

# Johns Hopkins All Children's Hospital 2019 Community Health Needs Assessment



# Executive Summary

“Let both sides explore what problems unite us instead of belaboring those problems which divide us . . . In your hands, my fellow citizens, more than mine, will rest the final success or failure of our course.” – *President John F. Kennedy, inaugural address given January 20, 1961.*

To more effectively explore the health care problems which unites us as a community Johns Hopkins All Children’s Hospital, BayCare Health System, Florida Department of Health, Advent Health and Moffitt Cancer Center came together to collaborate resources, expertise, and community connections (The Collaborative). While the primary intent of the Collaborative is focused on fulfilling a federal requirement known as a Community Health Needs Assessment, another objective to be recognized is stretching resources and objectives to comprehensively eliminate health disparities throughout a community as a whole.

The collaborative is a data-driven partnership, which has combined resources in an endeavor to evaluate five (5) counties in West Central Florida (Hillsborough, Pasco, Pinellas, Polk and Sarasota), through documenting not only the self-rated health needs in each individual county, but by permitting dynamic cohort cross-evaluation to assess, challenge and overcome self-identified community health needs.

Exploratory in-depth interviews, online and printed public surveys, stakeholder groups, community focus groups, communal conversations, secondary research and a prioritization filter have produced the attached priorities by county. These priorities will inform decision-making towards goals and objectives to improve community health outcomes through measurable objectives used throughout the multi-year endeavor. The complete full collaborative report will be published and disseminated in August 2019.

This abbreviated report, that assesses the health issues in the organization’s community and that community’s access to services related to those issues, represents the data collected and analyzed over the past five (5) months. It is this quantitative and qualitative data which will serve as a roadmap for Johns Hopkins All Children’s Community Connector Groups use to streamline the areas of concentration for the pediatric population that Johns Hopkins All Children’s Hospital holds as a core business community responsibility.

This roadmap will assist and guide Johns Hopkins All Children’s Hospital, along with the partners, an opportunity to cultivate a cultural revolution moving our community towards the elimination of social determinants and self-rated community health needs.



## **Purpose**

The Johns Hopkins All Children's Hospital Community Health Needs Assessment (CHNA) is required by the Internal Revenue Service (IRS) in response to regulations set forth in the Patient Protection and Affordable Care Act (PPACA). Enacted on March 23, 2010, the PPACA requires not-for-profit hospital organizations to conduct a CHNA once every three (3) taxable years that meets the requirements of the Internal Revenue Code 501(r) set forth by the PPACA. It also requires each hospital to adopt an implementation strategy that addresses the community health needs identified in the CHNA.

The CHNA and implementation strategy will be working documents to be used through the multi-year community engagement process. These working documents will be utilized to inform the decision-making process from which measurable objectives to improve community health outcomes will be outlined by community-rated health need. The data-driven collaboration of partners is only one (1) collaboration which will ensure the modifications are comprehensively evaluated, disrupted and attained. Community, academic and government entities will be partners in generating the implementation plan and realizing the community health improvements. As in 2016, we will post not only the CHNA, but the implementation plan upon generation and accomplishments will be updated quarterly in an external facing dashboard.

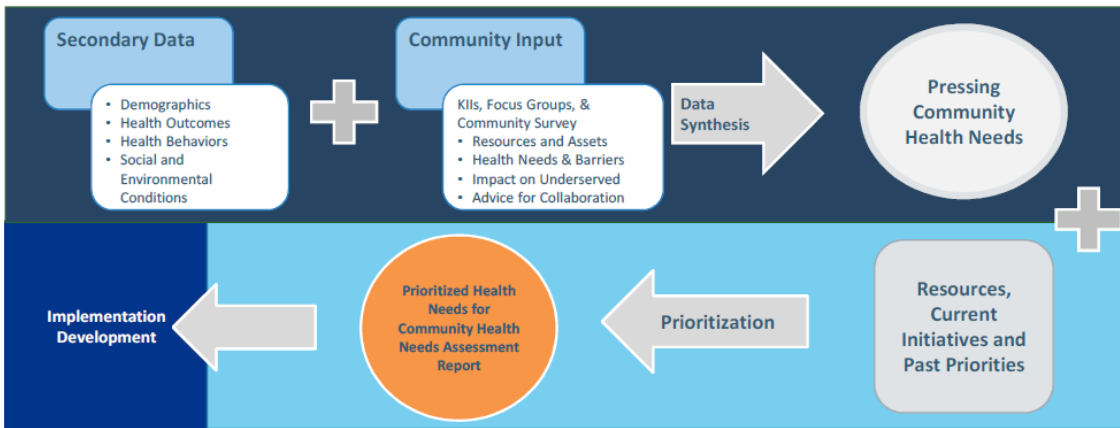
To ensure a robust data-driven CHNA key stakeholder groups included but were not limited to, community residents, community leaders, educators, health professionals, school nurses, health advocates, youth advocates and other experts both internal and external to Johns Hopkins All Children's Hospital.

## **Community Benefits Service Area**

The combined resources of the collaborative in an endeavor has permitted the evaluation of five (5) counties (Hillsborough, Pasco, Pinellas, Polk and Sarasota). Historically, Johns Hopkins All Children's identified the City of St. Petersburg as its sole Community Benefits Service Area (CBSA). This was based on the population with largest usage of the emergency center and the majority of recipients of community benefits contributions and programming. However, appreciating that Johns Hopkins All Children's provides services to a 17-county catchment area, it has elected to extract the data collected and analyzed for Pinellas and Hillsborough Counties first, with fore coming activity to encompass Sarasota County.

The expansion of the CBSA will permit Johns Hopkins All Children's Hospital to participate more robustly in the various counties Johns Hopkins All Children's provides services based on the similar criteria of population with usage of services and the majority of recipients within the county who will experience community benefit contributions and programming. Additionally, it will enable Johns Hopkins All Children's to participate in the dynamic cohort cross-evaluation with greater impact.

## **Overview of CHNA Process**



Healthy Communities Institute Inc.. 2019

## Collaborative Approach

The 2019 CHNA process was an enhanced approach due to the desire to not only optically but, effectively collaborate within all partners. This approach, which differed from previous years processes established a partnership between these organizations, facilitating the combination of resources and expertise, to better understand and address health issues which residents each organizations provides services to encounter. The collaborative group includes a partnership of local not-for-profit hospitals and the local department of health. Collaborative partners included: AdventHealth, BayCare, Moffitt Cancer Center, Tampa General Hospital, Lakeland Regional Health, and a variety of county Florida Departments of Health. Through this collaboration these partners will not only realize the community health needs assessment IRS tax exemption requirement, but they have established a pathway to accomplish an unique, broad, holistic approach to determine activities and services which will constitute a cultural health transformation in a community, county and/or region.

## Secondary Data

Secondary data was collected (by the research partner Healthy Communities Institute (HCI)) on the county, state and national levels to better compare the health of Pinellas and Hillsborough Counties. HCI then analyzed the secondary data to determine demographics, health outcomes and health behaviors, and social/environmental conditions.

- Demographics
  - *Pinellas County* is located on the West Central Coast of Florida and is the state's most densely populated county with almost one (1) million residents (in 2017: 975,280). With 111,915 residents being foreign born, this helps to make up a diverse demographic. The largest age group of the population is aged between 55 to 64 years old (30%) and 13.7% being under 15 years old.
  - *Hillsborough County* is located on Florida's West Central Coast (just east of Pinellas), and is the state's fourth-most populous county, with almost 1.5 million residents (in 2017: 1,436,888). Making it a diverse county with 222,469 residents being foreign born. The largest age group of the population is aged between 25 and 44 years old (26.9%) and 18.5% being under 15 years old. Please see below for the full snapshot of each county demographics.



# Community Input

The 2019 CHNA contained three (3) specific local data gathering techniques; key informant interviews, focus groups with community partners and stakeholders, and a comprehensive community survey. Johns Hopkins All Children’s Hospital resources, assets, needs, and barriers were also established to better understand the full health profile of Pinellas and Hillsborough Counties.

## Key Informant Interviews

Key Informant Interviews (KIIs) were conducted with 20 Pinellas County and 25 Hillsborough County community partners and/or stakeholders to better diagnose the health of the community, as well as, the needs and inequalities facing our community. These 45 phone interviews were conducted with a variety of community members including: county school boards, Operation Par, non-profit hospitals, YMCA, Juvenile Welfare Board of Pinellas, Healthy Start Coalition, Agency for Persons with Disabilities, Area Agency on Aging, Catholic Charities, Forward Pinellas, Mt. Herman Missionary Baptist Church, county departments of health, Pinellas County Oral Health Coalition and other key community organizations/non-profits.

## Primary Data- Community Survey

For this 2019 CHNA, “community” is defined as the residents of Pinellas County (48 zip codes) and of Hillsborough County (53 zip codes).

- *Pinellas:* 33777, 33744, 33786, 33761, 33763, 33764, 33765, 33767, 33755, 33756, 33759, 34698, 34685, 34688, 33762, 33707, 33785, 33773, 33774, 33760, 33770, 33771, 33778, 33714, 33708, 34677, 34681, 34683, 34684, 33781, 33782, 34695, 33776, 33772, 33706, 33716, 33701, 33702, 33703, 33704, 33705, 33710, 33711, 33712, 33713, 34689, 33715, 33709
- *Hillsborough:* 33503, 33508, 33509, 33510, 33511, 33527, 33530, 33534, 33547, 33548, 33549, 33550, 33556, 33558, 33559, 33563, 33564, 33565, 33566, 33567, 33568, 33569, 33570, 33571, 33572, 33573, 33575, 33578, 33579, 33583, 33584, 33586, 33587, 33592, 33594, 33595, 33596, 33598, 33601, 33602, 33603, 33604, 33605, 33606, 33607, 33608, 33609, 33610, 33611, 33612, 33613, 33614, 33615, 33616, 33617, 33618, 33619, 33620, 33621, 33622, 33623, 33624, 33625, 33626, 33629, 33630, 33631, 33633, 33634, 33635, 33637, 33646, 33647, 33650, 33655, 33660, 33661, 33662, 33663, 33664, 33672, 33673, 33674, 33675, 33677, 33679, 33680, 33681, 33682, 33684, 33685, 33686, 33687, 33688, 33689, 33694

The community survey consisted of 71 questions unique to Pinellas and Hillsborough Counties. Surveys were created based on the partner’s past CHNA data, individual survey questions of relevance, health topics of interest and similar survey banks. The survey was available through Survey Monkey (electronically created and provided by HCI) and via a print copy. The survey was sent to community partners, hospital systems, health departments, community health centers, DMVs, and local events. Surveys were dispersed to an agreed upon community partner list, produced by the collaborative, in an effort to reach a diverse population. Surveys were

accessible online and in paper form, for slightly more than two (2) months (February 20 – May 1, 2019).

Demographic data collected was a good representation or mirror of the actual demographic breakdown within each county. This was an intentional strategy of the collaborating partners, data representation was an important step to figure what the significant health issues needing to be addressed.

In total, there were 6,489 residents of Pinellas County surveyed and 5,277 residents of Hillsborough County.

### ***Pinellas County Data***

Most respondents were between 55 and 64 years old (27.32%), had a four (4) year college degree (24.69%), were White (74.90%), female (72.99%) and reported speaking primarily English at home (95.42%). Most residents had an annual household income between \$25,000 and \$49,999 (19.27%), while 19.07% made less than \$25,000, per year. Most respondents reported having their own transportation (86.08%) and over half reported having commercial health insurance (59.44%).

#### **Risky Behaviors**

- Drug abuse
- Alcohol abuse
- Distracted driving (texting, eating, talking on the phone)

#### **Health Problems**

- Mental Health Problems Including Suicide
- Heart Disease/ Stroke/High Blood Pressure
- Being Overweight
- Aging Problems (for example: difficulty getting around, dementia, arthritis)

#### **Quality of Life**

- Low Crime/Safe Neighborhoods
- Access to Health Care
- Good Jobs and Healthy Economy

### ***Hillsborough County Data***

Most respondents were between 25 and 34 years old (23.12%), had a 4-year college degree (23.96%), were White (60.40%), female (72.46%) and reported speaking primarily English at home (81.81%). Most residents made less than \$25,000 per year (19.74%), while 18.51% had an annual household income between \$25,000 and \$49,999. Most respondents reported having their own transportation (86.38%) and over half reported having commercial health insurance (56.75%). The survey data revealed significant health needs and barriers in their communities.

## ***Hillsborough County Data continued***

### **Risky Behaviors**

- Drug abuse
- Alcohol abuse
- Distracted driving (texting, eating, talking on the phone)

### **Health Problems**

- Mental Health Problems Including Suicide
- Being Overweight
- Domestic Violence/Rape/Sexual Assault
- Heart Disease/Stroke/High Blood Pressure

### **Quality of Life**

- Low Crime / Safe Neighborhoods
- Access to Health Care
- Good Schools
- Good Jobs and Healthy Economy

## **Community Prioritization**

Prioritization exercises were conducted by the partners, HCI and a local consultant service and completed in their respective counties. HCI staff described the data above (complete data) to the community members and displayed data placemats for quick data consumption and general knowledge of each health focus topic area. Individuals attending the event were randomly assigned to one of 15 focus groups. The 15 focus groups covered 11 health topic areas: Access to Care, Cancer, Diabetes, Exercise, Nutrition & Weight, Heart Disease & Stroke, Immunizations & Infectious Disease, Maternal, Fetal, & Infant Health, Mental Health & Mental Disorders, Oral Health, Respiratory Disease & Substance Abuse. Groups discussed what the data found, trends arose, questions unanswered and the overall “story” of the data. Focus groups presented to the entire room about each topic. Individuals were given a clicker and asked to rate each health topic area on two (2) specific scales, 1-10. One (1) being the lowest and 10 being the highest. The first scale dealt with scope and severity of the health topic; One (1) represented low severity and not much of a community health issues, while ten was the inverse. The second scale was based on ability to impact. With one (1) representing low/or inability to impact health issue, while ten (10) being high ability to impact health concern.

Please see below for the prioritization of the health topic areas (per county), which were ranked and rated in real time after the focus group discussions:



### ***Pinellas County***

1. Mental Health & Mental Disorders
2. Access to Care
3. Exercise, Nutrition & Weight
4. Substance Abuse
5. Heart Disease & Stroke
6. Diabetes
7. Maternal, Fetal & Infant Health
8. Immunizations & Infectious Disease
9. Cancer
10. Oral Health
11. Respiratory Disease

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8. Immunizations & Infectious Disease
9. Cancer
10. Oral Health
11. Respiratory Disease

## **Next Steps**

Now that our standardized Assessment Phase has been deployed, data has been collected and analyzed, the community health needs will be prioritized for the pediatric population by the Community Connector Groups during the Evaluation and Justification Phase. These Community Connector Groups will assist Johns Hopkins All Children's Hospital in analyzing each health issue, performing an environmental scan, seek to address health equity and identify health disparities to ensure the groups development of a community benefit strategic implementation plan before engaging and establishing accountable partners during the Johns Hopkins All Children's Hospital *Unified4Allkids*. It will be during the Implementation/Improvement Phase that Johns Hopkins All Children's will work with our collaborators on the Call to Action. The Call to Action will include the production of a Community Benefit Strategic Implementation Plan, outlining implementation strategies to achieve the goals and objectives generated by the Community Connector Groups, monitor and develop the public dashboard documenting the cultural change being pursued to address the self-identified community health needs.