



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 health 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:

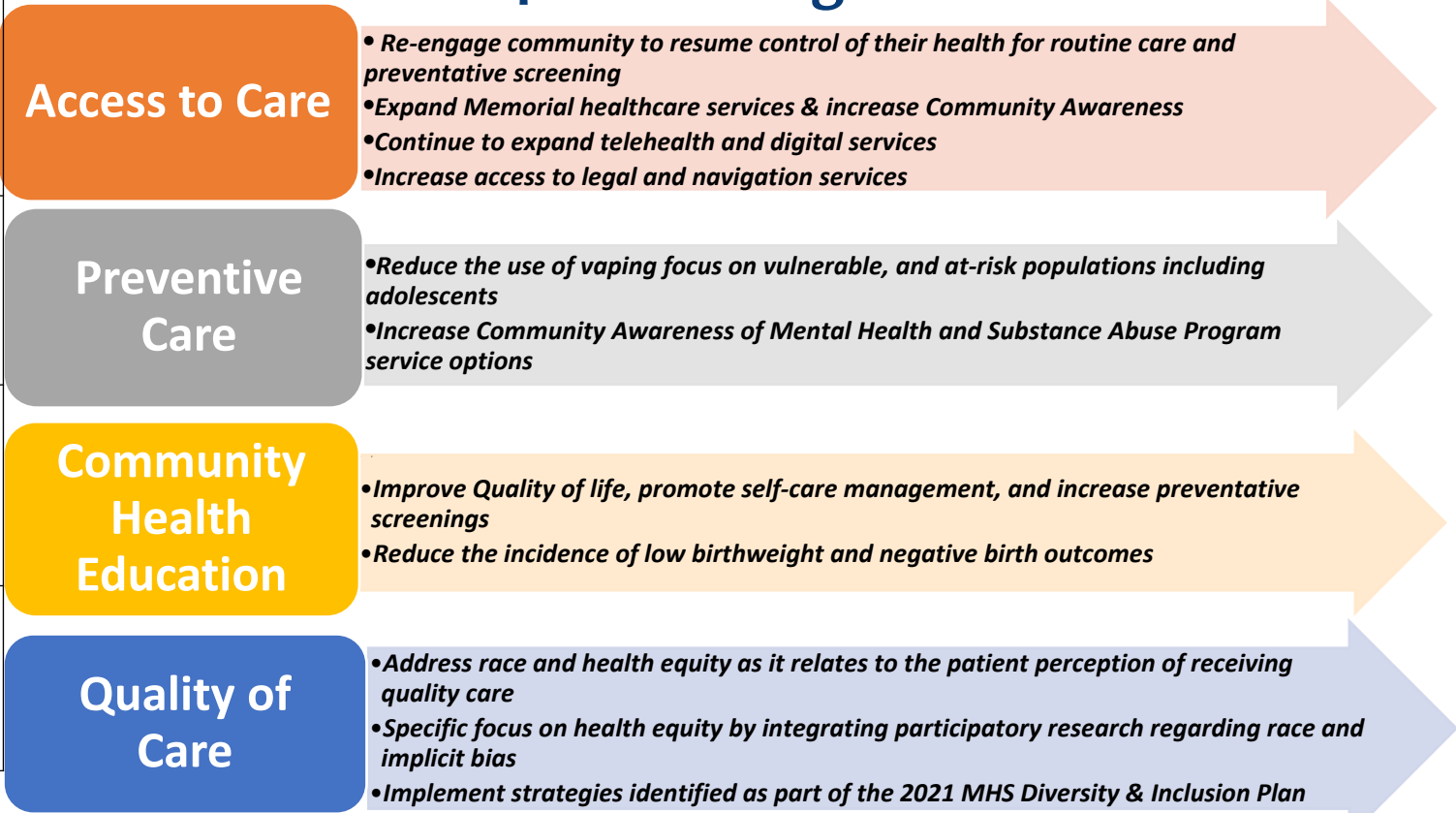
- **Qualitative:** (Focus Groups, Key Informants, Community Conversations, Advisory Council)
- **Quantitative:** (US Bureau of the Census, BRHPC Health Data Warehouse, Florida Charts)



Data Source

Qualitative: ✓ Focus Groups ✓ Key Informants Quantitative: ✓ US Bureau of the Census ✓ BRHPC Health Data Warehouse ✓ Florida Charts
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2021- 2024 Prioritizing the Needs





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



Priority #4 -Quality of Care

Goal: Improve the quality of care for all patients

Implement strategies identified as part of the 2021 MHS Diversity & Inclusion Plan

- a. Implement strategies developed by through the Memorial MHS Diversity and Inclusion plan
- b. Provide race equity, implicate bias, LGBTQ+ training to MHS staff
- c. Continue to hire a multicultural, diverse work force