenings

LivWell Program

- Improve the health status of patients with chronic conditions including:
  - Diabetes
  - Overweight
  - High blood pressure
  - Heart diseases
  - Behavioral health

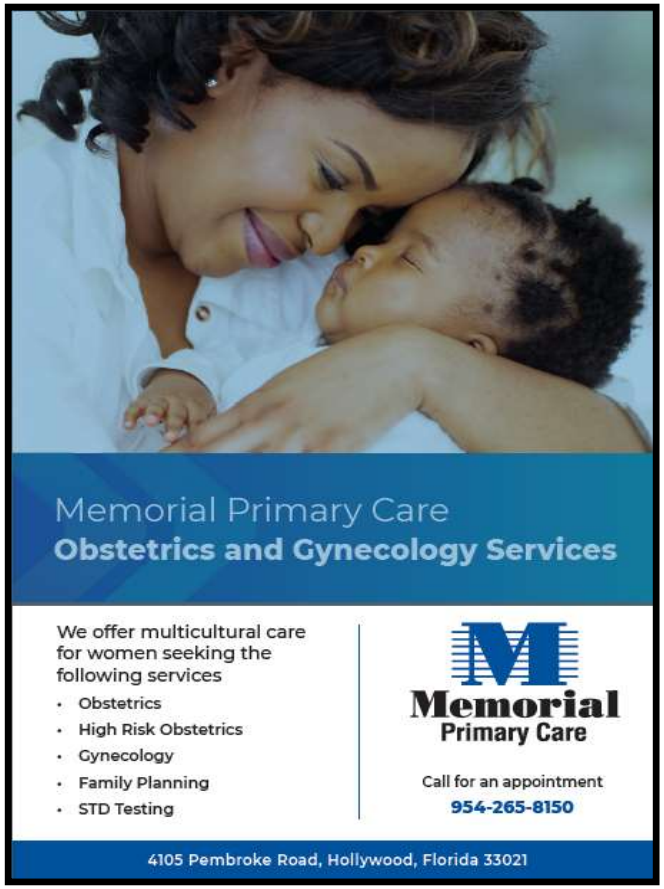
LivWell – Practical Medicine

Support group with community partners

- Support groups: 26
- Attendees: 331

- Topics:
  - Health Literacy
  - Dental and vision needs
  - Medication management
  - Self care/stress reduction
  - Chronic disease self management

Reduce the incidence of low birthweight and negative birth outcomes



Black Maternal Health Outcomes

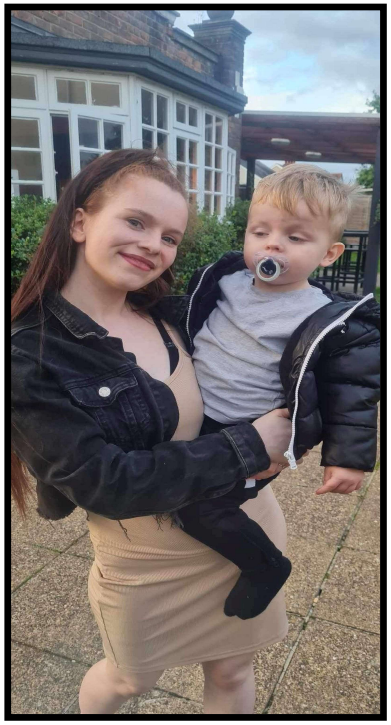
BLACK MATERNAL HEALTH STATISTICS	HYPERTENSION	HIGH RISK HEMORRHAGE
Total Number of Eligible Pregnant Women	65	11
Number of Women Educated on Pregnancy and Post Partum Warning Signs since May 16, 2022	65	11
Number of Deliveries	51	10
Women who transmitted BP readings timely, during post partum period (Day 1-14)	37	N/A
Number of BP monitors provided to those without a monitor	43	N/A
Scheduled Post-Partum Appointment. (HEDIS Metric- Timeliness to Post-partum care w/I (7-84 days)	45	8
Completed Post-Partum Appointment. (HEDIS Metric Timeliness to Post-partum care (7-84 days)	43 8 - have upcoming appointments	8

*Sponsor: Essential Hospitals Institute & CVS Foundation

Dedicated to Improving Black Maternal Outcomes at MHS:

Dr. Tim Desantis, Chief OBGYN
Dr. Todra Aderson, MHM CMP
Dr. Laurie Scott, Maternal Fetal Medicine
Dr. Randy Katz, Regional ED Director MHS
Dr. Jennifer Goldman, Chief MPC
Laurie Sabatino, OB APRN
Dionne Blackwood, VP MPC Ambulatory Services
Tammy Reese, Director Care Coordination MPC
Mary Roberts, Director MHS Family Birthplace
Gessy Targete, Director MHM Family Birthplace
Jane McCarthy, Director MRH Family Birthplace
Monica King, CEO Healthy Start
Samantha Silver, Healthy Start
Dorothy Stirrup, Healthy Start
Maria Mendez, Healthy Start Team Leader
Tim Curtin, VP Community Services
Amanda Lopez, Team Leader CYS
Yani Quintana, Team Leader CYS

Teen mothers celebrate their children



Quality of Care

1. Address health access as it relates to serving vulnerable communities

2. Specific focus on health equity by addressing health related social needs

3. Implement strategies identified as part of the MHS community initiatives

Quality of Care Goals

Priority #4 – Quality of Care		
1. Address health access as it relates to serving vulnerable communities	**2. Specific focus on health equity by addressing health related social needs**	**3. Implement strategies identified as part of the MHS community initiatives**
Partner with trusted leaders in underserved communities/grass roots outreach efforts	Partner with community leaders to assist with fulfilling health related social needs	Focus on vulnerable neighborhoods with a proactive service delivery approach.
Facilitate focus groups in vulnerable communities to understand the patient experience	Continue to fulfill gaps through sponsorship and collaborations	Survey health of vulnerable communities
Provide patients with referrals/resources to improve socio-economic condition	Evaluate outcomes	Evaluate health of communities after 3 years

Address health access as it relates to vulnerable communities

Trusted leaders in under resourced communities

KOINONIA

POLICE PAL ATHLETIC LEAGUE

Community Enhancement Collaboration, Inc.
Our Hands • Our Home • Our Heart
We're in the Heart of the Community

ESTABLISHED IN 1908
ST. RUTH MISSIONARY BAPTIST CHURCH

Facilitate focus groups in underserved communities to better understand the patient experience

- Focus Groups - 5
- Attendees - 113

- Targeted Areas:
  - Dania Beach
  - Hallandale Beach
  - Hollywood
  - Miramar
  - West Park

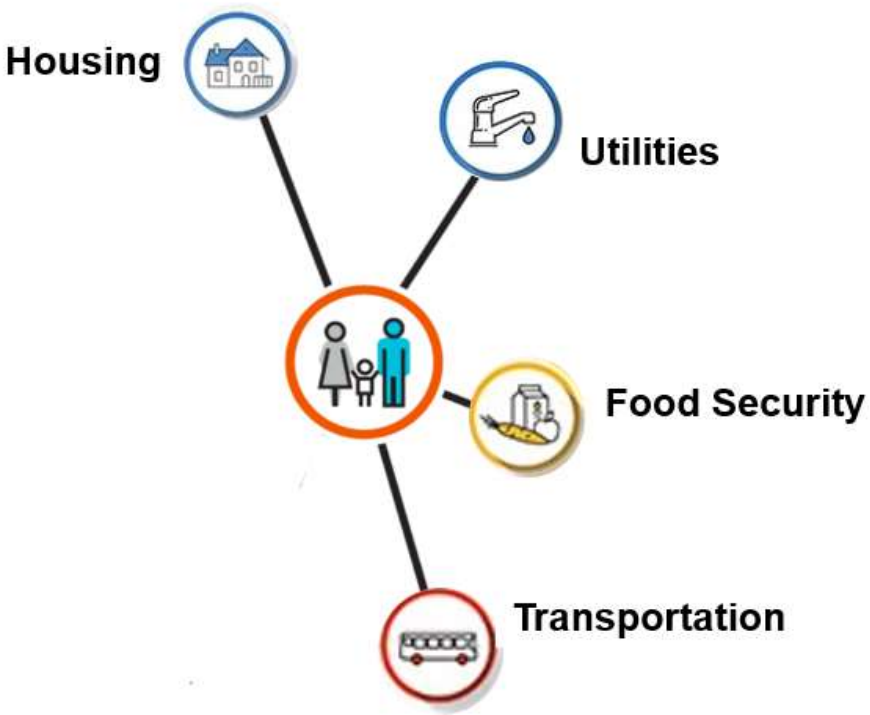
Community outreach utilizing the Mobile Health Centers

2023-2024	ENCOUNTERS	VACCINES GIVEN	COMMUNITY LOCATIONS
Pediatric Mobile	4,236	6,395	Broward County Public Schools, Girls and Boys Club, YMCA, Carver Ranches Library, OB Johnson Park
Adult Mobile	3,917	900	Dania Beach City Hall, Koinonia Worship Center, Food Pantries, and Health Fairs

Community HUB

Helping to Uplift and Bounce back

Why do we ask? Because we care!



The Hub helps our patients navigate through the fulfillment of health-related social needs.

Community

MEMORIAL HEALTHCARE SYSTEM

1. SDOH HUB Episodes

	2023					2024								Grand
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Total	35	79	85	107	117	181	204	212	327	310	225	306	42	2,230

2. Incoming Referrals to the SDOH HUB by Referring Location

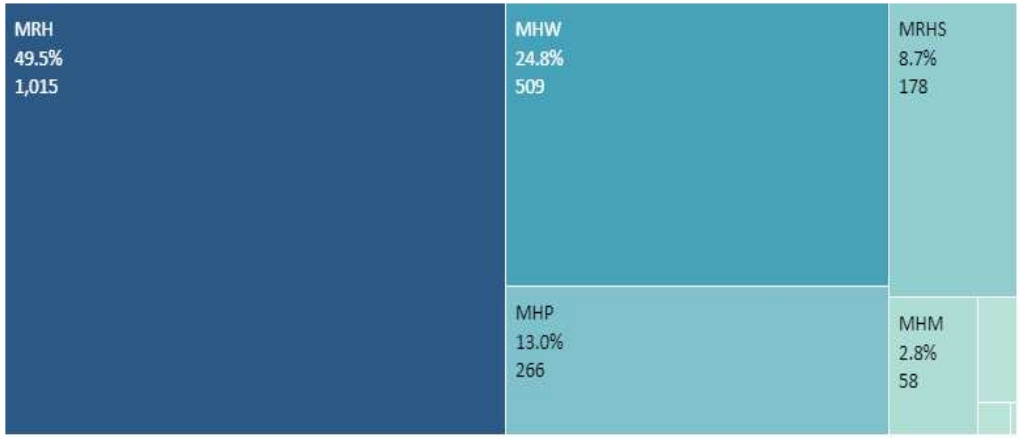
**More than 1 hospital may have made a referral.*

	2023					2024								Grand
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Other	1	6	3	4	1	5	4	26	32	39	28	34	4	187
JOE DIMAGGIO ..													5	5
MHM	2	4	5	3	11	6	4	2	7	3	4	7		58
MHP	5	22	11	17	15	17	24	28	27	38	23	35	4	266
MHW	2	3	1	3	7	37	49	46	107	86	71	87	10	509
MPC									1					1
MRH	22	38	51	61	61	94	102	96	127	133	82	129	19	1,015
MRHS	3	7	10	17	22	20	21	14	22	12	16	14		178
Pop Health			4	3	2	2	1	1	4	1	1			19
Grand Total	35	80	85	108	119	181	205	213	327	312	225	306	42	2,238

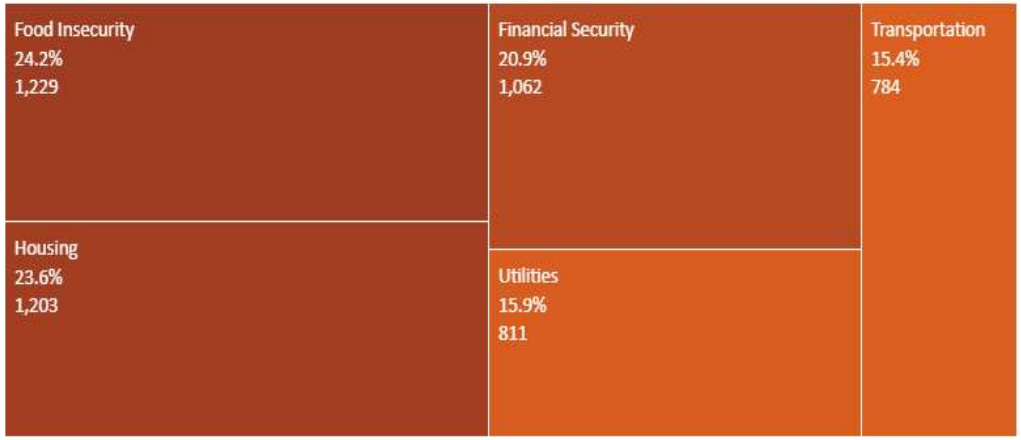
3. Incoming Referrals to the SDOH HUB by Domain

	2023					2024								Grand
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Total
Other	1	6	3	4	1	5	4	26	32	39	28	34	4	187
Financial Security	27	63	66	87	95	147	162	147	234	34				1,062
Food Insecurity	22	44	43	61	69	96	117	105	141	188	132	187	24	1,229
Housing	23	45	45	64	65	104	106	99	139	174	140	173	26	1,203
Transportation	20	35	32	39	31	50	67	64	95	121	82	130	18	784
Utilities	10	30	20	44	41	66	76	61	92	121	99	132	19	811
Grand Total	103	223	209	299	302	468	532	502	733	677	481	656	91	5,276

4. Incoming Referrals to the SDOH HUB by Referring Location



5. Incoming Referrals to the SDOH HUB by Domain



One City At A Time

Memorial has unveiled a population health initiative called “One City at a Time” that will station Memorial Primary Care Mobile Health Centers, or mobile units, within cities in South Broward for extended periods of time. Through this initiative we are bringing care, services, and resources directly to where some of our most vulnerable populations live.

Through strategic partnerships with local communities, governments, and non-profit organizations we aim to create innovative and effective programs that tackle these community issues related to Social Determinants of Health, head-on.

The Opportunity

01

As our initial welcome to the city we would like to host a Kickoff at a local park or community center. The kickoff allows us to bring the mobile vans and other community partners to connect with the members of your city.

02

As the main part of our intiative we want to bring our Mobile Health Vans to the community for 3 days over the course of 8-12 weeks. We want to select strategic locations in the community to bring the healthcare to those of the greatest need in your community.

03

Over the course of 2 years, after our initial 8-12 week engagement, our mobile vans will stay in your city once a week. We will conclude the 2 years by conducting a closeout survey.

Community | One City at a Time

Hallandale Beach:
- Adults – 208
- Pediatrics – 362

Dania Beach:
- Adults – 262
- Pediatrics – 446

Hollywood:
- Adults – 673
- Pediatrics - 767

Miramar:
- Adults – 348
- Pediatrics – 363

Pembroke Pines:
- Adults – 352
- Pediatrics – 403

Common diagnosis in adults
- Hypertension
- Diabetes

Eligibility assistance:
282 individual application
(Medicaid, Medicare, Kidcare, ACA,MPC)

SDOH referrals:
779 total linkages
Top 4 – housing, finances, utilities, food insecurity

Memorial Healthcare System

2024 - 2027

Community Health Needs Assessment

Implementation Strategy

CHNA 2024-2027

What is it:

- Dynamic Process involving Multi Sectors of the Community
- Draws upon Qualitative and Quantitative Population Health Status Data
- Identifies unmet community needs to improve heath of vulnerable populations
- Enables community-wide establishment of health priorities

Why do a Needs Assessment:

- ACA-Section 501(r)(3) - Requirement every 3 Years
- Joint Commission Standards - Needs of the Community must guide service delivery
- IRS Form 990 Requirement - Manner in which community information and health care needs are assessed
- Opportunity - Identify unmet community needs to improve the health of vulnerable populations. Improve coordination of hospital with other efforts to improve community health

Data Sources:

- **Qualitative** - Focus Groups, Key Informants, Community Conversations, Advisory Council
- **Quantitative** - US Bureau of the Census, BRHPC Health Data Warehouse, Florida Charts

2024- 2027 Prioritizing the Needs

Data Source

Data Source		
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ US Bureau of the Census ✓ BRHPC Health Data Warehouse ✓ Florida Charts	→	Access to Care
Qualitative: ✓ *Focus Groups* ✓ *Key Informants* ***Quantitative:*** ✓ *BRHPC Health Data Warehouse* ✓ *Florida Charts*	→	Community Health Education
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	→	Healthy Lifestyles and Wellness
Qualitative: ✓ Focus Groups **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	→	Health Related Social Needs

Improve access to:
- Maternal and Infant Health services
- Behavioral Health services
- Primary Care services

- Promote chronic disease self-care management
- Increase health education to older adult population
- Improve preventative health screenings through education

- Develop Health and Wellness activities and programs
- Promote exercise and fitness
- Promote Nutrition and Healthy Eating

- Improve Health Literacy
- Increase health related social needs assessment and referrals
- Expand community programs and partnerships

Memorial Healthcare System

Priority #1-Access to Care

- Improve access to Maternal and Infant Health services:
  a. Expand home visiting service delivery to support and connect women to a medical home
  b. Increase capacity of maternal depression program
  c. Focus on teen pregnancy, teen mothers and medical compliance (prenatal and postpartum care)

- Improve access to Behavioral Health services:
  a. Expand capacity for adolescent outpatient behavioral health services to meet demand
  b. Develop outreach plan to reach community about behavioral health services available
  c. Expand intensive adolescent behavioral services to increase youth and family capacity

- Improve access to Primary Care services:
  a. Expand Primary Care Service Locations
  b. Expand the Virtualist Program
  c. Continue to provide telehealth services

Priority #2 -Community Health Education

- Improve Quality of life by promoting chronic disease self-care management
  a. Provide virtual disease and care management programs
  b. Develop support groups with community partners specific to chronic diseases
  c. Continue community based chronic disease navigation programs

- Increase health education to older adult populations
  a. Coordinate with senior centers to educate older adults that can benefit from health workshops
  b. Provide caregivers services with resources and supports
  c. Develop support groups with community partners specific to older adult issues

- Preventative health screenings through education
  a. Expand knowledge of preventative cancer screenings to underserved communities
  b. Develop Preventative Screening Campaigns with trusted partners
  c. Continue to provide Preventative Screening Test in the Community (Breast Exams, BMI, Glucose & Cholesterol)

Priority #3 - Healthy Lifestyles and Wellness

- Promote Health and Wellness activities and programs
  a. Continue to offer services and programs to the community to address health and wellness
  b. Engage residents to address healthy living with chronic conditions by offering workshops
  c. Educate the community on the benefits of developing a healthy lifestyle

- Promote exercise and fitness
  a. Facilitate groups at the Fitness Zones throughout the region to expose community to exercise
  b. Coordinate with local wellness partners to encourage exercise and fitness among residents
  c. Community pop up fitness events to develop a routine which includes physical activity

- Promote Nutrition and Health Eating
  a. Expand screening to all patients and continue to provide access to healthy food
  b. Target educational sessions on nutrition and healthy eating at community events
  c. Partner with local non-profit organizations for healthy cooking demonstrations

Priority #4 – Health Related Social Needs

- Improve Health Literacy
  a. Train and develop staff to deliver Health Literacy classes utilizing best practice curriculum
  b. Coordinate with municipalities to deliver health literacy workshops in local community centers
  c. Expand services within faith-based organizations to bring health literacy to houses of worship

- Increase health related social needs assessments and referrals
  a. Increase staffing of the HUB to meet capacity expansion
  b. Implement the Pediatric HUB to assess youth and families
  c. Continue to identify community resource gaps to fulfill through new partnerships

- Increase community programs and partnerships
  a. Increase capacity related to food insecurity to meet increase community demand
  b. Coordinate with Community Relations to identify and connect with new partnerships
  c. Strategize to grow resource inventory for unmet patient and families needs