Memorial Healthcare System

2024 – 2027 CHNA

YEAR 1 PERFORMANCE

October 2025

2024- 2027 Prioritizing the Needs

Data Source

Data Source		
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ US Bureau of the Census ✓ BRHPC Health Data Warehouse ✓ Florida Charts	→	Access to Care
Qualitative: ✓ *Focus Groups* ✓ *Key Informants* ***Quantitative:*** ✓ *BRHPC Health Data Warehouse* ✓ *Florida Charts*	→	Community Health Education
Qualitative: ✓ Focus Groups ✓ Key Informants **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	→	Healthy Lifestyles and Wellness
Qualitative: ✓ Focus Groups **Quantitative:** ✓ BRHPC Health Data Warehouse ✓ Florida Charts	→	Health Related Social Needs

Access to Care	Improve access to: - Maternal and Infant Health services - Behavioral Health services - Primary Care services
Community Health Education	- Promote chronic disease self-care management - Increase health education to older adult population - Improve preventative health screenings through education
Healthy Lifestyles and Wellness	- Develop health and wellness activities and programs - Promote exercise and fitness - Promote Nutrition and Healthy Eating
Health Related Social Needs	- Improve health literacy - Increase health related social needs assessment and referrals - Expand community programs and partnerships

Memorial Healthcare System

Priority #1-Access to Care

- **Improve access to Maternal and Infant Health services**

Expand home visiting service delivery to support and connect women to a medical home

- *Number of maternal health home visitors increase by 29% (from 38 to 53 FTE)*
- *Number of home visits provided increased from 14,207 to 20,356 (YTD)*
- *61 women were successfully connected to a medical home*

Increase capacity of maternal depression program

- *MOMS staffing increased by 100% to support maternal depression (from 8 to 16 FTE)*
- *Number of women served for maternal depression increased 110% (from 204 to 424)*

Focus on teen pregnancy, teen mothers and medical compliance (prenatal and postpartum care)

- *140 teen mothers were successfully linked to a medical home, as well as prenatal and postpartum care county wide through the Teen REACH program.*

Maternal (and Paternal) Health Groups

Priority #1-Access to Care (continued)

- **Improve access to Behavioral Health services**

Increase capacity for adolescent outpatient behavioral health services to meet demand

- *Certified Community Behavioral Health Clinic (CCBHC) has served 144 youth and families.*
- *Expansion of home, school, and hospital based behavioral health services resulted in serving 1,857 youth and families compared to 1,423 in FY25.*

Develop outreach plan to reach community about behavioral health services available

- *Outreach plan to include additional health fair participation, nontraditional local marketing campaign, One City at a Time events (information dissemination), door hangars, Mobile Health marketing. Dissemination began in FY26-Q2.*

Expand intensive adolescent behavioral services to increase youth and family capacity

- *CAT Team (Intense Adolescent program) expanded from one to two teams (8 to 16 FTE)*
- *Expanded further with New Solutions Program (intensive child and adolescent team)*
- *FY25: Total number served = 128 youth and families*

Priority #1-Access to Care (continued)

- **Improve Access to Primary Care services**

  Vision: Expand 2-3 locations a year, serving adults, children & pregnant women

  - *Plantation site opened on April 9, 2025. FY26 Better Together – OB services.*
  - *Employer Health Solutions Primary Care services - City of Hollywood employees (12 patients/day in FY25).*
  - *FY25 One City at a Time (OCAT) served 2,950 residents in 5 designated cities.*
  - *FY 25-6 Better Together: Broward County Residents access to Primary and OB care. Over 200 calls (25% MHS).*
  - *FY26 Shops of Cooper City - LOI, Young Circle Hollywood and University and Griffin Rd sites.*
  - *FY26 new Pediatric Mobile Health van.*
  - *FY26 Pediatrics - GME Continuity Clinics East and West.*

  Expand the Virtualist Program

  - *3 full-time providers offering 1,200 same-day appointments per month*
  - *Averaging 640 calls/month in FY25 and 955/month in FY26*

  Continue to provide Telehealth Services

  - *FY25: Provided 40,105 visits (Primary Care, Mobile Van, and virtual/same day providers)*

Improve Access to Primary Care Services

Priority #2 -Community Health Education

- **Improve quality of life by promoting chronic disease self-care management:**

Provide virtual disease and care management programs

- *As of April 2025, the Telehealth Maternity Care Program has enrolled 1,817 women in the program and distributed 624 BP cuffs.*
- *Clinical pharmacy specialists have provided diabetes/gestational diabetes care to 1,156 patients through 3,789 telehealth visits in CY2024 and served 965 patients through 1,884 visits in CY2025.*

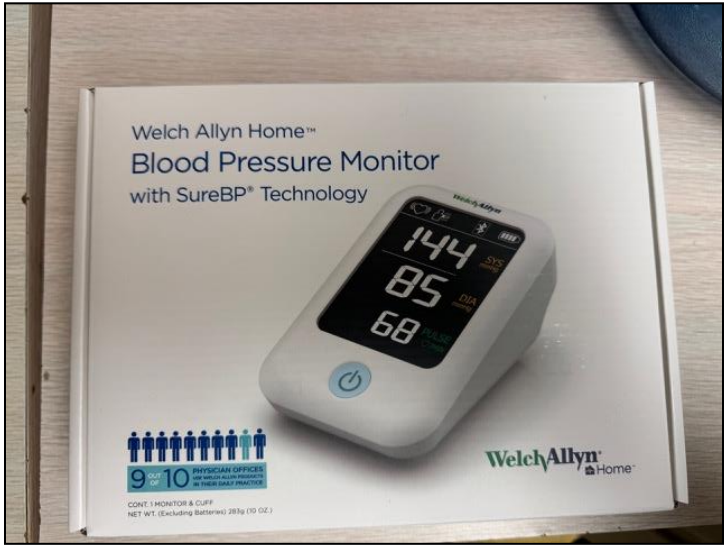
Develop support groups with community partners specific to chronic diseases

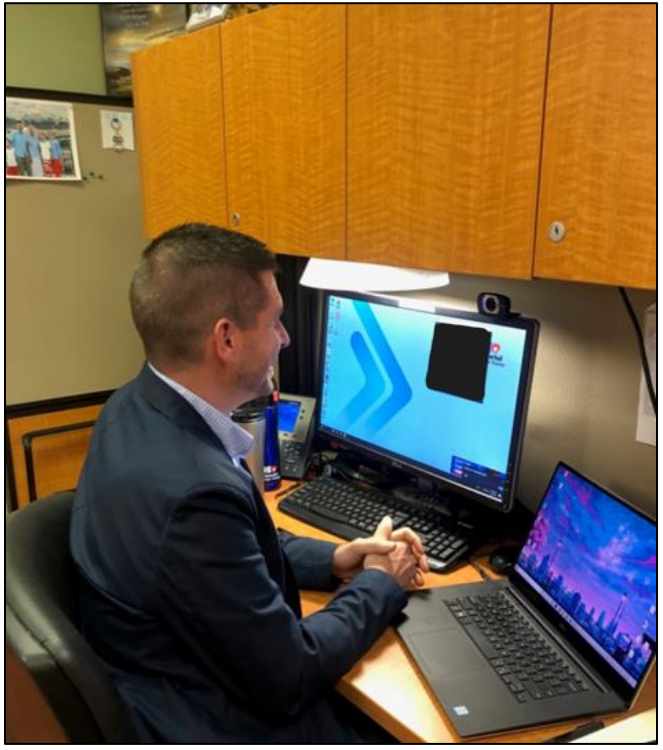
- *17 health education sessions were provided to 447 participants. Topics included heart health, medication management, diabetes management, hypertension, nutrition, and more.*
- *Partners include: American Heart Association, National Alliance on Mental Illness (NAMI) and others.*

Continue community-based chronic disease navigation programs

- *FLDOH funding health coach and LCSW to Sickle Cell Medical Home care team group therapy.*
- *Transportation to and from appointments: 1,321 Lyft rides to 87 patients. Serving 13 new patients per month.*
- *Sickle Cell – ED navigating patients entering ED to medical home.*
- *FY26 partner with North Broward on similar process to navigate to Sickle Cell Medical Home.*

Promoting Chronic Disease Self-care Management





Priority #2 -Community Health Education (continued)

- **Increase health education to older adult populations**

Coordinate with senior centers to educate older adults that can benefit from health workshops

- *Lunch and Learn health education series for older adults began in FY26-Q1. Senior Center locations will include Dania Beach, Hallandale Beach, Hollywood, Miramar, and Pembroke Pines.*

Provide caregivers services with resources and supports

- *Memorial CARES (Caregivers Access to Resources, Education, and Support) is provided in Hollywood and will be expanding to all south county.*
- *Area Agency on Aging provides caregivers education and resources county wide through the monthly Dementia Care and Cure Initiative (DCCI) online education and support groups.*

Develop support groups with community partners specific to older adult issues

- *Support groups will address coping with life transitions and loss, managing physical health and chronic conditions, enhancing social connections and relationships, mental health concerns, planning for the future, end-of-life and more.*
- *Partners include Area on Aging, Broward Elderly and Veterans Services, Southwest Focal Point.*

Health Education with Seniors

Memorial CARES Program

Caregivers

Access to

Resources available in Broward County

Education from our community

Supports

Priority #2 -Community Health Education (continued)

- **Preventative health screenings through education**

Expand knowledge of preventative cancer screenings to underserved communities.

- *FY25: MPC attended 71 community health fairs and events including education of preventative cancer screenings for lung, colon, cervical, and breast cancer.*

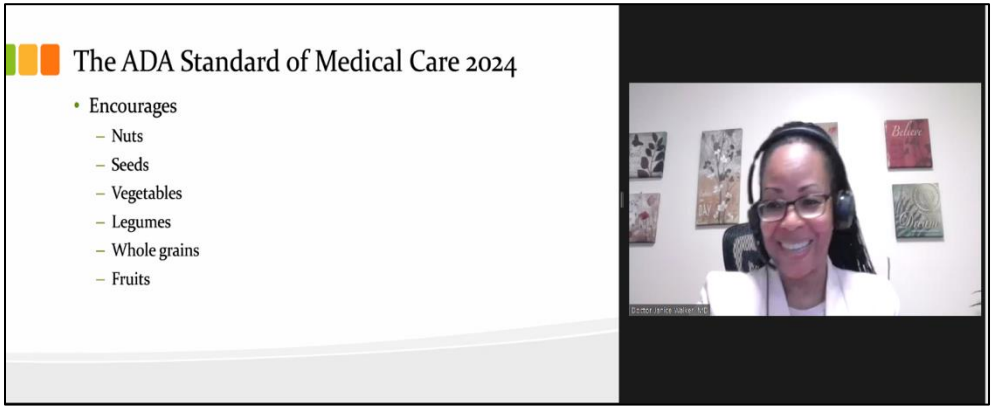
Develop Preventative Screening Campaigns with trusted partners.

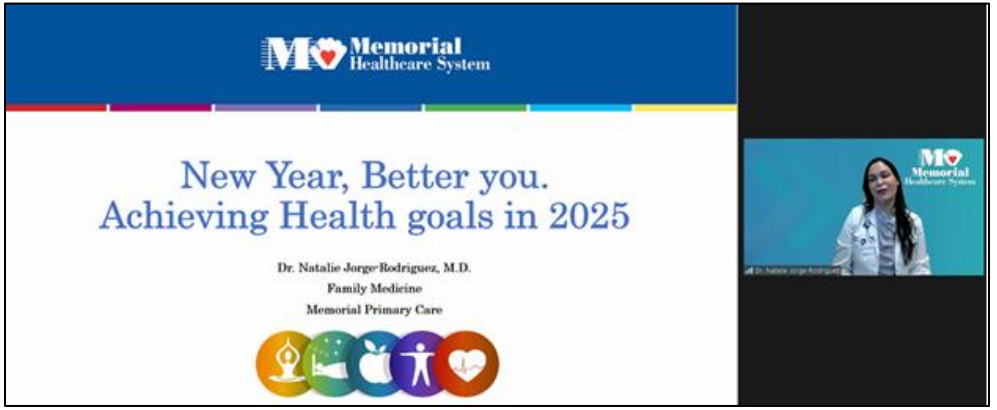
- *FY25: MPC collaborated with American Cancer Society on colon cancer screenings. 8K were screened.*
- *FY25: Partnering with FLDOH to fund breast and cervical cancer screenings.*
- *FY26: MPC partnering with the American Cancer Society to increase rates of lung cancer screenings.*

Continue to provide Preventative Screening Test in the Community

- *MHS Mobile Health: Provide breast exams, BMI, glucose and cholesterol preventive screening tests, and educational materials to ensure patients are informed. In FY25, 1,104 patients screened.*

Community Health Education





Priority #3 - Healthy Lifestyles and Wellness

- **Develop Health and Wellness activities and programs**

Continue to offer services and programs to the community to address health and wellness

- *LivWell program (addressing chronic conditions) served 127 patients and families in FY25*

Engage residents to address healthy living with chronic conditions by offering workshops

- *Community Health Education and Senior Lunch and Learn series to continue in FY26 – Q2*
- *Continue to offer health education workshops at Rebel's Drop-In program (OPBH)*
- *The Sickle Cell Medical Home hosted 130 support group sessions on Stress Management and Resilience in FY25*

Educate the community on the benefits of developing a healthy lifestyle

- *Empower families through nutrition, physical activity, and mental well-being services*

Older Adult Education

Priority #3 - Healthy Lifestyles and Wellness (continued)

- **Promote Exercise and Fitness:**

Facilitate groups at the Fitness Zones throughout the region to expose community to exercise

- *Disseminate Fitness Zone maps community wide, online, at health fairs, and other outlets*
- *Facilitate Fitness Zones group events at locations beginning in FY26-Q3*

Coordinate with local wellness partners to encourage exercise and fitness among residents

- *Engage community partners such as FLIPANY, YMCA, Boys and Girls Clubs, Police Athletic Leagues, and community recreation centers in educating the community on the benefits of fitness and exercise*

Community pop up fitness events to develop a routine which includes physical activity

- *Identify "fitness desserts" throughout south county*
- *Develop a pop-up fitness program to serve those residing in identified areas*

Health and Fitness Opportunities

Priority #3 - Healthy Lifestyles and Wellness (continued)

- **Promote Nutrition and Healthy Eating**

Expand screening to all patients and continue to provide access to healthy food

- *HUB screening data has resulted in 1,037 patients being provided fresh fruits and vegetables*
- *Mobile Health will continue screening for food insecurity*
- *3,064 families were provided healthy food distributions throughout south county in FY25*

Target educational sessions on nutrition and healthy eating at community events

- *Provided nutritional education services to 1,031 participants in Healthy Start program*
- *Delivered nutrition services to 391 older adults at Senior Partners*
- *Offer nutrition sessions at all hospitals, One City at a Time kickoffs and through the community health education series.*

Partner with local non-profit organizations for healthy cooking demonstrations

- *FLIPANY to provide cooking demonstration events for residents*
- *University of Florida to offer healthy cooking classes to older adults at Senior Partners Center*

Health and Nutrition

Priority #4 – Health Related Social Needs

- **Improve Health Literacy**

Train and develop staff to deliver Health Literacy classes utilizing best practice curriculum

- *Explore and review Health Literacy models to utilize best practices in FY26-Q3*
- *Develop a Health Literacy Master Trainer model to develop staff as trainers*

Coordinate with municipalities to deliver health literacy workshops in local community centers

- *Coordinate with Dania Beach, Hallandale Beach, Hollywood, Miramar, and Pembroke Pines to deliver health literacy workshops in their communities at local centers (FY26-Q3)*

Expand services within faith-based organizations to bring health literacy to houses of worship

- *Health Literacy workshops will be held at St. Ruth's Missionary Baptist Church (Dania Beach), Greater Mount Pleasant AME Church (Hollywood), and Koinonia Worship Center (West Park) in FY26-Q4*

Health Literacy Impact

Priority #4 – Health Related Social Needs (continued)

- **Increase health related social needs assessments and referrals**

Increase capacity of the HUB to meet capacity expansion

- *Adult HUB increased staffing by 100% (from 4 to 8 FTE)*
- *The expansion resulted in serving 3,281 patients with 8,604 needs*

Implement the Pediatric HUB to assess youth and families

- *Pediatric HUB began operations in FY25 with 2 FTE*
- *Since inception, the Peds HUB has served 214 families with 638 social needs identified*

Continue to identify community resource gaps to fulfill through new partnerships

- *Identify ongoing unmet needs through the HUB patient assessments*
- *Create partnerships/sponsorship to fill the unmet patient needs*

Priority #4 – Health Related Social Needs (continued)

- **Expand community programs and partnerships:**
  - **Increase capacity related to food insecurity to meet increase community demand**
  - **Coordinate with Community Relations to identify and connect with new partnerships**
  - **Strategize to grow resource inventory for unmet patient and families needs**
    - *Identify small, emerging food pantries throughout south county*
    - *Develop partnerships to provide support for growth (i.e., volunteers, grant writing)*
    - *Provide resources to assist in growth and expansion*
    - *Develop new partnerships to assist south county residents*
    - *Expand food pantry resource listing and disseminate to all throughout south county*
    - *Continue to identify grass roots food pantries that benefit south county residents*