Parrish Medical Center | Parrish Healthcare

2025-2027
COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY

Contents

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- Integrated Care Navigation and Care Transitions
  - Kristina Weaver, Executive Director Population Health and Care Navigation
  - Heather Minnear, Manager, Community Health Navigator
  - Lisa Balas, Manager, Case Management
  - Lara Chicone, Sr. Behavioral Health Navigator
- Community Health Partners (CHP) Members and Key Informant Participants include, but are not limited to, representatives from the following:

211
All Black Inc
American Addiction Centers
Anthem Health Plans
Assisting Hands
Aware Recovery
Banyan Treatment Center
Brave Health
Brevard County Schools
Brevard Homeless Coalition
Brevard Prevention Coalition
Brevard Recovery Festival
Brevard Schools
Career Source
Charlie Health
Circles of Care
Citizen
City of Titusville
Community of Hope
Curative Cares
FL Dept of Health
Eastern Florida College
Eckerd Connects
Family Promise
Florida Free Tobacco
FHCP
Harmony Hills
HfH Supportive Housing
Hope of North Brevard
Housing Authority City of Titusville
Journey Pure
Lifetime Counseling
Lifepoint Ministries
Live Well Behavioral Health
NAMI
North Brevard Charities
Palm Point
Peace Club
Recovery Unplugged
Royal Oaks Skilled Nursing
Serinity Springs Recovery
Simply Healthcare
Space Coast Health Centers
Space Coast Transportation Planning Organization
The Grove Church
The Sober Pad
UCF, MSW Student
UF/IFAS Extension
Under the Bridge Ministries
Up Health
Vitas
Women's Center

II. Introduction and Background

According to federal health reform legislation not-for-profit hospitals must conduct a Community Health Needs Assessment (CHNA) once every three years and develop a plan to meet the health needs of the community served. The federal guidelines require that the CHNA and Implementation Plan be adopted by an authorized governing body of the hospital before the last day of the taxable year or previous two taxable years. If needed, the Implementation Plan has an additional four and a half months for adoption after the end of the taxable year in which the hospital facility is required to complete its CHNA report. In compliance with the federal guidelines, Parrish Healthcare is pleased to present the following Community Health Improvement Plan for addressing key priorities identified in the 2025 CHNA approved by the North Brevard County Hospital District Board of Directors on August 4, 2025.

III. Executive Summary

North Brevard County Hospital District, d/b/a Parrish Medical Center, is an independent, not-for-profit; public community hospital founded in 1958 by the State of Florida. Parrish Medical Center has grown from a 28-bed single story hospital to become part of the nation's first Joint Commission Integrated Care Certified network of healthcare providers known as Parrish Healthcare. Parrish Healthcare includes:

- Parrish Medical Center: a Cleveland Clinic Connected member and a 208-bed acute care hospital
- Parrish Healthcare Centers: featuring outpatient diagnostics, urgent care, physician offices and other services
- Parrish Medical Group: a NCQA-certified multi-specialty physician group featuring primary care and specialty care practices throughout North Brevard County
- Parrish Health & Wellness Center
- Parrish Home Health Care
- Parrish Sleep Center
- Parrish Wound Healing & Hyperbaric Medicine Center
- Parrish Health Network®: a regional network of healthcare providers, services, and insurers.

IV. Mission Vision Values

Mission | Healing Experiences For Everyone All The Time®
Vision | Healing Families—Healing Communities®
Values | Safety, Loyalty, Integrity, Compassion, Excellence, Stewardship

V. How the Implementation Strategy was Developed

The implementation strategy was developed after the comprehensive Community Health Needs Assessment ("CHNA") was completed. The CHNA was approved during the regular meeting of the Board of Directors held on Monday, August 4, 2025. The full CHNA report may be found at the following link: www.parrishhealthcare.com/communitybenefit.

Parrish Healthcare convened a group of key community stakeholders to evaluate, discuss and prioritize the findings within the assessment.

A group of approximately 30 community stakeholders (representing a cross-section of Parrish Healthcare Care Partners and community-based agencies and organizations) convened to evaluate, discuss, and prioritize the health issues for our community.

VI. Identified Community Health Needs

Prioritization of the health needs identified was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey. In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. MENTAL HEALTH
2. SUBSTANCE USE
3. CANCER
4. NUTRITION, PHYSICAL ACTIVITY & WEIGHT
5. HEART DISEASE & STROKE
6. ACCESS TO HEALTH CARE SERVICES
7. DISABLING CONDITIONS
8. TOBACCO USE
9. INJURY & VIOLENCE
10. INFANT HEALTH & FAMILY PLANNING
11. RESPIRATORY DISEASES

VII. Social Determinants of Health

Social determinants of health (SDOH) have a major impact on people's health, well-being and quality of life. SDOH also contribute to wide health disparities and inequities. Healthy People 2030 advocates for public health organizations and their partners, in sectors like education, transportation, and housing, to take action to improve the conditions in people's environments beyond promoting healthy choices. Examples of SDOH include:

- Safe housing, transportation and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Perceptions of SDOH as a problem in the community among the key informants 83.1% rated the issue as either a major or moderate problem citing reasons such as lack of affordable housing, homelessness, poverty levels, uninsured or under insured. To understand the unmet social needs of patients, Parrish Healthcare uses a standardized, evidence-based assessment to gather information, which is then used to create a care plan and connect patients to appropriate resources.

VIII. Significant Health Needs

Based on the evaluation of our past activities, the results of the most recent needs assessment, and the Parrish Healthcare's mission, the Board approved the following key focus areas from which to develop our 2026-2028 Implementation Strategy:

(1) Access to Health Care Services;

(2) Heart Disease & Stroke;

(3) Cancer (Oncology);

(4) Respiratory Diseases (Asthma, COPD)

IX. Care Navigation A Person-Centered Approach

As the nation's first certified integrated care system,[1] we are proud to be a leader in transforming healthcare from fragmented care to coordinated, collaborative care. We do this through our unwavering commitment to our mission, vision and values, and to continuous improvement. As part of our integrated care model, we implemented many effective strategies to meet the needs of the people and communities we serve including our care navigation program.

Parrish Healthcare developed its care navigation program within a person-centered/whole person framework. This approach extends beyond the traditional disease-focused model, to one that is holistic. A holistic model is a whole person model that recognizes the interplay of exercise, nutrition, environment, mental health stressors, and other factors, on one's overall health. Moreover, a holistic model empowers patients and incorporates a philosophy of wellness at any stage of care.

The objectives of our patient care navigation program are to: (a) improve access to health care services by linking patients and families to primary care services, specialist care, and community-based health and social services; (b) provide a holistic patient/person-centered care approach to get to know the person; understand their unique circumstances; (c) identify and resolve barriers to care such as any SDOH; and (d) provide patient education and support to foster adherence to self-management regimen.

Our Care Navigators work one-on-one with patients and actively guide them through the healthcare system. Our navigators work on the person's/patient's behalf to overcome barriers that are in the way of the patient receiving the care and treatment they require. The specific patient populations with which our care navigators work include persons fighting cancer, overcoming substance use disorders, as well as those learning to live with diabetes, heart failure, chronic obstructive pulmonary disease, sleep disorders, mental illness, among other chronic and potentially disabling conditions.

[1] Integrated care certification was awarded by The Joint Commission, an independent, not-for-profit organization that accredits and certifies nearly 21,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Parrish Healthcare's first integrated care certification was earned in 2016 and was recertified in 2019 and 2022.

X. Strategic Areas of Focus & Planned Actions

A. Access to Health Care Services

Access to Health Care Services means the timely use of personal health services to achieve the best health outcomes. It generally requires three distinct steps: (1) Gaining entry to the health care system (usually through insurance coverage); (2) Accessing a location where needed health care services are provided (geographic availability), and; (3) Finding a health care provider whom the patient trusts and can communicate with (personal relationship). Feedback as top concerns from the key informants during the prioritization exercise related to opportunities with Access to Health Services included:

- Lack of Health Insurance
- Barriers to Access, specifically related to appointment availability with PCP and finding a PCP
- Primary Care Physician Ratio
- Emergency Room Utilization

B. Heart Disease & Stroke Prevalence

Feedback as top concerns from the key informants during the prioritization exercise related to opportunities with Heart Disease & Stroke Prevalence included:

- Leading Cause of Death
- Access to more Providers
- Affordable Medication/Supplies

C. Cancer

In Brevard County lung cancer is the leading cause of death followed by female breast cancer, prostate cancer and colorectal cancer. Nearly 76% of respondents believe cancer is a major to moderate problem in the community, citing the following concerns:

- Leading Cause of Death
- Access to Cancer Care and Specialists
- Raising Awareness about Screenings

D. Respiratory Diseases

While we have made year-over-year improvements in mortality trends related to respiratory diseases, chronic obstructive pulmonary disease (COPD) remains among the deadliest of those diseases. In our primary service area prevalence of asthma (a contributing factor to developing COPD), is on the rise. Over half of the respondents believe this to be a major to moderate problem.

E. Planned Actions

Planned Actions	Access to Health Care Services	Heart Disease & Stroke	Cancer	Respiratory Diseases
Maintain Joint Commission Integrated Care Certification.	✓	✓	✓	✓
Maintain national quality accreditations (e.g. Primary Stroke, Commission on Cancer).	✓	✓	✓	✓
Utilize community outreach mechanisms to raise awareness and educate the North Brevard county adult population about available resources.	✓	✓	✓	✓
Improve Emergency Department workflows to reduce wait-times.	✓	✓	✓	✓
Operate retail pharmacy to improve access to affordable medicines.	✓	✓	✓	✓
Operate Parrish Medical Group (PMG) primary and specialty care providers (e.g. cardiologists, orthopedic surgeons, urology, GI, OB/GYN, etc.; nationally certified as a medical home; expand network of providers to improve availability of appointments and provider ratios.	✓	✓	✓	✓
PMG to provide virtual visit options to further improve accessibility.	✓			
Continue to support and partner with Space Coast Health Centers, a federally qualified look-alike for improved access to primary, specialty and behavioral health care to the medically underserved	✓	✓	✓	✓
Operate Parrish Sleep Disorders Center and continue to provide Inspire implants to treat sleep apnea, a leading risk factor for heart attack or stroke.	✓	✓	✓	✓
Utilize Robotic technology to expand access to minimally invasive treatments.	✓	✓	✓	✓
Expand Cardiology services to include addition of Electrophysiology Lab.	✓	✓		
Continue to enhance Interventional Radiology capabilities.	✓	✓	✓	✓
Operate freestanding, comprehensive cancer center to include radiation oncology and infusion services as well as cancer boutique providing wigs, scarves, prosthetics, etc.	✓		✓	
Continue to offer Maternity Care services within an area designated as a maternity desert.	✓			
Rank equal to or better than nation for quality and safety as measured by CMS, LeapFrog, and other national health ranking agencies.	✓	✓	✓	✓
Enhance Air Ambulance Response Times within N. Brevard supporting addition of second air ambulance to be located in N. Brevard.	✓			

Enhance tele-neurology services to improve Stroke treatment and outcomes.	✓	✓		
Utilize care navigator program to offer interventions and care coordination to remove barriers and improve adherence to the self-management regimen including remote patient monitoring	✓	✓	✓	✓
Collaborate with area providers and coordinate care within Parrish Healthcare's integrated care delivery system (e.g. PHN, PMG, Cleveland Clinic, Mayo, etc.).	✓	✓	✓	✓
Utilize evidence-based state, regional and national resources such as Vizient Southeast to develop policies, protocols, and training for care partners (employees, medical staff, volunteers); e.g. safe prescribing protocols, zero harm policy, etc.	✓	✓	✓	✓
Continue to serve as the area's lowest cost, highest quality provider	✓	✓	✓	✓
Offer financial assistance to qualified patients and helps patients with no insurance to qualify for Medicaid, Medicare or other means of coverage.	✓			
Affiliate with most commercial insurances plans and participate in Medicare and Medicaid and continue to qualify as a Disproportionate Share Hospital,	✓			
Utilize evidence-based state, regional and national resources such as Vizient Southeast to develop policies, protocols, and training for care partners (employees, medical staff, volunteers); e.g. safe prescribing protocols, zero harm policy, etc.	✓			
Partner with MedFast Urgent Care Center, one of the area's largest networks of urgent care centers to provide quality alternative for non-emergency care needs.	✓			
Provide access to fitness centers and wellness programs.	✓	✓	✓	✓
Utilize Community Health Partners to support closing SDOH gaps within N. Brevard	✓			
Ongoing clinical competency and skills training to continually advance care, treatment and outcomes; and ensure we maintain a high performing workforce on behalf of the patients and community served.		✓	✓	✓
Upgrade existing electronic health record to improve efficiency and leverage digital health innovations to improve provision of integrated care and patient and provider experiences.	✓	✓	✓	✓
Anticipated Impact	Access to Health Care Services	Heart Disease & Stroke	Cancer	Respiratory Diseases
Reduce avoidable ED visits by raising awareness of right care, right place, right time.	✓			
Increase No. of Patients assigned to PMG or SCHC as Medical Home	✓			
Increase No. of Patients receiving early detection screenings (mammo, PSA, colorectal, lung)	✓	✓	✓	✓
Reduce Heart/Stroke Mortality rates in N. Brevard	✓	✓		✓
Reduce Cancer Mortality rates in N. Brevard	✓		✓	
Improve care coordination across hospital, primary care, specialty, and community partners.	✓	✓	✓	✓
Increased access to timely primary, specialty, behavioral health, and urgent care services	✓	✓	✓	✓
Expand availability of virtual and digital care solutions to reduce access barriers	✓	✓	✓	✓
Improved patient access to affordable medications and financial assistance programs	✓	✓	✓	✓

Increased cancer, heart disease, and stroke prevention and early-detection screenings	✓	✓	✓	✓
Lower readmissions through enhanced navigation, transitional care, and remote monitoring	✓	✓	✓	✓
Improved outcomes for sleep apnea and reduce related cardiovascular risk	✓	✓		✓
Enhanced air ambulance response and critical care response times in North Brevard	✓			
Improved patient self-management and adherence through care navigation and RPM	✓	✓	✓	✓
Reduced health disparities by addressing social determinants and community resource gaps	✓	✓	✓	✓
Increased SDOH referrals and successful social service connections	✓			
Planned Resources	Access to Health Care Services	Heart Disease & Stroke	Cancer	Respiratory Diseases
Health and social service providers either through direct employ or via PHN (E.g. primary care, oncologists, radiologists, pulmonologists, cardiologists, endocrinologists, etc.).	✓	✓	✓	✓
Care Navigator program.	✓	✓	✓	✓
Educational, awareness raising materials.	✓	✓	✓	✓
People, time, resources for outreach activities (health fairs, screening events, support groups, workshops, in-kind/cash donations, etc.).	✓	✓	✓	✓
Post-Acute Rehab Services.	✓	✓	✓	✓
Parrish Healthcare people, processes and technologies for elevated access to	✓	✓	✓	✓
People, time, resources for advocacy and building community activities and civic, governmental board involvement	✓	✓	✓	✓
Planned Collaboration	Access to Health Care Services	Heart Disease & Stroke	Cancer	Respiratory Diseases
PHN/PMG primary care, specialists, tertiary providers.	✓	✓	✓	✓
Space Coast Health Care Centers	✓	✓	✓	
Cleveland Clinic Connected	✓	✓	✓	✓
Area University Student Programs: (e.g. graduate nursing, etc.).	✓	✓	✓	✓
Community Health Partnership members (e.g. city and county government, schools, churches, social services, etc.).	✓	✓	✓	✓
Jess Parrish Medical Foundation	✓		✓	
First responders, County, City & Private Paramedics, Police, Fire, etc.	✓			
Area advocacy groups: (E.g. Commission on Cancer, LeapFrog, Patient Safety Foundation, State legislators, etc.).	✓			

Measurements	Access to Health Care Services	Heart Disease & Stroke	Cancer	Respiratory Diseases
HEIDS data (primary care setting)	✓	✓	✓	✓
CMS Core Set compliance (acute care setting including Behavioral)	✓	✓	✓	✓
Care Navigation program enrollment data	✓	✓	✓	✓
No. of early detection screenings performed	✓	✓	✓	✓
Care Navigation program referral data	✓	✓	✓	✓
Community Benefit Inventory for Social Accountability (CBISA)	✓	✓	✓	✓
Communications (media) metrics (e.g. reach, frequency)	✓	✓	✓	✓
Incident Reports (RL solutions)	✓	✓	✓	✓

XI. Conclusion

Written comments regarding the CHNA or the implementation Strategy may be submitted to Parrish Healthcare by contacting communications@parrishmed.com, or calling 321.268-6110, or by mail to:

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