COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY

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, PMC is please present the following CHNA and Implementation Plan, which has been reviewed and approved by the North Brevard County Hospital District Board of Directors on January 8, 2018.

THE CHNA PROCESS

A Community Health Needs Assessment (CHNA) is a systematic, data-driven approach used to study the health status, behaviors and needs of residents served by North Brevard County Hospital District, d/b/a Parrish Medical Center's (PMC). Through the CHNA, PMC is able to make informed decisions about resource allocation and strategic priorities to address and/or to close healthcare gaps, while serving to fulfill our mission, vision and values on behalf of the community(ies) we serve:

Mission | Healing Experiences for everyone all the time®

Vision | Healing Families—Healing Communities®

Values | Safety, Loyalty, Integrity, Compassion, Excellence, Stewardship

The CHNA Service Area

The study area is defined legally by the enabling legislation and in accordance with PMC's Geographic Boundaries Policy 9500-93. PMC's service area, encompassing the tax district's boundary, is defined by the geographic area established by the following six (6) zip code areas:

32754, 32755, 32796, 32780, 32927, 32926

The CHNA Planning & Implementation Team

PMC assembled a team to review the past CHNA regarding process and outcomes. The team evaluated what worked well and what needed improvement in the past process of data gathering, community input, implementation plan formulation and the resulting implementation outcomes. Professional Research Consultants, Inc. (PRC) was selected as our data collection and analysis consultant.

Additionally, PMC engaged its Community Health Partners (CHP), which functions as a community advisory panel. CHP members include, but are not limited to:

- health and human services,
- municipalities,
- schools,
- civic groups,
- nongovernmental social service agencies,
- businesses,
- local, state and national associations,
- religious organizations,
- state departments,
- law enforcement,
- fire departments,
- patients and community residents

Members were chosen because of their wide and diverse representation of the community.

CHP members include, but are not limited to, representatives from:

2-1-1 Brevard, Inc.	Brevard C.A.R.E.S.
Brevard County	Cancer Centers of Brevard
CareerSource Brevard	Circles of Care, Inc.
First United Methodist Church of Titusville	Hospice of St. Francis
Fl. Dept. of Health in Brevard County	Greater Titusville Renaissance
Indian River City United Methodist Church	Indian River Medical Office
MedFast Urgent Care Centers, LLC	North Brevard Medical Support
North Brevard Children's Medical Center	OMNI Healthcare
Women's Center	Park Avenue Baptist Church
Parrish Medical Center	Parrish Medical Center Emergency Dept.
Parrish Medical Group	Parrish Occupational Health Clinic & Pharmacy
Parrish Senior Consultation Center	REF Nurse LLC
St. Francis Pathways to Healthcare	St. James AME Church
Team Health	United Way of Brevard County

Primary and Secondary Data Sources

This study includes data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) that allows for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey. Analysis of the data was conducted by PRC.

In the case of data obtained from external source material, the report may cite the source material rather than describe the method of collecting the data. In order to obtain the most encompassing needs assessment PMC collected the data using two methods.

1. Telephone Interview
2. Online Key Informant Survey

Telephone Interview

To ensure the best representation of the population surveyed, a telephone interview method — landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 300 individuals age 18 and older in the CHNA service area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the service area as a whole. All administration of the surveys, data collection and data analysis was conducted by PRC. **For statistical purposes, the maximum rate of error associated with a sample size of 300 respondents is ±5.7% at the 95 percent level of confidence**.

This random sampling of the population produces a highly representative sample, however, in order to minimize bias it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This was accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (post stratification), so as to eliminate any naturally occurring bias.

Specifically, once the raw data was gathered, respondents were examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status.) A statistical application package applied weighting variables that produced a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

Online Key Informant Survey

An Online Key Informant Survey was also implemented as part of this process. These key informants included physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

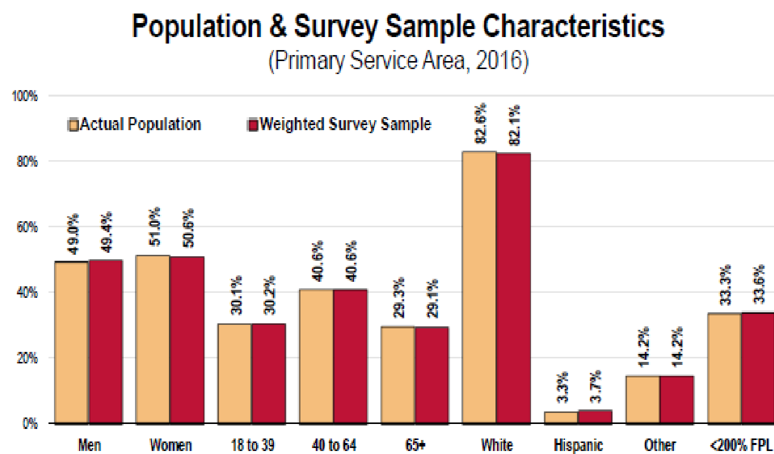
Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online. Reminder emails were sent as needed to increase participation. In all, 73 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participated
Community/Business Leader	22	5
Other Health Provider	25	4
Physician	196	42
Public Health Representative	7	3
Social Services Provider	59	19

Population and Survey Sample Characteristics

The following chart outlines the characteristics of the CHNA area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]



Sources:
- Census 2010, Summary File 3 (SF 3). US Census Bureau.
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc.

The poverty descriptions and segmentation used in this implementation plan are based on administrative poverty thresholds determined by the U.S. Department of Health & Human Services.

These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2014 guidelines place the poverty threshold for a family of four at $23,850 annual household income or lower.)*

In sample segmentation: **low income** refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; **mid/high income** refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Benchmark Data

To assist in determining the significance of the findings benchmark data was utilized from the following sources:

1. Florida Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings. These data are reported in the most recent *Behavioral Risk Factor Surveillance System Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the U.S. Department of Health & Human Services.

2. Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2015 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the U.S. population with a high degree of confidence.

3. Healthy People 2020

The Healthy People 2020 initiative is science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

The Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in the Community Health Needs Assessment represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons or those who only speak a language other than English or Spanish— are not represented in the survey data.

Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In addition, this assessment does not include secondary data from existing sources which can provide relevant data collected through death certificates, birth certificates, or notifications of infectious disease cases in the community.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

CHNA PRIORITIES

On June 8, 2016, PMC hosted a CHP event attended by more than 50 residents, representing approximately 50 psycho-social agencies, government entities, business leaders, patients and engaged citizens. A representative from PRC explained the process of telephone interviewing and Key Informant online surveys to obtain the raw data and presented the CHNA report.

The floor was opened for discussion to verify if the community members present thought this was a well-balanced, thorough community health needs assessment. Through an open forum discussion the attendees agreed that this was a suitably comprehensive and accurate needs assessment.

The attendees were then asked to provide additional insight into the findings. Several elaborated on different identified needs with personal and professional accounts of the scope and complexity of the problem and why it was important for the community to address this need. In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad.

The participants were asked to evaluate each health issue along two criteria:

1. **Scope & Severity** —gauging the magnitude of the problem in consideration of the following:
    - How many people are affected?
    - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
    - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

2. **Ability to Impact** —measuring the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

An electronic voting process was used to help us determine our CHNA Priorities.

During separate meetings, we presented the overview of obtaining CHNA and the prioritized list of needs to the Community Health Partnership, the North Brevard Coalition, the Parrish Medical Group physician enterprise members and the Parrish Health Network Board. We engaged these community-focused group members in discussion about the process and the results. Each organization gave approval of the process and results of the CHNA.

PRIORITY #1 | ACCESS TO SPECIALITY CARE

Diabetes & Pre Diabetes

Goal:
Strengthen access to specialty provider-based and supportive services and increase the utilization of healthcare services by community members.

Objective:
Increase access to specialty care services for residents of North Brevard County.

Strategy/Actions:

- ✓ Parrish will seek to expand patient availability of specialty care in at least two ways first by increasing the support and efficiency of our PMG/PHN endocrinologist; and second by expanding PHN membership and utilization of Diabetic Specialists. This will reduce the current wait time of approximately six months for an initial specialist visit down to less than four months.

- ✓ Parrish will provide ongoing clinical and information technology specialists to increase access to the existing PHN endocrinologist.

- ✓ Parrish will provide business development, liaison, clinical quality and information technology resources to expand network membership sufficiently to increase patient access and reduce wait times to meet the goal stated in the above paragraph.

- ✓ Parrish will work with our endocrinologist and Diabetes Education department to offer ongoing diabetes education to the local physicians and other providers. This will assist patients to receive a higher level of care within their primary care setting.

- ✓ Network PCPs will establish or expand a patient medical history, signs and symptoms protocol to identify and screen patients for pre-diabetes/diabetes. This will result in a five percent increase in patients identified with pre-diabetes.

- ✓ Parrish will provide diabetes screening at health fairs and at select critical need population focused community events. Network PCPs will maintain staffing and information technology to identify and provide a screening test for their patients.

- ✓ Parrish will collaborate with the Central Florida YMCA to bring its pre-diabetes program to the community served.

- ✓ Increase access to initial and refresher diabetic education/teaching, especially as it pertains to reducing obesity and controlling blood sugars through exercise and proper nutrition.

- ✓ Parrish Diabetes Education department will maintain office hours in the community and provide after-hours diabetes education classes as needed to make available initial and refresher patient education within a two week timeframe after receiving physician orders. Diabetes Education will be represented at network and critical-need-population-focused community events to provide an educational overview, supporting handouts and healthcare pathway information to the community members.

- ✓ Parrish will maintain their Diabetes Education Department in the face of lowering reimbursements and has pledged $25,000 additionally to provide assistance to the uninsured/under insured community members in receiving diabetes education.

PRIORITY #2 | ACCESS TO HEALTHCARE SERVICES

Primary Care Services and Supportive Services

GOAL:
Strengthen access to provider-based and supportive services, and increase the utilization of healthcare services by community members.

OBJECTIVE:
Increase access to primary care services for residents of North Brevard County.

Strategies/Actions:

- ✓ Cost of Prescriptions and Skipping/Stretching Prescriptions.
  - Parrish will help foster community availability and enrollment in affordable prescription drug coverage and promote the use of generic prescriptions.
  - Community education will be provided, detailing the importance of taking medications in accordance with the physician prescription.
  - At least 75 percent of patients will fill and take their prescriptions as prescribed by the physician.
  - The network providers will reach a 75 percent utilization of generic prescription drugs for treatment of their patients.

- ✓ Cost of Physician Visits
    - o Parrish will help foster community availability and enrollment in affordable health insurance. We will continue to support Federally Qualified Healthcare Centers to make available economically viable physician services to the community. Because of access to physicians, Emergency Department utilization for non-emergency services will be reduced by 5 percent over three years.
    - o Parrish has committed more than $600,000 per year to make physician visits accessible to community members.

- ✓ Finding a Physician
    - o Parrish will maintain a list of hospital-credentialed physicians on its website and promote use of the website through community outreach resources.
    - o We will promote the physician locator resources of organizations like 2-1-1 Brevard and the Community Health Foundation.
    - o Physician listing information will be maintained at local social service agencies for the benefit of their constituents. These community resources will reduce by 20 percent the issue of residents not being able to find physicians that they can access for care.
    - o Parrish has committed to spend $20,000 per year through its community outreach resources including website and community agency support to provide physician information to the citizens within our service area.

- ✓ Emergency Room (ER) Utilization
    - o The culmination of the above mentioned solutions to accessing healthcare in addition to utilizing non-physician providers, government and community agencies will reduce the need for citizens to present to the ER for care.
    - o ER utilization for non-emergency care will be reduced by 5% over three years.

- ✓ Ratings of Local Healthcare
    - o The network has committed to all of the primary care physician members to obtain Patient Centered Medical Home status. This will put its members in the top 20 percent of all primary care providers in the nation regarding quality, cost and access.
    - o PMC ranked in the top 10 percent of hospitals for value-based purchasing, which is a primary benchmark for organizational ratings. As organizations join the network, resources will be provided to bring the new members up to these

standards. The community will have an increasing number of healthcare providers performing at the highest ratings in healthcare evaluations.
    - Parrish will continue to dedicate the resources necessary to attain Patient Centered Medical Home status for its primary care physicians and top percentile Value Based Purchasing recognition for the hospital.

Dental Care

GOAL:

Strengthen access to provider-based dental and supportive services and increase the utilization of healthcare services by community members.

OBJECTIVE:

Increase access to dental care for uninsured and underinsured residents in North Brevard County.

Strategies/Actions:

- ✓ Regular Dental Care in order to reduce the need for Emergency Department utilization for dental needs.
    - Working with the Department of Health, Oral Health Florida, the University of Florida and other school systems, the state and local dental associations, dental providers and dental insurance companies, Parrish will institute and grow a core system of basic dental care for the community.
    - Through limited ongoing availability and special events, low-income residents will have access to basic needs such extractions, filings and minor oral healthcare.
    - We have dedicated $24,000 per year and the utilization of staff for dental referrals and special events to provide these services. We are working with the other parties to increase this funding and patient access.

- ✓ Dental Insurance Coverage
    - Parrish will help foster community availability and enrollment in affordable dental insurance. We will continue to support Federally Qualified Healthcare Centers and the DOH to make available economically viable insurance covered dental services to the community.
    - We will make available care partners through insurance contracting, business development and population health to facilitate dental insurance coverage for community members.

- ✓ Children's Dental Care
    - Through working with the dental providers listed above, we will facilitate child oral health education and care. Early education and intervention will reduce the prevalence and severity of the child dental care needs.
      The $24,000 per year and provided staff are included in children's dental care as well.

Mental Health Services (Mental/Emotional/Behavioral – MEB)

GOAL:

Improve access to evidence-based screening, assessment, treatment and support programs for MEB health and child protection.

OBJECTIVE:

Strengthen access to MEB programs and services for adults and children in North Brevard County.

Strategies/Actions:

- ✓ Increase awareness of MEB resources available in the community.
    - People not knowing who to contact concerning MEB information and therapy.
    - Working with 2-1-1 Brevard, law enforcement and other Community Health Partnership members, including news and educational publications, community members will be informed about MEB contact information and services.

- ✓ Parrish will use its previously discussed community outreach pathways and programs to provide this educational campaign.

- ✓ The greatest opportunity for prevention and intervention is among young people.
    - By utilizing the Parrish MEB health team and incorporating programs like Sources of Strength, we will work with the school system and community centers to educate and support young people concerning mental health issues. These efforts will increase the presence and utilization of Sources of Strength and other programs in schools and community centers.
    - We have allotted $50,000 to fund these programmatic and outreach efforts.

- ✓ Help educate and create awareness of community stigma preventing people from seeking and/or getting the necessary care.
  - o Through the Parrish MEB health team, we will provide a community awareness and de-stigmatization campaign for mental health issues. The result will be more open community discussions and de-stigmatization concerning mental health issues and treatment.
  - o Parrish will use its previously discussed community outreach pathways and programs to provide this educational campaign.

PRIORITY #3| Healthy Lifestyles

Heart Disease/Stroke Prevention

GOAL:

Reduce incidence or acute heart attack and stroke among North Brevard adults.

OBJECTIVE:

Increase the percentage of North Brevard adults who report knowing signs of heart attack and stroke and knowledge of actions to take; support resources available.

Strategies/Actions:

- ✓ Stroke Prevalence:
  - o Parrish will expand the educational and support offerings to our exiting support group. This will improve psychological and physical outcomes and lead to a 10 percent growth of the Stroke Support Group over the next three years.
  - o We will dedicate the necessary care partners to lead and teach the support group and meet the goals stated above.

- ✓ High Blood Pressure Prevalence
  - o Parrish will utilize community outreach mechanisms to educate the population on ways to avoid high blood pressure and will establish early detection screening for community members. Avoidance and early detection will reduce the morbidity associated with this condition.
  - o Outreach will be via established means discussed within the implementation plan. Early detection screening will be coordinated through physician practices and the American Heart Association.

Nutrition/Physical Activity/Weight Management

GOAL:

Increase engagement in physical activity and educational opportunities to reduce obesity among North Brevard adults.

OBJECTIVE:

Reduce adult and childhood obesity rates in North Brevard County.

Strategies/Actions:

- ✓ Utilizing the combination of Parrish Health and Fitness Center, nutritional counseling and other community members, such as the Department of Health, we will make available programs to assist adults and children with nutrition education and physical activity.
    - This will help the participants get to and maintain a healthier weight than their baseline.

- ✓ Parrish will make available discounts and limited scholarships for Health and Fitness Center services.
    - These incentives and in-kind staff provisions will assist the DOH in their Healthy Weight Brevard initiative.

Tobacco Cessation and Substance Abuse

GOAL:

Increase access to evidence-based tobacco cessation and substance abuse prevention programs and services in North Brevard County.

OBJECTIVE:

Reduce percentage of adults reporting tobacco products/other substance abuse in North Brevard County.

Strategies/Actions:

- ✓ Education to the community with emphasis on school-age children:
  - By utilizing the Parrish MEB health team and incorporating programs like Sources of Strength, we will work with the school system and community centers to educate and support young people concerning the dangers of substance abuse and how to break the addiction if needed.
  - These efforts will increase the presence and utilization of Sources of Strength and other programs in schools and community centers and reduce substance abuse by school-age children.
  - PMC funded $50,000 to Sources of Strength and other programmatic and outreach efforts.

- ✓ Strengthen safe prescribing protocols for opioids; provide access to education to the community.

- ✓ Resources will be applied to study the treatment scenarios of PMG/PMC Emergency Department physicians prescribing opioids and, when appropriate, to make the necessary reductions set as goals.

Cancer Prevention and Education

GOAL:

Reduce incidence of skin and colorectal cancers among North Brevard residents.

OBJECTIVE:

Increase the percentage of North Brevard adults who report engaging in preventive behaviors (early detection screenings and use of sunscreen).

Strategies/Actions

- ✓ Skin Cancer Prevalence – Education on avoidance and early detection screening.
  - Parrish will utilize community outreach mechanisms to educate the population on ways to avoid skin cancer and will establish early detection screening for community members. Avoidance and early detection will reduce the life-years lost through skin cancer deaths.

- Outreach will be via established means discussed within the implementation plan. Early detection screening will be coordinated through physician practices and the American Cancer Society.

- ✓ Colorectal Cancer – Education on avoidance and early detection screening
  - Parrish will utilize community outreach mechanisms to educate the population on ways to avoid colorectal cancer and will establish early detection screening for community members.
  - Avoidance and early detection will reduce the life-years lost through colorectal cancer deaths.
  - Outreach will be via established means discussed within the implementation plan. Early detection screening will be coordinated through physician practices and the American Cancer Society.

- ✓ Due to the need to increase access to cancer care, Parrish established a Cancer Center and will continue to raise awareness of the center's programs and services within the CHNA service area.

Injury & Violence Prevention

GOAL:
Reduce the prevalence of firearms accidents/injuries/fatalities through increased access to weapons safety and safe storage training.

OBJECTIVE:
Increase the percentage of North Brevard adults who report engaging in safe weapon practices and storage.

Strategies/Actions:

- ✓ Parrish will work with local law enforcement, weapons dealers, gun ranges and community members to provide professional training on the proper storage and use of weaponry to include the comprehensive responsibilities of gun ownership.
  - An emphasis will be on anger management and the penalties for misuse of weapons. This will reduce the incidence of accidental and impulsive shootings.

- ✓ We will work with the entities listed to determine the appropriate resources needed to support this training and education.

CHNA IMPLEMENTATION PLAN PROGRESS REPORTING

The CHNA Implementation Plan affirms our 60+-year commitment to the serving the health and wellness needs of the North Brevard community. The plan documents how we will meet the identified community needs, and ensures that the results of the assessment and its impact on the health of the community will be reported and communicated. PMC will work collaboratively with local and regionally based providers such as Parrish Medical Group, independent providers, Mayo Clinic, Nemours, Florida Department of Health Brevard County and the insurance industry to facilitate the clinical and education constructs to this implementation plan.

Each community strategy and action initiative has a set of measurable objectives and is aligned with the 2016-2019 CHNA priorities. Evaluation and progress on the implementation of community initiatives will be reported annually within the community benefit report.
For a full copy of the North Brevard County CHNA, visit www.parrishhealthcare.com/myhealth-portal/community-resources.