Memorial Healthcare System

2021 - 2024
Community Health Needs Assessment
Implementation Strategy

CHNA 2021-2024

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)

2021- 2024 Prioritizing the Needs

Data Source

Qualitative:
- ✓ Focus Groups
- ✓ Key Informants

Quantitative:
- ✓ US Bureau of the Census
- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

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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***

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***

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***

Quality of Care

- ***Address race and health equity as it relates to the patient perception of receiving quality care***
- ***Specific focus on health equity by integrating participatory research regarding race and implicit bias***
- ***Implement strategies identified as part of the 2021 MHS Diversity & Inclusion Plan***

Memorial Healthcare System

Priority #1-Access to Care

Goal: Improve access to affordable healthcare

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

a. To be the leader for environmental safety in healthcare
b. Digital Engagement- Personal outreach approach
c. Encourage use and expand digital platforms for healthcare services
d. Create virtual tours of MPC locations to increase patient confidence

Expand Memorial healthcare services & increase Community Awareness

a. Open 2 new specialty services within primary care
b. Invite community to grand openings/Open houses at both locations
c. Create marketing strategies to communicate new service lines

Priority #1-Access to Care

Goal: Improve access to healthcare

Continue to expand telehealth and digital services

a. Provide access to mobile devices including Wi-Fi
b. Provide education on telehealth technology
c. Continue to develop telehealth platforms for remote patient monitoring

Increased access to legal and navigation services

a. Continue Legal Aid partnership located within MPC
b. Partner with community stakeholders to provide Health Literacy workshops
c. Expand Navigation Services to other Service lines (i.e. Sickle cell clinics)
d. Provide care coordination focusing on SDOH needs with community partners

Priority #2-Preventative Care

Goal: Improve access to preventative care

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

a. Coordinate with United Way for County wide vaping marketing campaign
b. Provide Vaping prevention education to adolescents and venerable populations
c. Utilize remote vaping and tobacco prevention education for patient access on demand

Increase Community Awareness of Mental Health and Substance Abuse Program service options

a. Expand care coordination to ensure warm patient handoffs from MPC to Behavioral Health
b. Expand telehealth for substance abuse (SA) and Mental health (MH) services
c. Provide outreach to community about SA/MH services available
d. Develop intensive Mental Health model for adolescents and young adults
e. Create ED Care Coordination for patients and families in crisis due to SA/MH episode

Priority #3 -Community Health Education

Goal: Promote wellness through patient education

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

a. Provide virtual disease management programs
b. Develop support groups with community partners specific to chronic diseases
c. Continue community based chronic disease navigation programs

Reduce the incidence of low birthweight and negative birth outcomes

a. Increase prenatal care compliance in targeted communities
b. Focus on teen pregnancy, teen mothers and medical compliance (prenatal and postpartum care)
c. Develop community outreach team to focus on low-income neighborhoods to decrease health disparities

Priority #4 -Quality of Care

Goal: Improve the quality of care for all patients

Address race and health equity as it relates to the patient perception of receiving quality care

a. Partner with trusted leaders in underserved communities through grass roots outreach efforts
b. Facilitate focus groups in underserved communities to understand the minority patient experience
c. Partners with community stakeholders to assist with fulfilling SDOH needs
d. Provide patient with referrals to improve socio-economic conditions (OIC,CSB)

Specific focus on health equity by integrating participatory research regarding race and implicit bias

a. Work with DI department to further assist with research on the patient experience
b. Act on research findings to improve health equity
c. Evaluate outcomes