2024 - 2027

Community Health Needs Assessment

Implementation Plan

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

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

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. Increase 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. Develop Virtualist Program
  c. Bolster 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. Develop Preventative Screening Campaigns with trusted community partners
  b. Continue to provide Preventative Screening education and testing throughout the community

Priority #3 - Healthy Lifestyles and Wellness

- Develop 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

- 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 Healthy Eating:
  a. Expand SDOH 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

- Expand 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