Community Health Needs Assessment Implementation Strategy 2019 - 2021

Annual Update
Prioritizing the Needs in 2018

Access to Care
- Implementation of a care coordination and transitional care program
- Consideration for diversity issues (i.e.: languages spoken, undocumented populations)
- Assistance with navigation of the health insurance system including legal-medical partnerships
- Continued education of the uninsured/uninsured about new MHS Primary Care sites including collaboration/partnerships to ensure widespread information-sharing.

Preventive Care
- Prenatal Care for the prevention of low birthweight and other negative health outcomes
- Immunizations
- Education for the prevention of opioid use.

Community Health Education
- Chronic disease self-management (Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma)
- Health promotion and wellness
- Education for the prevention of sexually transmitted infections

Quality of Care
- Consideration for diversity issues including languages spoken, patients with disabilities, gender issues (i.e. gender identity, gender expression and sexual orientation)
- Diversification and training of clinical and non-clinical staff
- Coordination of care
- Consideration for the impact of macro-conditions (i.e. systemic racism) on population health

Emergency Response
- Design and implementation of an all hazard regional response and recovery system
- Education of first responders through simulation

Data Source

Qualitative:
- Focus Groups
- Key Informants
- Community Conversations

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

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- Focus Groups
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## ACCESS TO CARE

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| Prevent Avoidable hospital readmissions for high risk patients with chronic health conditions | Reduce 30 day hospital readmission rates by implementing a Transition of care program supported within EPIC  
Benchmarks to be established in year 1 | FY19  
• Created a work group with IT, Case Management, Nursing, Billing, Coding, Physicians, Social Work, Pharmacy, Administration  
• Identified program criteria, developed work flows, visit types, billing codes, team member roles, and tracking and reporting needs | On Track   | Continue build out of EPIC template to facilitate documentation and billing requirements for the program, Test the documentation template, coding and billing transmissions and data capture, evaluate and report outcomes |
| Develop a Community based ED Healthcare Navigation Service Program   | Improve compliance with patient utilizing health services ineffectively or in appropriately by educating and linking the patient to a Medical home,  
Reduce ED returns by 1% annually. Benchmark 13% | FY19  
• ED Health Navigation Services: Provided navigation services to 2,997 patients.  
• 65% Linked to a medical home  
• 9% Returned to ED W/I 30 days of receiving ED health navigation service. | On Track   | Continue to identify opportunities to incorporate the ED Health Navigation Program as phase one of the Transition of Care Program |
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| Improve healthcare literacy to SBHD Residents | Improve healthcare literacy by providing monthly educational workshops | FY19  
• Sponsored 16 workshops throughout SBHD  
• HITS and the community partners provided assistance to 328 residents | On Track | Continue to provide monthly healthcare literacy workshops |
| Provide health navigation services        | Provide individual/family health insurance navigation services during Open enrollment at a minimum of 3 MPC locations | FY19  
• Screened for Market Place Coverage- 412  
• Eligible -357  
• Applications submitted-325  
• Current MIH/PCC-353  
• Purchased-37 | On Track | Provide health navigation services for FY20 Open Enrollment period |
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| Improve Access to affordable healthcare and expand MPC community/geographical footprint | Increase community awareness of Memorial Primary Care Services and locations using marketing campaign's social media, fliers, mailings, door-to-door marketing to residents and Community. | FY19  
- Provided 7,265 Walk in visits (Average cost saving over $1 million)  
- Created same day visits at all MPC locations  
- SBCHS Rebranded as Memorial Primary Care (MPC)  
- Marketing Events included: Health Fairs, Chamber events, Faith based community partners, Schools, Community centers, Provider lectures and door-to-door neighborhood outreach | On Track | Practice Signage Completion in FY2020, Continue to market Primary care services in the community, push social media, monitor Health grades and Google site/reviews |
## PREVENTATIVE CARE

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<td>Reduce mortality and morbidity associated with low birthweight</td>
<td>Increase the percentage of pregnant women who receive prenatal care within the first trimester or within 42 days of enrollment, Benchmark 95%</td>
<td>FY19- Achieved 95% Compliance</td>
<td>On Track</td>
<td>Continue to provide high quality prenatal services and track outcomes</td>
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<tr>
<td>Further develop education and outreach strategies to prevent low birthweight</td>
<td>Provide monthly prenatal events in collaboration with community partners</td>
<td>FY19</td>
<td>On Track</td>
<td>Continue to provide high quality educational and outreach programs and track outcomes</td>
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**FY19**
- Education and outreach provided through Memorial Healthy Start, MOMS, and Nurse Family Partnership programs resulted in 8,692 residents receiving pre and post natal services including: nutritional, child birthing, breast feeding, yoga/relaxation, safe baby practices and self sleep classes including linkage back to the primary care medical home
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<td>Reduce major causes of illnesses, disability and death by improving</td>
<td>Increase the number of immunization and number of children served by 2% over</td>
<td>FY19 3% Increase over PY 567 children served 1,798 Immunizations provided</td>
<td>On Target</td>
<td>FY20- Increase participation in Vaccinate Broward Campaign by providing no cost</td>
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<td>immunization compliance for preventable infectious diseases in children</td>
<td>prior year. FY18- 550 children received 1,522 immunizations provided</td>
<td></td>
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<td>immunization at 5 MPC practice locations, Host Annual BTSHF in August 2019</td>
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**Fiscal Year (FY):**
- FY18: 2018-2019
- FY19: 2019-2020
- FY20: 2020-2021
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| Reduce Opioid Related deaths through education | Provide quarterly educational lectures and workshops on Opioid prevention | FY19-  
  • Provided 4,863 youth and 1,014 parents with education on the dangers and harmfulness of opioid use.  
  • Provided 7 community events to 118 residents on the use of Narcan used to reverse the effects of Opioids | On Track | Continue to provide education on Opioid prevention and other health harming substances |
# COMMUNITY HEALTH & EDUCATION

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| Improve the Quality of life, promote self care management, reduce healthcare cost by preventing and minimizing the effects of chronic diseases | Develop a home DOC-In-A BOX telehealth program and provide a minimum of 250 unduplicated home telehealth visits to patients with 2 or more chronic conditions with barriers to self care over 3 years. Evaluate PCP compliance and the hospital utilization within 30 days of the home telehealth visit, establish benchmarks and improve outcomes by 1% each year. | FY19-20  
- Secured grant funding (Jan 2018)- Q4 FY18, Developed scope, identified program criteria, developed work flows, visit types, team member roles, IT documenting, and reporting build out. Purchased portable telehealth equipment with peripherals for remote assessment, paired technology to secured EPIC EHR. Hired and trained staff. Develop marketing material and self care management tools  
  - 1st telehealth home visit September 2018. As of September 2019 MPC completed 251 home visits  
  - Benchmarks established | On Track | Provide more than 500 home visits by December 2020 |
| Improve compliance with chronic disease self management            | Increase the number of MyChart users by 2% annually to promote self care management, shared decision making, increase access and improve the patient experience Goal >50% | FY19  
- Average monthly MyChart Activation for MPC 54%                   | On Track | Continue to promote and encourage MyChart Activation for MPC patients |
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| Improve health status for patients at risk for chronic health conditions with multiple social determinants living in ALICE households | LivWell program will provide motivational interviewing, wrap around case management and PEARLS. A minimum of 120 individuals                                                                                 | FY19  
• LivWell program provided 108 participants with a minimum of 8 home visits, wrap around case management services, and monthly group activities                                                                 | On Target  | Continue enrollment in the LivWell Program                                            |
| Increase awareness of Mental health promotion and wellness                                                                          | Provide health promotion and wellness workshops in the community addressing mental health topics                                                                                                     | FY19  
• Facilitated the First Mental Health Summit in Pembroke Pines                                                                                                                                                                         | On Target  | Continue to promote and provide mental health wellness activities in the community                                          |
| Optimize the use of telehealth between primary care and behavioral health                                                        | Provide telehealth visits for behavioral health during the PCP visit for PHQ-9 score above 14 for further evaluation. Goal 100%                                                                            | FY19  
• Facilitated 91 telehealth visits for behavioral health during the PCP visit for PHQ-9 score above 14 for further evaluation                                                                                                | On Target  | Continue to encourage care team to use telehealth unit in each PCP practice. Work with IT and BH to create a dashboard    |
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| Decrease STI morbidity by providing STI education through out the community | Provide STI education for a minimum of 1,500 youth annually at local middle and High schools utilizing an evidenced based curriculum | **FY19**  
• Provided 2,368 youth and young adults with STI/STD education | On Target | Continue to provide STI education to youth and young adults in the community |
| Screen patients for HIV | Provide HIV test for at risk individuals annually and non risk once per lifetime. Link reactive individuals to HIV medical care with in 72 hours | **FY19**  
• Created a best practice alert in EPIC, and criteria for frequent HIV testing for High Risk individuals  
• Provided Rapid HIV test at MPC  
• Offered-13,674  
• Tested-7,637  
• Reactive and linked to HIV medical care with in 72 hours-2 | On Target | Create bulk orders for annual HIV testing, Expand Opt-Out testing to MPC |
### QUALITY OF CARE

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| Improve the health, safety and wellbeing of lesbian, gay, bisexual   | Provide MHS staff with education on LGBT health care disparities and cultural competent care | FY19 - MHS developed an online training titled : Affirming the LGBTQ Community with Caring Communication.  
• Partnered with Sun Serve to provide gender affirming healthcare | On Track     | Address gender sensitivity employee training through a grant funded initiative |
| and transgender (LGBT) community                                    |                                                                            | FY19 - Gender identification questions were build into the set of intake questions located in the social history of the EHR | On Track     |                                                            |
| Develop tools within EPIC to help identify gender disparities        | Develop a standard set of questions that identify (LGBT) population         | FY19 - MHS developed an online training titled : Affirming the LGBTQ Community with Caring Communication.  
• Partnered with Sun Serve to provide gender affirming healthcare | On Track     | Continue to develop EPIC to capture expanded LGBT information               |
| Assure cultural competency training for employees, including gender  | MHS will provide training modules on the Language of Caring                 | FY19-20 - 72% of all MHS employees have completed all training modules  
• 81% of all MHS employees have completed half of training modules | On Track     | Continue to provide the Language of Caring training                          |
| identity and disability issues                                       |                                                                            | FY19-20 - 72% of all MHS employees have completed all training modules  
• 81% of all MHS employees have completed half of training modules | On Track     |                                                            |
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<td>Identify and address social determinants of health (SDOH) that affect individual health status</td>
<td>Develop a SDOH web based platform with EPIC to assess individual risk by determinant</td>
<td>FY19 • Developed a SDOH calculator within EPIC, Auto populated SDOH referral by risk currently in development</td>
<td>On Target</td>
<td>Developing SDOH calculator for JDCH</td>
</tr>
<tr>
<td>Partner with local organizations that can address specific SDOH</td>
<td>Partner with Legal Aid Services of Broward County an provide a minimum of 110 MPC patients with Civil legal issues affecting their health and demonstrate improvement in health outcomes</td>
<td>FY19 • Secured partnership and grant funding for a full-time attorney located within MPC for 24 months (June 2019-May 2021). Attorney hired Staff training to begin FY2020-Q2</td>
<td>On Target</td>
<td>Educate/train MPC staff on program services and referral process. Track and report outcomes. Demonstrate return on value (ROV)</td>
</tr>
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<td>Educate residents on community resources available and how to effectively access services</td>
<td>Provide Community Resource Educational Workshops Quarterly</td>
<td>FY19 • Provided 11 “How To Be Your Own Case Manager” workshops throughout SBHD for families to learn how to access food and services. Linked 203 patients to Community Enhancement Center (CEC) for ongoing food insecurity issues</td>
<td>On Target</td>
<td>Will continue to provide this monthly at various locations throughout SBHD</td>
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QUALITY OF CARE

Social Determinants of Health

Social Connections

JAN 22
2019 Slightly Isolated

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
More than three times a week
## EMERGENCY RESPONSE

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<td>Develop a All Hazards Response and Recovery System</td>
<td>Design and build an All Hazard Regional Response and Recovery System</td>
<td>FY19&lt;br&gt;• Received quotes for Zumro Shelters, Mobile Oxygen Generation System. Box trucks and utility van, Awaiting quotes for water system and generators</td>
<td>On Target</td>
<td>Orders placed for Zumro Shelters, and Mobile Oxygen Generation System. Order box trucks and utility van, Awaiting quotes for water system and generators</td>
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<td>Develop All Hazards Response and Recovery System Policies &amp; Procedures</td>
<td>Develop policies for Deployment and Recovery Phases</td>
<td>FY19&lt;br&gt;• Plan to develop policies and procedures using State Medical Response Team and Disaster Medical Assistant Team models.&lt;br&gt;• Have been communicating with State Department of Health about developing and signing an MOA with the State for deployment purposes</td>
<td>On Target</td>
<td>Continue to develop policies and procedures related to the Emergency Response System</td>
</tr>
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<td>Identify Deployment Teams</td>
<td>Explore possibility to supplement using the Florida Department of Health in Broward County under MRC.</td>
<td>FY19&lt;br&gt;• Investigating the option of MHS assuming a coordinating role of MRC on behalf of the County.&lt;br&gt;• Will develop a formal proposal and submit to Executive Leadership</td>
<td>On Target</td>
<td>Formal proposal will be developed by the MHS Director of Emergency Preparedness</td>
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## EMERGENCY RESPONSE

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<td>Partner with County and State Agencies to support Regional Response and Recovery Efforts</td>
<td>Provide ongoing training and simulation exercises to first responders, staff and volunteers</td>
<td>FY19 • MHS received MOU from FAU, Awaiting response from FAU on contract changes</td>
<td>On Track</td>
<td></td>
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**On Track**

![Image of emergency response equipment]