



MEMORIAL HEALTHCARE SYSTEM



**2024 – 2027 CHNA**

**YEAR 1 PERFORMANCE**

**AUGUST 2025**



## 2024- 2027 Prioritizing the Needs

### Data Source

**Qualitative:**

- ✓ Focus Groups
- ✓ Key Informants

**Quantitative:**

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

### Access to Care

Improve access to:

- Maternal and Infant Health services
- Behavioral Health services
- Primary Care services

**Qualitative:**

- ✓ Focus Groups
- ✓ Key Informants

**Quantitative:**

- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

### Community Health Education

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

**Qualitative:**

- ✓ Focus Groups
- ✓ Key Informants

**Quantitative:**

- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

### Healthy Lifestyles and Wellness

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

**Qualitative:**

- ✓ Focus Groups

**Quantitative:**

- ✓ BRHPC Health Data Warehouse
- ✓ Florida Charts

### Health Related Social Needs

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



# Priority #1-Access to Care

- **Improve access to Maternal and Infant Health services**

**Expand home visiting service delivery to support and connect women to a medical home**

- *The number of maternal health home visitors increase by 29% (from 38 to 53 FTE)*
- *Number of home visits provided increased from 14,207 to 20,356 (YTD)*
- *61 women were successfully connected to a medical home*

**Increase capacity of maternal depression program**

- *MOMS staffing increased by 100% to support maternal depression (from 8 to 16 FTE)*
- *Number of women served for maternal depression increased 110% (from 204 to 424)*

**Focus on teen pregnancy, teen mothers and medical compliance (prenatal and postpartum care)**

- *140 teen mothers were successfully linked to a medical home, as well as prenatal and postpartum care county wide through the Teen REACH program*



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# Maternal (and Paternal) Health Groups





# Priority #1-Access to Care (continued)

- **Improve access to Behavioral Health services**

**Increase capacity for adolescent outpatient behavioral health services to meet demand**

- *Certified Community Behavioral Health Clinic (CCBHC) has served 144 youth and families*
- *Expansion of home, school and hospital based behavioral health services resulting in serving 1,857 youth and families compared to 1,423 in FY25*

**Develop outreach plan to reach community about behavioral health services available**

- *Outreach plan to include additional health fair participation, nontraditional local marketing campaign, One City at a Time events (information dissemination), door hangars, Mobile Health marketing. Dissemination began in FY26-Q2*

**Expand intensive adolescent behavioral services to increase youth and family capacity**

- *CAT Team (Intense Adolescent program) expanded from one to two teams (8 to 16 FTE)*
- *Expanded further with New Solutions Program (intensive child and adolescent team)*
- *Total number served in FY25 = 128 youth and families*





# Priority #1-Access to Care (continued)

- **Improve Access to Primary Care services**

**Vision: Expand 2-3 locations a year, serving adults, children & pregnant women**

- *Plantation site opened on April 9, 2025. FY26 Better Together – OB services.*
- *Employer Health Solutions Primary care services - City of Hollywood employees. (12 patients/day in FY25)*
- *FY25 One City at a Time (OCAT) served 2,950 residents in 5 designated cities*
- *FY 25-6 Better Together: Broward County Residents access to Primary & OB Care. Over 200 calls (25% MHS).*
- *FY 26 Shops of Cooper City - LOI, Young Circle Hollywood and University & Griffin Rd sites.*
- *FY 26 new Pediatric mobile health van.*
- *FY 26 Pediatrics - GME Continuity Clinics East & West.*

**Expand the Virtualist Program**

- *3 full-time providers offering 1,200 same-day appointments per month. (Avg. 640 calls/month in FY25 and 955/month in FY26)*

**Continue to provide Telehealth Services**

- *In FY25: Provided 40,105 visits (Primary Care, Mobile Van, and Virtual/Same Day Providers)*



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# Improve Access to Primary Care services





# Priority #2 -Community Health Education

- Improve Quality of life by promoting chronic disease self-care management:

**Provide virtual disease and care management programs**

- *As of April 2025, the Telehealth Maternity Care Program has enrolled 1,817 women in the program and distributed 624 BP cuffs.*
- *Clinical pharmacy specialists have provided diabetes/gestational diabetes care to 1,156 patients through 3,789 telehealth visits in CY2024 alone and have served 965 patients through 1,884 visits in CY2025.*

**Develop support groups with community partners specific to chronic diseases**

- *17 health education sessions were provided to 447 participants. Topics included heart health, medication management, diabetes management, hypertension, nutrition and more.*
- *Partners include: American Heart Association, National Alliance on Mental Illness (NAMI) and others.*

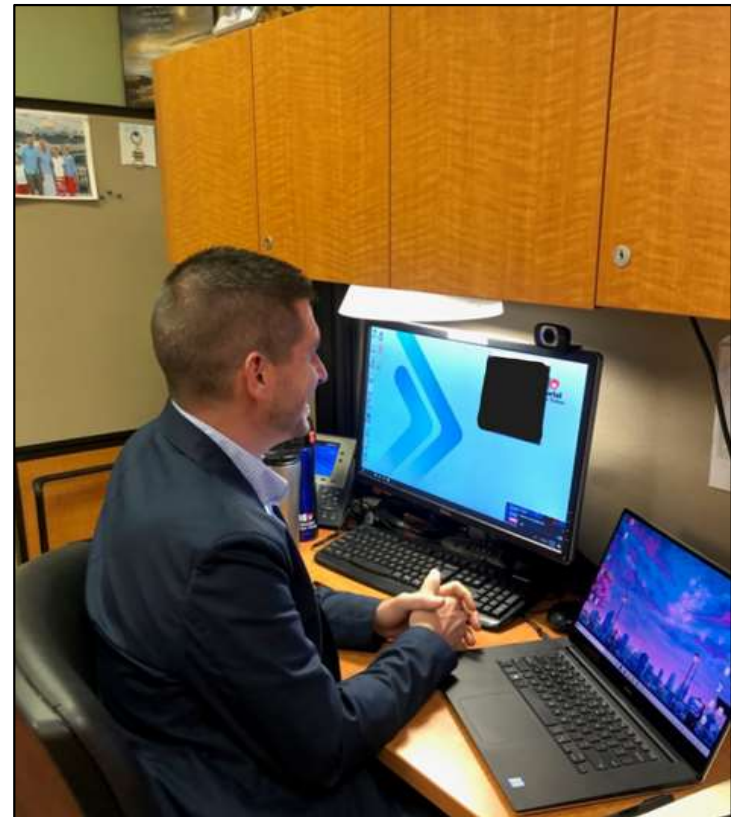
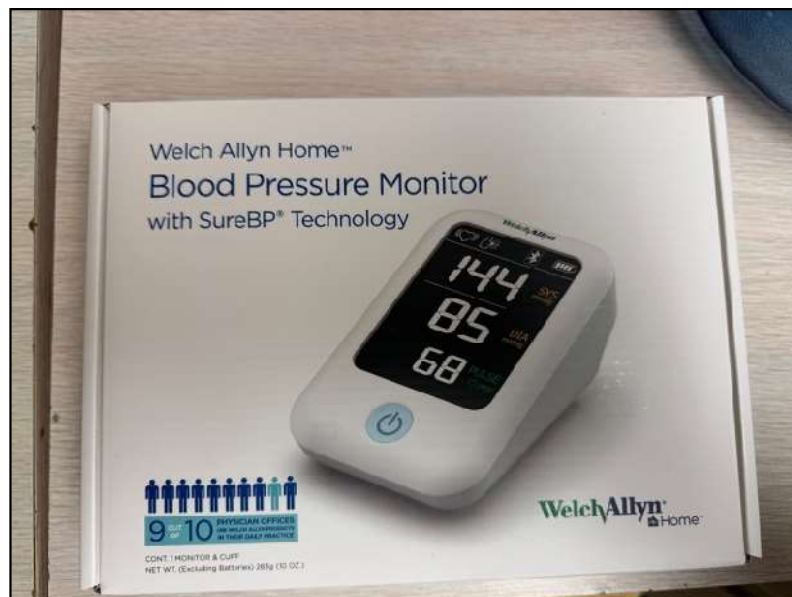
**Continue community-based chronic disease navigation programs**

- *FLDOH funding health coach and LCSW added to Sickie Cell Medical Home Care Team -Group therapy.*
- *Transportation to & from appointments: 1,321 Lyft rides to 87 patients. Serving 13 new patients per month.*
- *Sickie Cell – ED navigating patients entering ED to medical home.*
- *FY26 partner with North Broward on similar process to navigate to SC Medical Home.*





# Promoting chronic disease self-care management





# Priority #2 -Community Health Education (continued)

- Increase health education to older adult populations

**Coordinate with senior centers to educate older adults that can benefit from health workshops**

- *Lunch and Learn health education series for older adults began in FY26-Q1. Senior Center locations will include Dania Beach, Hallandale Beach, Hollywood, Miramar and Pembroke Pines*

**Provide caregivers services with resources and supports**

- *Memorial CARES ( Caregivers Access to Resources, Education and Support) is provided in Hollywood and will be expanding to all of south county*
- *Area Agency on Aging provides caregivers education and resources county wide through the monthly Dementia Care and Cure Initiative (DCCI) online education and support groups*

**Develop support groups with community partners specific to older adult issues**

- *Support groups will address coping with life transitions and loss, managing physical health and chronic conditions, enhancing social connections and relationships, mental health concerns, planning for the future, end-of-life and more*
- *Partners include Area on Aging, Broward Elderly and Veterans Services, Southwest Focal Point*



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# Health Education with Seniors





# Memorial CARES Program

Caregivers

Access to

Resources available in Broward County

Education from our community

Supports







# Priority #2 -Community Health Education (continued)

- Preventative health screenings through education

**Expand knowledge of preventative cancer screenings to underserved communities.**

- *FY25, MPC attended 71 community health fairs and events including education of preventative cancer screenings for lung, colon, cervical, and breast cancer.*

**Develop Preventative Screening Campaigns with trusted partners.**

- *FY25 MPC collaborated with American Cancer Society on colon cancer screenings. 8K were screened.*
- *FY 25 partnering with FLDOH to fund Breast & Cervical Cancer screenings.*
- *FY26 MPC partnering with the American Cancer Society to increase rates of Lung Cancer screenings.*

**Continue to provide Preventative Screening Test in the Community**

- *MHS mobile health: provide breast exams, BMI, glucose and cholesterol preventive screening tests and educational materials to ensure patients are informed. In FY25, 1,104 patients screened.*





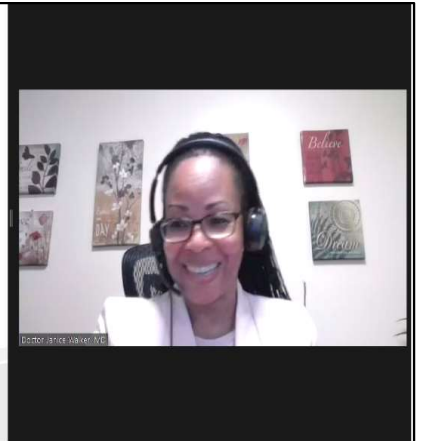
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# Community Health Education



## The ADA Standard of Medical Care 2024

- Encourages
  - Nuts
  - Seeds
  - Vegetables
  - Legumes
  - Whole grains
  - Fruits

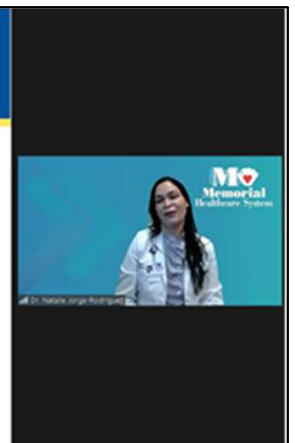




New Year, Better you.  
Achieving Health goals in 2025

Dr. Natalie Jorge-Rodriguez, M.D.  
Family Medicine  
Memorial Primary Care







# Priority #3 - Healthy Lifestyles and Wellness

- Develop Health and Wellness activities and programs

Continue to offer services and programs to the community to address health and wellness

- *LivWell program (addressing chronic conditions) served 127 patients and families in FY25*

Engage residents to address healthy living with chronic conditions by offering workshops

- *Community Health Education and Senior Lunch and Learn series to continue in FY26 – Q2*
- *Continue to offer health education workshops at the Rebels Program (OPBH)*
- *The Sickle Cell Medical Home hosted 130 support group sessions on Stress Management and Resilience in FY25.*

Educate the community on the benefits of developing a healthy lifestyle

- *Empower families through nutrition, physical activity, and mental well-being services*





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# Older Adult Education







## Priority #3 - Healthy Lifestyles and Wellness (continued)

- **Promote Exercise and Fitness:**

**Facilitate groups at the Fitness Zones throughout the region to expose community to exercise**

- *Disseminate Fitness Zone maps community wide online, at health fairs and other outlets*
- *Facilitate Fitness Zones group events at locations beginning in FY26-Q3*

**Coordinate with local wellness partners to encourage exercise and fitness among residents**

- *Engage community partners such as FLIPANY, YMCA, Boys and Girls Clubs, Police Athletic Leagues and community recreation centers in educating the community on the benefits of fitness and exercise*

**Community pop up fitness events to develop a routine which includes physical activity**

- *Identify “fitness desserts” throughout south county*
- *Develop a pop-up fitness program to serve those residing in identified areas*





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# Health and Fitness opportunities







## Priority #3 - Healthy Lifestyles and Wellness (continued)

- **Promote Nutrition and Healthy Eating**

**Expand screening to all patients and continue to provide access to healthy food**

- *HUB screening data has resulted in 1,037 patients being provided fresh fruits and vegetables*
- *Mobile Health will continue screening for food insecurity*
- *3,064 families were provided healthy food distributions throughout south county in FY25*

**Target educational sessions on nutrition and healthy eating at community events**

- *Provided nutritional education services to 1,031 participants in Healthy Start program*
- *Delivered nutrition services to 391 older adults at Senior Partners*
- *Offer nutrition sessions at all hospitals, One City at a Time kickoffs and through the community health education series.*

**Partner with local non-profit organizations for healthy cooking demonstrations**

- *FLIPANY to provide cooking demonstration events for residents*
- *University of Florida to offer healthy cooking classes to older adults at Senior Partners Center*



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# Health and Nutrition





# Priority #4 – Health Related Social Needs

- **Improve Health Literacy**

**Train and develop staff to deliver Health Literacy classes utilizing best practice curriculum**

- *Explore and review Health Literacy models to utilize best practices in FY26-Q3*
- *Develop a Health Literacy Master Trainer model for develop staff as trainers*

**Coordinate with municipalities to deliver health literacy workshops in local community centers**

- *Coordinate with Dania Beach, Hallandale Beach, Hollywood, Miramar and Pembroke Pines to deliver health literacy workshops in their communities at local centers (FY26-Q3)*

**Expand services within faith-based organizations to bring health literacy to houses of worship**

- *Health Literacy workshops will be held at St. Ruth's Missionary Baptist Church (Dania Beach), Greater Mount Pleasant AME Church (Hollywood) and Koinonia Worship Center (West Park) in FY26-Q4*



# Health Literacy Impact





# Priority #4 – Health Related Social Needs (continued)

- Increase health related social needs assessments and referrals

**Increase capacity of the HUB to meet capacity expansion**

- *Adult HUB increased staffing by 100% (from 4 to 8 FTE)*
- *The expansion resulted in serving 3,281 patients with 8,604 needs*

**Implement the Pediatric HUB to assess youth and families**

- *Pediatric HUB began operations in FY25 with 2 FTE*
- *Since inception, the Peds HUB has served 214 families with 638 social needs identified*

**Continue to identify community resource gaps to fulfill through new partnerships**

- *Identify ongoing unmet needs through the HUB patient assessments*
- *Create partnerships/sponsorship to fill the unmet patient needs*





## Priority #4 – Health Related Social Needs (continued)

- Expand community programs and partnerships:
  - Increase capacity related to food insecurity to meet increase community demand
  - Coordinate with Community Relations to identify and connect with new partnerships
  - Strategize to grow resource inventory for unmet patient and families needs
    - *Identify small, emerging food pantries throughout south county*
    - *Develop partnerships to provide support for growth (i.e. volunteers, grant writing)*
    - *Provide resources to assist in growth and expansion*
    - *Develop new partnerships to assist south county residents*
    - *Expand food pantry resource listing and disseminate to all throughout south county*
    - *Continue to identify grass roots food pantries that benefit south county residents*