Memorial Healthcare System

Community Health Needs Assessment Implementation Strategy 2019 -2021

Annual Update

Prioritizing the Needs in 2018

Data Source		
Qualitative: ✓ Focus Groups ✓ Key Informants ✓ Community Conversations **Quantitative:** ✓ US Bureau of the Census ✓ BRHPC Health Data Warehouse ✓ Florida Charts	**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 underinsured/uninsured about new MHS Primary Care sites including collaboration/partnerships to ensure widespread information-sharing.
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	**Preventive Care**	• Prenatal Care for the prevention of low birthweight and other negative health outcomes • Immunizations • Education for the prevention of opioid use.
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	**Community Health Education**	•Chronic disease self-management (Congestive Health Failure, Diabetes, Chronic Obstructive Pulmonary Disease, Asthma) •Health promotion and wellness •Education for the prevention of sexually transmitted infections
Qualitative: ✓ Focus Groups ✓ Community Conversations **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	**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
Qualitative: ✓ Focus Groups	**Emergency Response**	•Design and implementation of an all hazard regional response and recovery system •Education of first responders through simulation

ACCESS TO CARE

Goal	Objective	Action/Outcome	Status	Planned Action
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

ACCESS TO CARE

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
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

ACCESS TO CARE

Goal	Objective	Action/Outcome	Status	Planned Actions FY20-21
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

Goal	Objective	Action	Status	Planned Action FY20-21
Reduce mortality and morbidity associated with low birthweight	Increase the percentage of pregnant women who receive prenatal care within the first trimester or within 42 days of enrollment, Benchmark 95%	FY19- Achieved 95% Compliance	On Track	Continue to provide high quality prenatal services and track outcomes
Further develop education and outreach strategies to prevent low birthweight	Provide monthly prenatal events in collaboration with community partners	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	On Track	Continue to provide high quality educational and outreach programs and track outcomes

PREVENTATIVE CARE

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
Reduce major causes of illnesses, disability and death by improving immunization compliance for preventable infectious diseases in children	Increase the number of immunization and number of children served by 2% over prior year. FY18- 550 children received 1,522 immunizations provided	FY19 3% Increase over PY 567 children served 1,798 Immunizations provided	On Target	FY20- Increase participation in Vaccinate Broward Campaign by providing no cost immunization at 5 MPC practice locations, Host Annual BTSHF In August 2019

PREVENTATIVE CARE

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
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

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
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

COMMUNITY HEALTH & EDUCATION

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
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

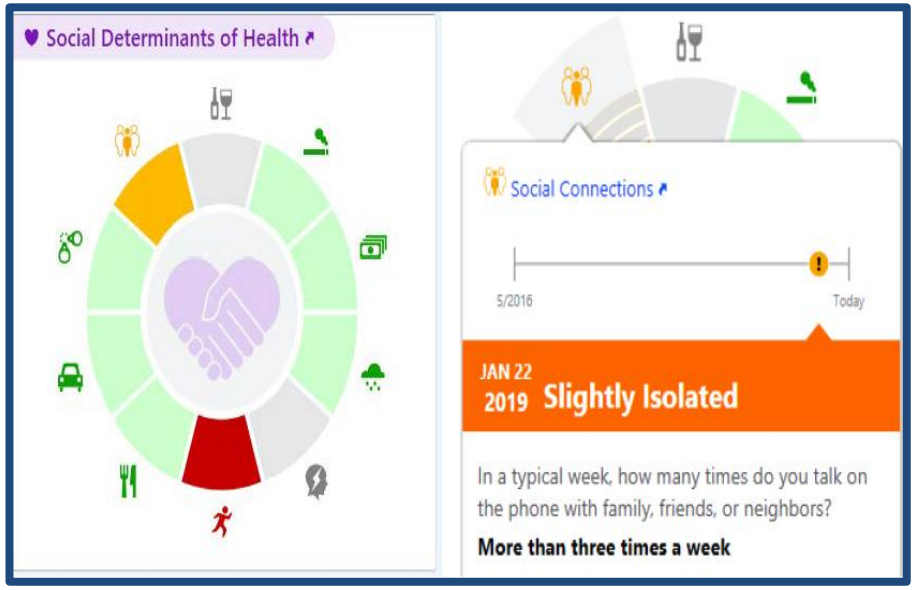
COMMUNITY HEALTH & EDUCATION

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
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 • Provide 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

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
Identify and address social determinants of health (SDOH) that affect individual health status	Develop a SDOH web based platform with EPIC to assess individual risk by determinant	FY19 • Developed a SDOH calculator within EPIC, Auto populated SDOH referral by risk currently in development	On Target	Developing SDOH calculator for JDCH
Partner with local organizations that can address specific SDOH	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	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	On Target	Educate/train MPC staff on program services and referral process. Track and report outcomes. Demonstrate return on value (ROV)
Educate residents on community recourses available and how to effectively access services	Provide Community Resource Educational Workshops Quarterly	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	On Target	Will continue to provide this monthly at various locations throughout SBHD

QUALITY OF CARE



EMERGENCY RESPONSE

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
Develop a All Hazards Response and Recovery System	Design and build an All Hazard Regional Response and Recovery System	FY19 • Received quotes for Zumro Shelters, Mobile Oxygen Generation System. Box trucks and utility van, Awaiting quotes for water system and generators	On Target	Orders placed for Zumro Shelters, and Mobile Oxygen Generation System. Order box trucks and utility van, Awaiting quotes for water system and generators
Develop All Hazards Response and Recovery System Policies & Procedures	Develop policies for Deployment and Recovery Phases	FY19 • Plan to develop policies and procedures using State Medical Response Team and Disaster Medical Assistant Team models. • Have been communicating with State Department of Health about developing and signing an MOA with the State for deployment purposes	On Target	Continue to develop policies and procedures related to the Emergency Response System
Identify Deployment Teams	Explore possibility to supplement using the Florida Department of Health in Broward County under MRC.	FY19 • Investigating the option of MHS assuming a coordinating role of MRC on behalf of the County. • Will develop a formal proposal and submit to Executive Leadership	On Target	Formal proposal will be developed by the MHS Director of Emergency Preparedness

EMERGENCY RESPONSE

Goal	Objective	Action/Outcome	Status	Planned Action FY20-21
Partner with County and State Agencies to support Regional Response and Recovery Efforts	Provide ongoing training and simulation exercises to first responders, staff and volunteers	FY19 • MHS received MOU from FAU, Awaiting response from FAU on contract changes	On Track