Parrish Medical Center | Parrish Healthcare

2019 – 2022
COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY

Contents

I. STEERING COMMITTEE MEMBERS

Parrish Medical Center | Parrish Healthcare

- Susan Bentley, Care Navigator
- Kiara Buckner, Communications Coordinator
- Valerie Carver, Client Health Navigator
- LeeAnn Cottrell, Executive Director, Information Governance
- Paul Fender, Manager Process Improvement
- Laurel Ivy, Care Navigator
- Heather Minnear, Care coordinator RN
- Peggy McLaughlin, Care Navigator
- Edwin Loftin, Sr. VP Acute Care
- Chris McAlpine, Sr. VP, Transformation
- Natalie Sellers, VP Communications/Community & Corporate Services
- Kristina Weaver, Director Care Navigation
- Community Health Partners (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	Indian River Medical Office
Indian River City United Methodist Church	North Brevard Medical Support, Team Health
MedFast Urgent Care Centers, LLC	OMNI Healthcare
North Brevard Children's Medical Center	Park Avenue Baptist Church
Women's Center	Parrish Medical Center Emergency Dept.
Parrish Medical Center	Parrish Occupational Health Clinic & Pharmacy
Parrish Medical Group	REF Nurse LLC
Parrish Senior Consultation Center	St. James AME Church
St. Francis Pathways to Healthcare	United Way of Brevard County

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, PMC is pleased to present the following CHNA and Implementation Plan, which has been reviewed and approved by the North Brevard County Hospital District Board of Directors on February 3, 2020.

III. EXECUTIVE SUMMARY

North Brevard County Hospital District, d/b/a Parrish Medical Center, is an independent, not-for-profit; public community hospital founded nearly 60 years ago by the State of Florida. Parrish Medical Center, now known as Parrish Healthcare, has grown from a 28-bed single story hospital to an integrated network of healthcare providers. Parrish Healthcare includes:

- Parrish Medical Center: a Mayo Clinic Care Network member and a 210-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 Medical Group Diagnostics: retail-based diagnostics
- Parrish Health & Fitness Center: a comprehensive medical wellness center
- Parrish Home Health Care
- Parrish Sleep Center
- Parrish Wound Healing 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 a special meeting of the Board of Directors held on Monday, September 23, 2019. The full CHNA report may be found at the following link: www.parrishhealthcare.com/communitybenefit. Strategies and action plans were developed based on a consensus among steering committee members after input from each of the respective disciplines, including Parrish's Community Health Partners (CHP), which functions as a community advisory panel.

Parrish Healthcare has created three broad categories of significant health needs –Body, Wellness and Mind –and formed subgroups under each category pertaining to each health need addressed in the CHNA. Parrish Healthcare has developed specific action plans to address the significant health needs of the community served, identified below:

VI. SIGNIFICANT HEALTH NEEDS ADDRESSED UNDER COMMON THEME

Parrish Healthcare's significant health needs are being addressed under Body-Wellness –Mind as the common theme.

1. Body
    a. Cancer
    b. Respiratory Diseases
    c. Heart Disease and Stroke
    d. Diabetes
2. Wellness
    a. Oral Health
    b. Nutrition, Physical Activity and Weight
    c. Tobacco Use
3. Mind
    a. Mental Health
    b. Substance Abuse
    c. Injury and Violence

The only significant health needs not included in any one specific category above are "Access to Healthcare," and "Potentially Disabling Conditions" because they are incorporated into *each or most* of the significant health needs identified. According to Healthy People, a program of nationwide health-promotion and disease-prevention goals set by the United States Department of Health and Human Service, access to quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It generally requires three distinct steps:

1. Gaining entry into 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).

Parrish Healthcare's integrated care model serves to address and/or remove barriers to health services:

- Cost of care
  - ✓ Parrish is the area's lowest cost provider

- Inadequate or no insurance coverage
  - ✓ Parrish affiliates with most insurances
  - ✓ Parrish offers financial assistance to qualified patients and helps patients with no insurance to qualify for Medicaid, Medicare or other means of coverage.

- Lack of availability of services
  - ✓ Parrish Medical Center offers acute care services
  - ✓ Parrish Medical Group (PMG) offers primary and specialty care providers
  - ✓ Parrish Health Network (PHN) provides community access to providers of most medical specialties and continuously serves to close gaps in care.
  - ✓ Parrish Medical Center (PMC) maintains membership in the Mayo Clinic Care Network, which offers community access to tertiary care specialists.
  - ✓ Parrish Home Health provides access to care upon transition to the home.
  - ✓ Parrish Health & Fitness Center provides health and wellness access.

- Lack of culturally competent care
  - ✓ Parrish Medical Center/Parrish Healthcare serves as the nation's first to earn the Joint Commission's Integrated Care certification. Culturally competent care is among the standards required to be met to earn the certification.

Given the importance of access to healthcare as described above, Parrish Healthcare has made addressing access to healthcare a top priority, including initiatives in each of the healthcare needs addressed herein. Also, given that potentially disabling conditions may be a result of access to healthcare deficiencies, Parrish Healthcare includes initiatives in each (or most) of the significant health needs addressed herein.

VII. IDENTIFIED COMMUNITY HEALTH NEEDS

The significant health needs that have been identified in the CHNA are as listed below. The description of each health need set forth below was taken from the CHNA report. Please refer to the full CHNA report for further information regarding each health need.

1. **Heart Disease and Stroke**. Controlling risk factors for heart disease and stroke remain a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. Three health-related behaviors which contribute markedly to cardiovascular disease include: poor nutrition, lack of physical activity and tobacco use. In fact, 9 in 10 Primary Service Area adults report one or more cardiovascular risk factors, such as being overweight, physically inactive or having high blood pressure or cholesterol.

2. **Access to Healthcare**. Around half of Primary Service Area adults report having healthcare coverage through private insurance. Another 38% report having coverage via a government-sponsored program (e.g., Medicaid, Medicare, military benefits). Around 12% report not having health insurance coverage. Outside of insurance, some individuals have difficulty accessing needed healthcare due to lack of physician availability or high cost of services.

3. **Potentially Disabling Conditions**. Among the Primary Service Area respondents, most report having at least one chronic health condition. In fact, 48% of Primary Service Area adults report having three or more chronic conditions. Compared with people without disabilities, people with disabilities are more likely to: have trouble getting healthcare, be overweight, have lower employment, use tobacco and receive dental care. Other disabling conditions reported the Primary Service Area is a high rate of arthritis and rheumatism, as well as issues with vision, hearing and dementia.

4. **Cancer**. Although there are continued advances in cancer research, detection and treatment, cancer remains a leading cause of death in the U.S., second to only heart disease. Cancer-related checkups are recommended during routine doctors' visits. Community screening levels were measured relative to three cancer sites: (i) female breast cancer (mammography); (ii) cervical cancer (Pap smear); and (iii) colorectal cancer (sigmoidoscopy and fecal occult blood test). Among women age 50-74, almost two-thirds have had a mammogram within the past two years, which is lower than U.S. and Florida findings. Among Primary Service Area women age 21 to 65, 72.5% have had a pap smear within the past 3 years. Among adults age 50-75, 71.6% have had a colorectal screening – which marks an unfavorable decline in screening since 2016.

5. **Respiratory Disease**. Asthma and chronic obstructive pulmonary disease ("COPD") are significant public health burdens. Specific methods of detection, intervention and treatment exist that may reduce this burden and public health. The burden of such respiratory diseases affects individuals, their families and their communities. Acute respiratory infections, such as pneumonia and influenza, are the eighth leading cause of death in the nation.

6. **Diabetes**. The rate of diabetes mellitus continues to increase in the United States and throughout the world. This disease (i) can lower life expectancy by up to 15 years, (ii) increase the risk of heart disease by 2 to 4 times, and (iii) is the leading cause of kidney failure, lower limb amputations and adult-onset blindness. People from minority populations are more frequently affected by type 2 diabetes and minority groups constitute 25% of all adult patients with diabetes in the U.S. In the primary service area, 14.6% of adults have been diagnosed with diabetes and diabetes was described by some as a "major problem" in the community.

7. **Nutrition, Physical Activity/Weight**. Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Diet and weight are related to health status. Generally, most Americans need to improve some aspect of their diet. Physical activity can also improve the health and quality of life in humans, regardless of disease or disability. Around half of adults nationwide receive enough aerobic activity per day. Seven out of ten adults in the Primary Service Area are overweight.

8. **Mental Health**. Mental health and physical health are closely connected. Mental health plays a major role in people's ability to participate in health-promoting behaviors. While most Primary Service Area adults rate their overall mental health favorably, 17.6% believe their mental health is "fair" or "poor." More than one quarter of Primary Service Area adults have been diagnosed by a physician as having a depressive disorder. Further, many Primary Service Area adults experience signs of chronic depression and varying levels of stress. Among those rating mental health as a "major problem" in the community, they cite reasons which include: (i) limited providers, (ii) limited substance detox programs; (iii) cost; (iv) wait time to see a provider; and (v) insurance barriers.

9. **Substance Abuse**. Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative health outcomes. The effects of substance abuse are cumulative, and can significantly contribute to social, physical, and public health problems. Advances in research have led to evidence-based strategies to effectively address substance abuse. In the community, heroin/other opioids and alcohol were identified as the most problematic.

10. **Tobacco Use**. Tobacco use is the single most preventable cause of death and disease in the United States. Tobacco use can cause: cancer, heart disease, lung disease and premature birth. Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages.

11. **Injury and Violence**. Injuries are the leading cause of death for Americans ages 1 to 44 and a leading cause of disability for all ages regardless of sex, race/ethnicity or socioeconomic status. In fact, injuries and violence have a significant impact on the well-being of Americans by contributing to: premature death, disability, poor mental health, high medical costs and low productivity. Interventions addressing these social and physical factors have the potential to prevent unintentional violence and injuries.

12. **Oral Health**. Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions or show feelings and emotions. There has been significant improvement in oral health over the last 50 years in the United States. Social determinants affect oral health. Namely, people with lower levels of education and income, and people from specific racial/ethnic groups have higher rates of disease. Further, people with disabilities and other health conditions, such as diabetes, are more likely to have poor oral health.

VIII. CARE NAVIGATION FOCUSING ON BODY-WELLNESS-MIND

A. Why Care Navigation is Critical to Implementation Strategy

The goals of a patient care navigation program are to: (a) link patients and families to primary care services, specialist care, and community-based health and social services; (b) provide more holistic patient-centered care; and, (c) identify and resolve patient barriers to care.

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.

Among these strategies is our Care Navigation Program. Our Care Navigators (who help guide patients through the healthcare system and work to overcome obstacles that are in the way of the patient receiving the care and treatment they require) have proven to be effective with patients and families fighting cancer, as well as those learning to live with diabetes, heart failure, chronic obstructive pulmonary disease, sleep disorders, among other chronic and potentially disabling conditions.

The team offers interventions to self-management care through: (a) cost-effective patient education and support that fosters adherence to the self-management regimen; (b) care coordination, linking the services of Primary Care Physicians, navigator, and community resources; and (c) motivation techniques to engage patients in diabetes (or other chronic condition) self-management.

B. Focus on Body-Wellness-Mind

Parrish Healthcare developed its care navigation program within a body-wellness-mind framework. This approach extends beyond the traditional disease focused model, to one that is holistic. A holistic model is a whole person model, a body-wellness-mind approach which recognizes the interplay of exercise, nutrition, environment, stress, 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.
To that end, the health needs to be addressed during the period of this Implementation Strategy are grouped into body, wellness and mind categories, as more fully described as follows:

[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.

BODY

Parrish healthcare intends to understand the following initiatives to address the significant health needs identified relating to health issues affecting the body include (a) cancer; (b) respiratory disease; (c) heart disease and stroke; and (d) diabetes.

Planned Actions	Cancer	Respiratory Disease	Heart Disease & Stroke	Diabetes
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.	✓	✓	✓	✓
Utilize evidence-based health screenings and risk assessments within community, primary care, hospital, and post-acute settings.	✓	✓	✓	✓
Utilize care navigator program to offer interventions to care through: (a) cost-effective patient education and support that fosters adherence to the self-management regimen; (b) care coordination, linking the services of Primary Care Physicians and other community resources; and (c) motivation techniques to engage patients in care management.	✓	✓	✓	✓
Collaborate with area providers and coordinate care within Parrish Healthcare's integrated care delivery system (e.g. PHN, PMG, Mayo, etc.).	✓	✓	✓	✓
Utilize evidence-based state, regional and national resources such as National Patient Safety Foundation, Mayo Clinic Care Network to develop policies, protocols, and training for care partners (employees, medical staff, volunteers).	✓	✓	✓	✓
Operate comprehensive cancer program including outpatient Parrish Cancer.	✓			
Anticipated Impact	Cancer	Respiratory Disease	Heart Disease & Stroke	Diabetes
Increase the proportion of North Brevard adult population who complete an age, gender, condition-specific health risk assessment and screening and receive referrals to needed resources.	✓	✓	✓	✓
Improved community perception of access to providers and services.	✓	✓	✓	✓
Increase in early detection of disease among population served.	✓	✓	✓	✓

Planned Resources	Cancer	Respiratory Disease	Heart Disease & Stroke	Diabetes
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.	✓	✓	✓	✓
Sleep Disorders Center and respiratory therapy.	✓	✓	✓	✓
People, time, resources for advocacy and building community activities and civic, governmental board involvement (e.g., Economic Development Commission, Vizient, Joint Commission, American Lung, American Heart, American Cancer, etc.).	✓	✓	✓	✓
Planned Collaboration	Cancer	Respiratory Disease	Heart Disease & Stroke	Diabetes
Parrish Healthcare primary care, specialists, tertiary providers (PMG, PHN).	✓	✓	✓	✓
Area University Student Programs (E.g. graduate nursing, etc.).	✓	✓	✓	
Community Health Partnership members (e.g. law enforcement, city and county government, schools, churches, social services, etc.).	✓	✓	✓	✓
Area advocacy groups (E.g. Commission on Cancer, State legislators, etc.).	✓		✓	
Measurements Factors	Cancer	Respiratory Disease	Heart Disease & Stroke	Diabetes
HealthAware risk assessment completion rates (community)	✓	✓	✓	✓
HEIDS data (primary care setting)	✓	✓	✓	✓
CMS Core Set compliance (acute care setting)	✓	✓	✓	✓
Care Navigation program enrollment data	✓	✓	✓	✓
No. of early detection screenings performed	✓	✓	✓	✓
Referral data	✓	✓	✓	✓
Community Benefit Inventory for Social Accountability (CBISA)	✓	✓	✓	✓
Communications (media) metrics (e.g. reach, frequency)	✓	✓	✓	✓

WELLNESS

Parrish Healthcare intends to undertake the following initiatives to address the significant health needs identified relating to health issues affecting the body, including: (a) oral health; (b) nutrition, physical activity and weight; and (c) tobacco use.

Planned Actions	Oral Health	Nutrition, Physical Activity/Weight	Tobacco Use
Maintain Joint Commission Integrated Care Certification.	✓	✓	✓
Utilize community outreach mechanisms to raise awareness and educate the North Brevard county adult population about available resources.	✓	✓	✓
Utilize evidence-based health screenings and risk assessments within community, primary care, hospital, and post-acute settings.	✓	✓	✓
Utilize care navigator program to offer interventions to care through: (a) cost-effective patient education and support that fosters adherence to the self-management regimen; (b) care coordination, linking the services of Primary Care Physicians and other community resources; and (c) motivation techniques to engage patients in care management.	✓	✓	✓
Collaborate with area providers and coordinate care within Parrish Healthcare's integrated care delivery system (e.g. PHN, PMG, Mayo, etc.).	✓	✓	✓
Utilize evidence-based state, regional and national resources such as National Patient Safety Foundation, Mayo Clinic Care Network to develop policies, protocols, and training for care partners.	✓	✓	✓
Operate comprehensive Health & Fitness Center.		✓	
Anticipated Impact	Oral Health	Nutrition, Physical Activity/Weight	Tobacco Use
Increase the proportion of North Brevard adult population who complete an age, gender, condition-specific health risk assessment and screening and receive referrals to needed resources.	✓	✓	✓
Improved community perception of access to providers and services.	✓	✓	✓
Increase in early detection of disease among population served.	✓	✓	✓
Planned Resources	Oral Health	Nutrition, Physical Activity/Weight	Tobacco Use
Health and social service providers either through direct employ or via PHN (e.g. primary care, health & fitness specialists, etc.).	✓	✓	✓
Care Navigator program.	✓	✓	✓
Educational and awareness raising materials.	✓	✓	✓
People, time, resources for outreach activities (health fairs, screening events, support groups, workshops, in-kind/cash donations, etc.).	✓	✓	✓
People, time, resources for advocacy and building community activities and civic, governmental board involvement (e.g., Economic Development Commission, Vizient, Joint Commission, American Lung, American Heart, American Cancer, etc.).	✓	✓	✓
Collaborate with area providers and coordinate care within Parrish Healthcare's integrated care delivery system (e.g. PHN, PMG, Mayo, etc.).	✓	✓	✓

Planned Collaboration	Oral Health	Nutrition, Physical Activity/Weight	Tobacco Use
Parrish Healthcare primary care, specialists, tertiary providers (PMG, PHN).	✓	✓	✓
Area University Student Programs (e.g. graduate nursing, etc.).	✓	✓	✓
Community Health Partnership members (e.g. law enforcement, city and county government, schools, churches, social services, etc.).	✓	✓	✓
Area advocacy groups (e.g. Commission on Cancer, State legislators, etc.).	✓		✓
Measurements Factors	Oral Health	Nutrition, Physical Activity/Weight	Tobacco Use
HealthAware risk assessment completion rates (community)	✓	✓	✓
HEIDS data (primary care setting)	✓	✓	✓
CMS Core Set compliance (acute care setting)	✓	✓	✓
Care Navigation program enrollment data	✓	✓	✓
No. of early detection screenings performed	✓	✓	✓
Referral data	✓	✓	✓
Community Benefit Inventory for Social Accountability (CBISA)	✓	✓	✓
Communications (media) metrics (e.g. reach, frequency)	✓	✓	✓

MIND

Parrish Healthcare intends to undertake the following initiatives to address the significant health needs identified relating to health issues affecting the mind, including: (a) mental health; (b) substance abuse; and (c) injury and violence.

Planned Actions	Mental Health	Substance Abuse	Injury & Violence
Maintain Joint Commission Integrated Care Certification	✓	✓	✓
Utilize community outreach mechanisms to raise awareness and educate the North Brevard county adult population about available resources.	✓	✓	✓
Utilize evidence-based health screenings and risk assessments within community, primary care, hospital, and post-acute settings.	✓	✓	✓
Utilize care navigator program to offer interventions to care through: (a) cost-effective patient education and support that fosters adherence to the self-management regimen; (b) care coordination, linking the services of Primary Care Physicians and other community resources; and (c) motivation techniques to engage patients in care management.	✓	✓	✓
Collaborate with area providers and coordinate care within Parrish Healthcare's integrated care delivery system (e.g. PHN, PMG, ect).	✓	✓	✓
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.	✓	✓	✓

Anticipated Impact	Mental Health	Substance Abuse	Injury & Violence
Increase the proportion of North Brevard adult population who complete an age, gender, condition-specific health risk assessment and screening and receive referrals to needed resources	✓	✓	✓
Improved community perception of access to providers and services.	✓	✓	✓
Reduce the amount of opioids being prescribe outside of safe-prescribing protocols.	✓	✓	✓
Planned Resources	Mental Health	Substance Abuse	Injury & Violence
Health and social service providers either through direct employ or via PHN (e.g. psychiatrist, peer recovery specialists, primary care, etc)	✓	✓	✓
Care Navigator program	✓	✓	✓
Educational , awareness raising materials	✓	✓	✓
People, time, resources for advocacy and building community activities and civic, governmental board involvement (e.g., Economic Development Commission, Vizient, Joint Commission, etc.)	✓	✓	✓
Planned Collaboration	Mental Health	Substance Abuse	Injury & Violence
Parrish Healthcare primary care, specialists, tertiary providers (PMG, PHN)	✓	✓	✓
Area University Graduate Student Programs (e.g. Florida Tech Psychology Students, graduate nursing, etc.)	✓	✓	✓
Community Health Partnership members (e.g. law enforcement, city and county government, schools, churches, social services, etc.)	✓	✓	✓
Area advocacy groups (Brevard Youth Mental Health Task Force, Eckerd Foundation, Hannah's Hero's)	✓	✓	✓
Area behavioral health providers and detox centers (e.g. Palm Point, Doctors' Goodwill, etc.)	✓	✓	✓
Measurements Factors	Mental Health	Substance Abuse	Injury & Violence
HealthAware risk assessment completion rates (community)	✓	✓	
HEIDS data (primary care setting)	✓	✓	
CMS Behavioral Health Core Set compliance (acute care setting)	✓	✓	
Care Navigation program enrollment data	✓	✓	✓
Referral data	✓	✓	✓
Incident reports (e.g. RL solutions)			✓
Community Benefit Inventory for Social Accountability (CBISA)	✓	✓	✓
Communications (media) metrics (e.g. reach, frequency)	✓	✓	✓

IX. 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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Communications Department
951 N. Washington Avenue
Titusville, FL 32796