Parrish Medical Center | Parrish Healthcare

2022 – 2025
COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY

Contents

I. STEERING COMMITTEE 3

II. INTRODUCTION AND BACKGROUND 4

III. Executive Summary 4

IV. Mission Vision Values 4

V. How the Implementation Strategy was Developed 4

VI. IDENTIFIED COMMUNITY HEALTH NEEDS 5

VII. Social Determinants of Health 7

VIII. Significant Health Needs 8

IX. CARE NAVIGATION A PERSON-CENTERED APPROACH 8

A. Focus on Person-Centered (Whole Person) Care 9

B. Measures of Successful Care Navigation Program 9

X. Strategic Areas of Focus & Planned Actions 9

A. Access to Health Care Services 9

B. Heart Disease & Stroke Prevalence 10

C. Diabetes Prevalence 10

D. Planned Actions 10

XI. Conclusion 12

I. STEERING COMMITTEE

- Board of Directors, North Brevard County Hospital District
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  - Stan Retz, Vice Chairman
  - Herman Cole, Jr. Col. USAF (Ret.), Treasurer
  - Elizabeth Galfo, MD, Secretary
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- Executive Management Committee, Parrish Healthcare
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  - Chris McAlpine, SVP, Network Development/Transformation
  - Edwin Loftin, SVP, Acute Care Services/CNO
  - Natalie Sellers, SVP, Communications, Community & Corporate Services
- Clinical Alignment Care Partners, Parrish Healthcare
  - Susan Bentley, Care Navigator
  - Lara Chicone, Behavioral Health Navigator
  - LeeAnn Cottrell, Executive Director, Information Governance
  - Ericka Jacobs, Manager, Communications & People Development
  - Heather Minnear, Community Health Navigator
  - Peggy McLaughlin, Diabetes Care Navigator
  - Kristina Weaver, Director Care Navigation
- Community Health Partners (CHP) Members and Key Informant Participants include, but are not limited to, representatives from:

2-1-1 Brevard, Inc.	Brevard C.A.R.E.S.
Brevard County	Circles of Care, Inc.
Children's Advocacy Center of Brevard	CareerSource Brevard
Eckerd Connects	Hospice of St. Francis
First United Methodist Church of Titusville	Indian River Medical Office
Fl. Dept. of Health in Brevard County	North Brevard Medical Support, Team Health
Indian River City United Methodist Church	Park Avenue Baptist Church
MedFast Urgent Care Centers, LLC	REF Nurse LLC
North Brevard Children's Medical Center	St. James AME Church
Women's Center	United Way of Brevard County
Parrish Healthcare (PMC, PMG, PHN)	Space Coast Health Care Center
St. Francis Pathways to Healthcare	Happenings Health Bridge LLC
Space Coast Health Foundation	Brevard County Health Department
Greater St. James Missionary Baptist Church	Palm Point Behavioral Health
All Black AB	Community of Hope
Children's Home Society	Franklin Special Events
Florida Healthcare Plans	Holy Spirit Catholic Church
HealthSouth Sea Pines Rehabilitation Hospital	National Veterans Homeless Support
Jess Parrish Medical Foundation	Parrish Home Health
North Brevard Charities Sharing Center	St. Luke's Presbyterian Church
Port St. John Community Foundation	The Children's Center
St. Mary Missionary Baptist Missionary Church	Titusville City Government
Titusville Area Chamber of Commerce	Titusville Playhouse
Titusville Fire Department	
Tobacco Free Florida	

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 December 5, 2022.

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 Health & 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 13, 2022. The full CHNA report may be found at the following link: www.parrishhealthcare.com/communitybenefit.

Upon the completion of the assessment, Parrish Healthcare convened a group of key community stakeholders to evaluate, discuss and prioritize the findings within the assessment, which occurred on August 4, 2022.

A group of approximately 30 community stakeholders (representing a cross-section of Parrish Healthcare care partners, community-based agencies and organizations) convened to evaluate, discuss, and prioritize the health issues for our community. The meeting was led and facilitated by a PRC representative which included a presentation of key findings from the CHNA and ending with a prioritization exercise.

The group, using an online voting platform, assigned priority to the identified health needs (i.e., Areas of Opportunity). The following are the results of the prioritization exercise:

1. Mental Health
2. Substance Abuse
3. Heart Disease & Stroke
4. Access to Health Care Services
5. Nutrition, Physical Activity & Weight
6. Diabetes
7. Cancer
8. Infant Health
9. Tobacco Use
10. Respiratory Disease
11. Potentially Disabling Conditions
12. Injury & Violence

Of note, Mental Health, Substance Abuse and Nutrition, Physical Activity & Weight remained in the top five from the previous reporting period (2019-2022). Access to Health Care Service and Heart Disease & Stroke replaced Diabetes and Cancer in the top five.

VI. 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. Of the 2022 survey respondents 97% had a high blood pressure screening in the past two years and 92.9% were screened for high cholesterol in the past five years.

2. Access to Health Care. Around half (47.6%) of Primary Service Area adults report having healthcare coverage through private insurance. Another 36.4% report having coverage via a government-sponsored program (e.g., Medicaid, Medicare, military benefits). Around 16% (up from 12%) report not having health insurance coverage. Outside of insurance, the barriers to accessing health care, appointment availability and finding a doctor impacted the greatest share of the Primary Service Area adults. Of note, significant improvements since 2016 were reported in cost and convenience of a doctor visit and cost of prescriptions.

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 do not 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. A total of 15% of surveyed adults reported having ever been diagnosed with cancer. The most common types include skin cancer (36.5%), breast cancer (15.6%), and prostate cancer (14.4%).

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, 17.8% (up from 14.6%) of adults have been diagnosed with diabetes and diabetes was described by some as a "major problem" in the community. Another 10.2% of adults have been diagnosed with "pre-diabetes" or "borderline diabetes." Among adults who have not been diagnosed with diabetes, 59.5% report having had their blood sugar level tested within the past three years.

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, 21.2% (up from 17.6%) believe their mental health is "fair" or "poor." More than one quarter of Primary Service Area adults (25%) 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, alcohol, heroin/other opioids and cocaine/crack were identified as the top three most problematic.

10. Tobacco Use. Tobacco use is the single most preventable cause of death and disease in the United States. According to Healthy People 2030, "Although smoking is widespread, it is more common in certain group including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education level." Among all surveyed households in the Primary Service Area, 5.7% report that someone has smoked cigarettes, cigars, or pipes in their home on an average of four or more times per week over the past month. Of the 5.7%, 4.9% is among households with children. 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 include, 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.

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

Most surveyed adults in the Primary Service Area report no significant difficulty understanding written health information. However, 11.5% did report that written health information is "seldom" or "never" easy to understand. Parrish Healthcare has made health literacy a focused initiative since 2016 and with these latest reported results we can assume these efforts are making a positive difference and should be continued.

VIII. Significant Health Needs

Within the 2019 Implementation Strategy, we challenged ourselves with taking on all 12 Areas of Priority. An evaluation of our past activities associated with the 2019 CHNA can be found as an appendix within the attached CHNA report. To briefly summarize the evaluation of our past activities, Parrish Healthcare together with our integrated network and community health partnerships are making a difference. Our community is benefiting from the many dedicated resources, investments, initiatives, programs and services already in place and ongoing that serve to address each area of priority. However, more focused work and continued efforts are necessary in order to achieve population health targets established by Healthy People 2030, CMS, and others.

Based on these results and the evaluation of our past activities, we recommended and the Board approved narrowing our focus to three Areas of Priority from which to develop PMC's 2022-2025 Implementation Strategy:

(1) Access to Health Care Services,

(2) Heart Disease & Stroke, and

(3) Diabetes.

Parrish Healthcare believes that by narrowing our focus to these three key priorities, meaningful improvement can be achieved across the board.

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.

The objectives of a 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

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[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.

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 regiment.

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.

A. Focus on Person-Centered (Whole Person) Care

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. To that end, the health needs to be addressed during the period of this Implementation Strategy are more fully described as follows:

B. Measures of Successful Care Navigation Program

Within each of the identified areas of priority the Care Navigation Program is a strategic imperative. The success of the Care Navigation Program will be measured by the effectiveness of removing barriers to access:

- Conversion rate of uninsured/under insured within the navigation program who successfully have been enrolled in affordable option(s), such as Medicaid, Medicare, or other eligible program.
- Conversion rate of patients without an established PCP to having a PCP within the navigation program.
- Percent of patients within the navigation program with identified SDOH need reporting improvement;
- Percent of patients within the navigation program that adhere to Parrish Healthcare's prescribed, evidence-based condition-specific care maps and clinical pathways;
- Percent of patients within the navigation program completing timely, age and gender specific early detection health screenings;
- Reduction in avoidable ER visits among patients within the navigation program;
- Reduction of avoidable hospital readmissions among patients within the navigation program.

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), (3) Finding a health care provider whom the patient trusts and can communicate with (personal

relationship); and (4) Removing barriers related to Social Determinants of Health (SDOH). 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:
  - ✓ Related to appointment availability with PCP and finding a PCP
  - ✓ Related to SDOH (transportation, food insecurity, housing, literacy, etc.)
- Primary Care Physician Ratio
- Emergency Room Utilization
- Ratings of Local Health Care

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
- Heart Disease Prevalence
- Stroke Deaths
- High Blood Pressure Prevalence
- High Cholesterol Prevalence

C. Diabetes Prevalence

Feedback as top concerns from the key informants during the prioritization exercise related to opportunities with Diabetes Prevalence included:

- Diabetes Prevalence
- Kidney Disease Prevalence
- Ranked as top concern by key informants

D. Planned Actions

Planned Actions	Access to Health Care Services	Heart Disease & Stroke	Diabetes (Kidney Disease)	Ratings
Maintain Joint Commission Integrated Care Certification.	✓	✓	✓	✓
Maintain national quality accreditations (e.g. Baby-Friendly, Primary Stroke, Commission on Cancer).	✓	✓		✓
Utilize community outreach mechanisms to raise awareness and educate the North Brevard county adult population about available resources.	✓	✓	✓	✓
Rank in the top 10% in the nation for quality and safety as measured by CMS, LeapFrog, and other national health ranking agencies	✓	✓	✓	✓
Operate Parrish Medical Group (PMG) primary and specialty care providers; nationally certified as a medical home; expand network of providers to improve availability of appointments and provider ratios.	✓	✓	✓	✓
Utilize care navigator program to offer interventions and care coordination to remove barriers and improve adherence to the self-management regimen.	✓	✓	✓	✓

Affiliate with strategic clinical partners (e.g. Mayo) to provide access to tertiary and quaternary care	✓	✓	✓	✓
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 Vizient Southeast to develop policies, protocols, and training for care partners (employees, medical staff, volunteers); e.g. behavioral health screenings, SDOH screenings, 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 health screenings and risk assessments within community, primary care, hospital, and post-acute settings.	✓	✓	✓	✓
Partner with MedFast Urgent Care Center to provide quality alternative for non-emergency care needs.	✓	✓	✓	
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.	✓	✓	✓	
Continue to support Peer Recovery program within the Emergency Department for persons ready to address their substance abuse condition.	✓	✓	✓	
Offer Occupational Health and Employee Wellness Programs focused on primary care assignments, health coaching and preventative wellness screenings	✓	✓	✓	
Operate appropriate complement of outpatient centers, programs, and services.	✓	✓	✓	
Implement chronic care management and remote patient monitoring program to support post-acute disease management.	✓	✓	✓	
Partner with key charitable and civic organizations aligned with addressing the key areas of priority (e.g. Children's Advocacy Center, Rotary Clubs, Parks and Rec, Junior Achievement, Boys & Girls Club, Eckerd Connects, etc.)	✓	✓	✓	
Anticipated Impact	**Access to Health Care Services**	**Heart Disease & Stroke**	**Diabetes**	**Ratings**
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.	✓	✓	✓	✓
Improve community perception of access to providers and services.	✓	✓	✓	✓
Increase in early detection of disease among population served.	✓	✓	✓	✓
Reduce avoidable hospital readmissions among population served.	✓	✓	✓	✓
Reduce avoidable emergency room visits among population served.	✓	✓	✓	✓
Improve access to primary care and specialty in North Brevard.	✓	✓	✓	✓
Improve access to chronic disease-management programs/services in North Brevard	✓	✓	✓	✓
Increase patients with identified SDOH reporting improvement	✓	✓	✓	✓
Planned Resources	**Access to Health Care Services**	**Heart Disease & Stroke**	**Diabetes**	**Ratings**
Parrish Healthcare system resources, programs and services (e.g. acute care services, emergency care, outpatient services, post-acute services, primary care, etc.)	✓	✓	✓	✓

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.).	✓	✓	✓	✓
People, time, resources for activities to address improvements to access to care, heart disease & stroke, diabetes & kidney disease.	✓	✓	✓	✓
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, American Diabetes Association, etc.).	✓	✓	✓	✓

Planned Collaboration	Access to Health Care Services	Heart Disease & Stroke	Diabetes	Ratings
PHN/PMG primary care, specialists, tertiary providers.	✓	✓	✓	✓
Space Coast Health Care Center – federally qualified clinics	✓	✓	✓	✓
Area University Student Programs: (e.g. graduate nursing, psychology students, etc.).	✓	✓	✓	✓
Community Health Partnership collaborations (e.g. first-responders, law enforcement, city and county government, schools, churches, social services, civic and charitable organizations).	✓	✓	✓	✓
Area advocacy groups: (E.g. Commission on Cancer, LeapFrog, Patient Safety Foundation, State legislators, etc.).	✓	✓	✓	
Behavioral health and substance use community collaborations	✓			
Skilled Nursing Facility (SNF) collaborations	✓	✓	✓	
Fundraising collaborations	✓	✓	✓	

Measurements	Access to Health Care Services	Heart Disease & Stroke	Diabetes	Ratings
HealthAware risk assessment completion rates (community)	✓	✓	✓	✓
HEIDS data (primary care setting)	✓	✓	✓	✓
CMS Core Set compliance (acute care setting including Behavioral and SDOH screenings)	✓	✓	✓	✓
Care Navigation program enrollment data	✓	✓	✓	✓
Game Plan performance data	✓	✓	✓	✓
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:

Parrish Healthcare
Communications Department
951 N. Washington Avenue
Titusville, FL 32796