

**Johns Hopkins Health System
Fiscal Year 2018 Community Benefits Report Narrative
Johns Hopkins All Children's Hospital**



I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Hospital Characteristics:

1. **Hospital ID:** 103300
2. **Hospital name:** Johns Hopkins All Children's Hospital (JHACH)
3. **Health system name:** Johns Hopkins Health System (JHHS)
4. **Bed Designation:** 259
5. **Number of inpatient admissions in the fiscal year:** 6,613
6. **The percentage of the hospital's discharges in the fiscal year for patients who are uninsured** (include numerator, denominator, and percentage): 7 / 6,613 = 0.1%
7. **The percentage of the hospital's discharges in the fiscal year for Medicaid patients** (include numerator, denominator, and percentage): 4,556 / 6,613 = 68.9%
8. **The percentage of the hospital's discharges in the fiscal year for Medicare patients** (include numerator, denominator, and percentage): 13 / 6,613 = 0.2%
9. **The list of zip codes in the hospital's primary service area (PSA) as defined in the hospital's global budget:**
33712, 33771, 33705, 33713, 34208, 33781, 33702, 33710, 33711, 34221, 33714, 34668, 33709, 34203, 33756, 34609, 34205, 34266, 33782, 34209, 33703, 34207, 34667, 33755, 33707, 33704, 33760, 33770, 33777, 34653, 33701, 33772, 33773, 34234, 34654, 34655, 34698, 34689, 33774, 34683, 33952, 34219, 33765, 34652, 34232, 33764, 34608, 33647, 33778, 34286, 33813, 33511, 34293, 34601, 34684, 34606

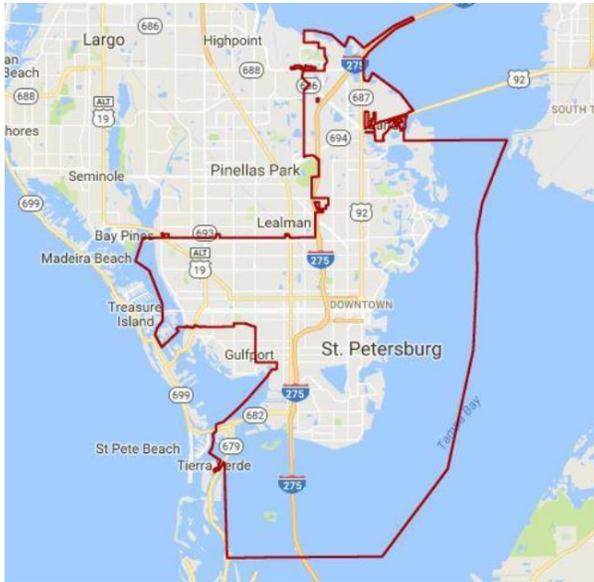
10. A list of all other hospitals sharing the PSA

Bartow Memorial Hospital, Bayfront Health Port Charlotte, Bayfront Medical Center, Blake Medical Center, Brandon Regional Hospital, Brooksville Regional Hospital, Charlotte Regional Medical Center, Community Hospital, Desoto Memorial Hospital, Doctors Hospital of Sarasota, Florida Hospital Tampa, Englewood Community Hospital, Fawcett Memorial Hospital, Florida Hospital, Carrollwood, Florida Hospital North Pinellas, Florida Hospital Zephyrhills, H. Lee Moffitt Cancer Center and Research Institute, Heart of Florida Regional Medical Center, Lake Wales Medical Center, Lakeland Regional Medical Center, Lakewood Ranch Medical Center, Largo Medical Center, Manatee Memorial Hospital, Mease Countryside Hospital, Mease Dunedin Hospital, Memorial Hospital of Tampa, Morton Plant Hospital, Morton Plant North Bay Hospital, Northside Hospital, Oak Hill Hospital, Palms of Pasadena Hospital, Pasco Regional Medical Center, Regency Medical Center, Regional Medical Center Bayonet Point, St. Anthony's Hospital, St. Joseph's Hospital, St. Joseph's North, St. Joseph's South, St. Petersburg General Hospital, Sarasota Memorial Hospital, South Bay Hospital, South Florida Baptist Hospital, Spring Hill Regional Hospital, Springbrook Hospital, Sun Coast Hospital, Tampa General HealthCare, Town and Country Hospital, Florida Hospital Tampa, Venice Regional Medical Center, Winter Haven Hospital

COMMUNITY BENEFIT SERVICE AREA

1. List all of the ZIP codes in the hospital CBSA:

33701, 33702, 33703, 33704, 33705, 33706, 33707, 33708, 33709, 33710, 33711, 33712, 33713, 33714, 33715, 33716



2. Describe how the hospital identified its CBSA:

In 2017, the City of St. Petersburg (population, 259,906) was identified as the CBSA for the purpose of the Johns Hopkins All Children's Hospital (JHACH) community health needs assessment. Although JHACH provides services to a 17-county catchment area, the CBSA reflects the population with the largest usage of the hospital's emergency center (10 of the top 12 zip codes are in St. Petersburg) and the majority of recipients of community benefit contributions and programming. Additionally, in anticipation of the Florida Department of Health-Pinellas County conducting its countywide community health improvement plan in 2017-18, JHACH opted to focus its community health needs assessment on the City of St. Petersburg, one of Pinellas County's 24 municipalities.

The CBSA covers approximately 137 square miles (61.75 sq mi land, 75.89 sq mi water) and is located in southern Pinellas County. The population of St. Petersburg is predominantly White (69%), 23.5% identifies as Black or African American, and 7.1% identifies as Hispanic or Latino (2016 American Community Survey 5-Year Estimates).

The median household income in St. Petersburg (\$51,474) is slightly higher than that of Florida (\$50,860) and acutely lower than the U.S. (\$57,617). Nearly 19% of children in St. Petersburg live in poverty while 33.8% live in a household on some type of public assistance. Though African Americans are only 24% of St. Petersburg's total population, and 43% of the City's poverty population: 75% of all children live with single moms; 77% of poor people live in single headed households; and 58% of single mothers live in poverty (2020 Plan Taskforce).

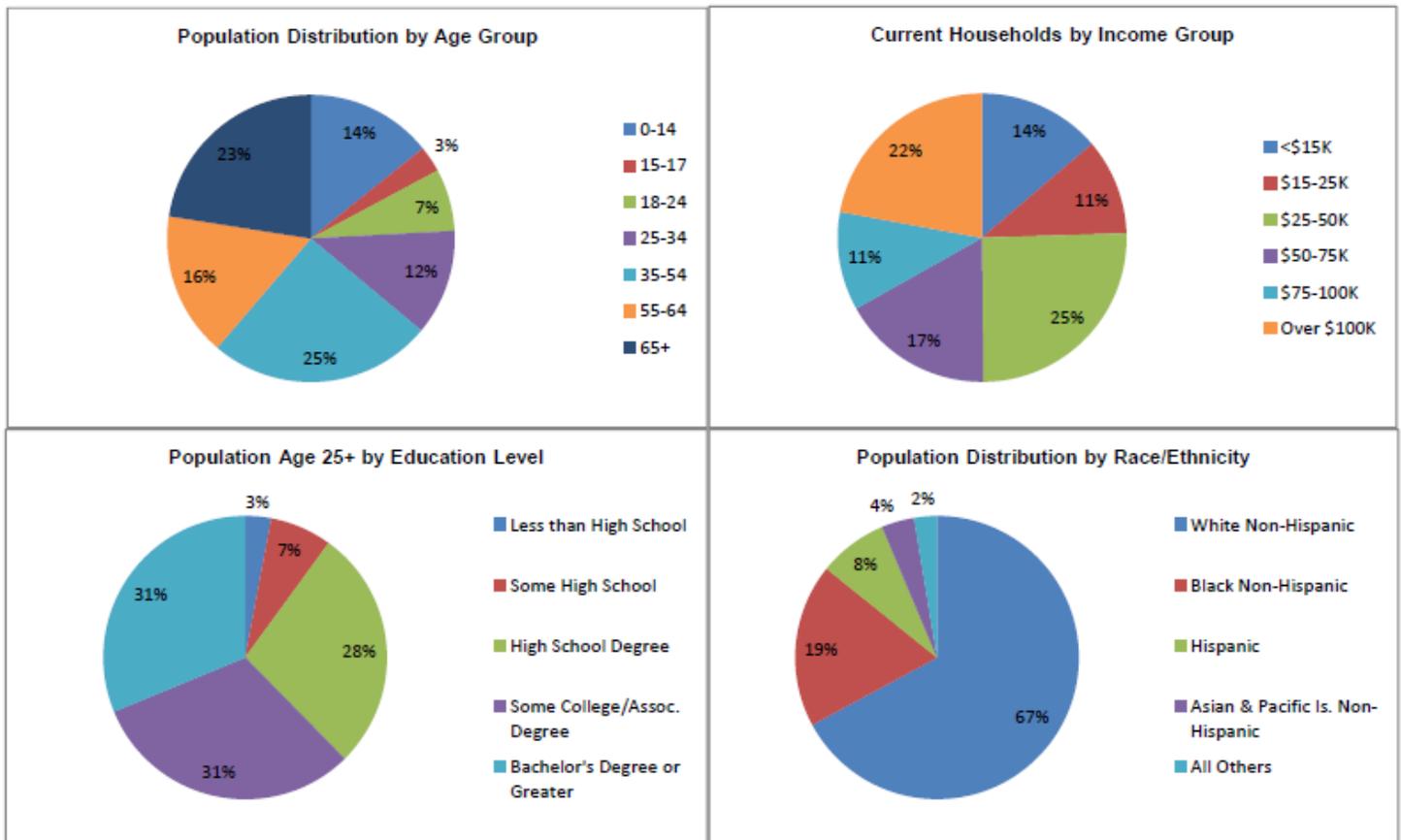
Notably, eight of the Pinellas County school district’s Transformation Zone elementary and middle schools can be found in St. Petersburg, home of JHACH’s main campus. The on-time high school graduation rate for the entire district is 80.1%, slightly lower than the state average (82%). While progress for Black/African American students has grown incrementally over the past five years, the on-time high school graduation rate is still only 65.5%, for those students (Florida Department of Education).

Furthermore, more than 42% of the CBSA’s adult population had an associate’s degree or higher, 47.8% had a high school diploma or some college, and 10% had less than a high school diploma (2016 ACS 5-Year Estimates).

Within this CBSA, Johns Hopkins All Children’s is focused on certain target populations, such as at-risk children and adolescents, uninsured families, women of childbearing age, and underinsured and low-income families and households.

Community Health Statistics and Demographics

2018 Demographic Snapshot Charts
 Area: ACH FY2018 CB SA
 Level of Geography: ZIP Code



II. COMMUNITY HEALTH NEEDS ASSESSMENT

Our hospital’s most recent community health needs assessment was completed on: JHACH conducted and published its 2016 Community Health Needs Assessment, which was approved by the JHACH Board of Trustees on 6/14/16.

Provide link: <https://www.hopkinsallchildrens.org/getmedia/2d2a4532-0788-4dd0-9055-c8db9f22ebd0/2016-JHACH-CHNA-Full-Report-Final.pdf;.aspx>.

Our hospital’s most recent implementation strategy was adopted on 03/15/18, by the JHACH Board of Trustees. Next, this plan moved to the Community Connector Groups (CCG) with key community partners producing strategies and tactics to accomplish the approved objectives, within the goal timeframe. The CCGs have collaborated to develop and lead the outlined plan. JHACH will review progress quarterly, starting 01/01/19, and a public online dashboard will be available for accountability of all partners, on JHACH Community Benefit webpage (to be published 01/19).

Provide link: TBD

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Are Community Benefits planning and investments part of your hospital’s internal strategic plan?

Yes

The Johns Hopkins All Children’s Hospital 2012-2018 Strategic Plan is centered around nine Strategic Goals. Community benefit efforts are included as part of Goal #2: Stakeholder Engagement and Goal #7: Population Health (please see link for full strategic goals, or see below for outlined goals specific to community benefit.

Link: <https://www.hopkinsallchildrens.org/About-Us/Strategic-Plan>

Goal #2 Stakeholder Engagement: Increase and strengthen relationships with internal and external stakeholders to broaden their levels of advocacy, donating, volunteering or referring.				
	Strategy	FY18 Strategy Metrics	Tactic (Process Milestone)	Tactic Completion Date
2.6	Leverage the community health needs assessment to work with community-based entities to identify and fill gaps in the safety net for children.	Develop and execute a comprehensive community benefit plan (CBP) that outlines a clear process and assigns deliberate accountabilities for internal and external stakeholders.		Ongoing
		Through CBP, identify at least two structural changes for each CHNA health area that are either 1.) led by internal staff and integrated with hospital daily		6/30/18

		operations; or b.) led by external stakeholders and supported by hospital in appropriate methods.		
		Through CBP, engage community organizations, leaders, and residents by hosting at least 8 community forums inviting input to CBP process and outcome.		Ongoing
		Develop and pilot Fit4AllTeens evidence-based community program in CB service area,		Ongoing
		Align with Healthy Steps (obesity clinic) to hire and train experts in mental health, nutrition and fitness.		6/30/18
		Define a food pharmacy model imitative for implementation on JHACH campus.		6/30/18

Goal #7 Population Health: Create the capabilities necessary to manage the care of chronic patient populations and to thrive in a reimbursement environment which emphasizes value over volume.

	Strategy	FY18 Strategy Metrics	(Process Milestone)	Tactic Completion Date
7.2	Develop the foundational elements of a data-driven organization which encourages the sharing of information across all key stakeholders	Implement phase 1 of the EDW by 6/30/18.	EDW phase 1 completion	6/30/2018

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary))

i. Senior Leadership

- 1. CEO
- 2. CFO
- 3. Other (please specify): Vice President, Government &Community Affairs

Describe the role of Senior Leadership.

Using the hospital’s Strategic Plan as its guide, Senior Leadership ensures that community benefit strategies and updates are discussed at the board level and the executive cabinet level. Senior Leadership has established a council structure whereby community benefit activities and strategies are addressed by the hospital’s Advocacy Council.

CEO – approves and focuses the hospitals mission / strategic goals to align with community benefit and community health needs

CFO – provides financial information necessary to report; and provides financial indirect costs to support community benefit operations

VP Government & Community Affairs – provides oversight of community programs, grants management and personnel direction to achieve strategic goals of the hospital, as well as, CHNA alignment with overall division goals. VP is responsible for directing community activities and events, based on community needs.

ii. Clinical Leadership

1. Physician
2. Nurse
3. Social Worker
4. Other (please specify)

Describe the role of Clinical Leadership

Using the hospital's Strategic Plan as its guide, Clinical Leadership is represented on the Advocacy Council, which is led by the Vice President of Government and Community Affairs. Clinical leaders ensure that community benefit strategies and updates are discussed at the hospital's department directors' meetings and their respective departmental meetings.

iii. Population Health Leadership and Staff

1. Population health VP or equivalent (please list)
2. Other population health staff (please list staff)

Describe the role of population health leaders and staff in the community benefit process.

iv. Community Benefit Operations

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

1. **Individual (please specify FTE)**
Manager, Community Engagement (1 FTE)
Coordinator, Community Engagement (1 FTE)
Senior Director of Finance, Accounting (.20 FTE)
Manager, Accounting (.20 FTE)

The Community Engagement Manager (CEM) and Coordinator collect, input and verify all community benefit data from internal audiences. The CEM compiles report, works with Finance on the initial audit and verification of community benefit report (CBR) financials, and writes the CBR narrative.

2. **Committee (please list members)**

Johns Hopkins All Children's Hospital Community Affairs Workgroup		
Representative	Area	Function within CB activities planning and reporting process
Alizza Punzalan-Randle , Community Engagement Manager	Community Benefit	Leads community benefit activities, oversees community health needs assessment, coordinates community benefit planning, helps integrate into hospital's strategic plan, informs senior leadership about community benefit program's needs and successes; lead for CBISA reporting software; lead for annual community benefit report.
Kimberly Berfield , Vice President, Government & Community Affairs; Stephanie Bovis , Government & Community Affairs Program Coordinator	Advocacy / Government Affairs	Monitors key policies, including financial assistance, billing and collections; participates in community health needs assessment; advocates for community benefit programs (internally and externally); helps tell community benefit story.
Kimberly Brown-Williams , Healthy Start Project Manager; Kellie Gilmore , Community Health and Wellness Manager; Petra Vybiralova , FL Suncoast Safe Kids Coalition Supervisor	Community programs	Participates in community health needs assessment, helps to develop implementation strategy, monitors implementation of community benefit programs, participates in evaluation, advocates for community benefit programs (internally and externally), helps tell community benefit story.
Christopher Whitby , Chief Financial Officer	Finance	Assures financial information in IRS Form 990, Schedule H and other community benefit reports is complete, accurate and consistent; advises on budget implications of community.
Connie Guinn , Donor Relations and Campaign Director	Foundation	Advocates for community benefit programs (internal and external), helps tell community benefit story.
Joe Conrod , Director of Diversity and Employee Relations	Human Resources	Advocates for community benefit programs (internal and external), helps tell community benefit story.
Cindy Driscoll , Executive Director of Kids Home Care; Kristin Maier , Director of Child Life; Dr. Fauzia Shakeel , Neonatologist; Dr. Flora Howie , Pediatric Developmental Medicine	Patient care	Provides clinical / patient / family perspective; recommends priorities.
Steven Dunn , Director of Strategic Planning	Planning and business development	Includes community benefit goals, objective and strategy into the hospital's strategic plans; contributes data and other info for community health needs assessment; recommends priorities.
Tracy West-Grubb , Quality Advisor	Population Health / QI	Informs group about hospital's population health strategies, quality improvement measures

3. ___ Department (please list staff)
4. ___ Task Force (please list members)
5. Other (please describe)

JHHS Community Health Improvement Strategy Council

The Johns Hopkins Hospital

- Sherry Fluke, Senior Financial Analyst, Govt. & Community Affairs (GCA)
- Sudanah Gray, Budget Analyst, GCA
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
- William Wang, Associate Director, Strategic Initiatives, GCA

Johns Hopkins Bayview Medical Center

- Patricia A. Carroll, Manager, Community Relations
- Kimberly Moeller, Director, Financial Analysis and Special Projects
- Selwyn Ray, Director, Community Relations JHBMC, Health and Wellness

Howard County General Hospital

- Laura Barnett, Director, Strategic Planning
- Fran Moll, Manager, Regulatory Compliance
- Scott Ryan, Senior Revenue Analyst

Suburban Hospital

- Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness
- Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness
- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
- Monique Sanfuentes, Administrative Director, Community Affairs & Population Health, Community Health and Wellness
- Sunil Vasudevan, Senior Director of Finance and Treasury, Finance and Treasury

Sibley Memorial Hospital

- Marti Bailey, Director, Sibley Senior Association and Community Health
- Courtney Coffey, Community Health Program Manager
- Angel Fernandez, Financial Analyst
- Marissa McKeever, Director, Government and Community Affairs
- Honora Precourt, Community Program Coordinator

Johns Hopkins All Children's Hospital

- Christopher Whitby, Vice President and Chief Financial Officer
- Kimberly Berfield, Vice President, Government and Community Affairs
- Stephanie Bovis, Program Coordinator, Community Benefit

Johns Hopkins Health System

- Christopher Davis, Senior Director, Tax Compliance
- Bonnie Hatami, Senior Tax Accountant
- Anne Langley, Senior Director, Health Policy Planning and Community Engagement
- Kimberly Scott, Manager, Regulatory Analysis Function

The JHHS Community Health Improvement Strategic Council (CHISC) convenes monthly to bring community benefit groups together with Tax, Financial Assistance and Healthy Policy staff from across the Health System to coordinate process, practice and policy. CHISC members discuss issues and

problems they face in community benefit reporting, regulatory compliance to state and federal community benefit requirements, and technical aspects of administering and reporting community benefit systems. When needed, a designated representative from the group contacts the governing agency for clarification or decision regarding the issues in question to ensure that all hospital reports are consistent in the interpretation of regulations.

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?

Spreadsheet yes no
 Narrative yes no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

JHACH individuals/departments tracked activities, events, & benefits throughout the year. Community benefit coordinator (CBC) collected all community benefit activities and events at the end of the 2018 fiscal year for review. The CBC collected and verified all data was complete and determined which category the activity or event fell under. Internal records were recorded in excel and translated into an online system CBISA. CBISA was utilized to compute all community benefit activities and events for the fiscal year. The CBC met with the Senior Director in Finance to complete the audit of community benefit and hospital financials. Upon finalization, the CBC and Senior Director of Finance presented the information to the Vice President of Government & Community Affairs and Chief Financial Officer. Once accepted, the President and Chief Executive Officer was presented with the information and gave final approval.

d. Does the hospital’s Board review and approve the FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet yes no
 Narrative yes no

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

Yes No (Not applicable to Florida hospitals)

**IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES
 (DESCRIBE THREE)**

Initiative I: Fit4AllKids

<p>Does this initiative address a need identified in your CHNA?</p>	<p>This initiative addresses the community identified need: Childhood Obesity</p> <p>The prevalence of obesity in children aged 2-4 years in Pinellas County is estimated to be between 29.5-33.5% while high school students obesity prevalence is approximately 25- 29.9% (Communities Putting Prevention to Work: Pinellas County, Florida).</p> <p>Childhood obesity data specific to St. Petersburg is limited therefore we are reporting data collected and provided by Pinellas County Schools (PCS) during school health assessments conducted in 2012. A total of 26 schools are represented in the targeted zip codes. The Body Mass Index (BMI) report compiled by PCS measured 10,348 elementary, middle and high school students wherein 36% of surveyed students fell into the At Risk and Obese categories. (Source: Pinellas County Schools) According to the Pinellas County Healthy Weight Profile (2013), approximately 28% of middle school students and 37% of high school students in Pinellas County did not get sufficient physical activity in 2012. However, only about 7% of middle school students and 10% of high school students in the county reported that they were obese.</p>
<p>When did this begin (mo/yr)? Does it have an end date or trigger event that will end it?</p>	<p>This initiative began in <u>08/06</u>, which was supported by the hospital’s community affairs budget. Select activities have been sustained through grant funding, which we intend to continue writing for/ will continue to seek funding.</p>
<p>What population does this initiative target? (# of people and describe target population)</p>	<p>School- aged children and their families</p>
<p>Total Number of People Reached by Initiative</p>	<p>2,800 (participants and special events) (Over 2 million with social media campaign and online health education videos)</p>
<p>What category of intervention best fits this initiative?</p>	<p>i. Chronic condition-based intervention ii. Acute condition-based intervention iii. Condition-agnostic treatment intervention iv. Social determinants of health intervention v. Community engagement intervention vi. Other (specify)</p>
<p>Does your hospital work with other groups to deliver this, if so list?</p>	<p>Yes, Pinellas County Schools, Pinellas Parents for Healthy Schools, JHACH Medical Education, Healthy Steps Clinic, City of St. Petersburg, DOH- Pinellas, American Heart / American Stroke Association, Feeding Tampa Bay, UF/IFAS Extension , YMCA of Greater St. Petersburg, JWB, JHACH Endocrinology, Pinellas County Human Services</p>
<p>Primary Objective</p>	<p>Provide families with education and resources to make healthy choices and reduce childhood obesity in Pinellas County by offering both intervention as well as prevention programs and services. Programs include family interventions, family classes, student nutrition, culinary classes, and a healthy eating awareness campaign (online).</p>

How initiative is delivered?	<p>JHACH has made a commitment to help address the problem of childhood obesity by creating a task force of pediatric physicians, dietitians, physical therapists, educators and advocates to help children maintain a healthy weight and body size, and be more active and fit.</p> <p>Fit4Allkids nutrition, fitness and motivational experts offer fun and interactive classes that encourage children and teens to do their personal best and reach their own individual goals. Programs are delivered at schools and in the community.</p>
What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.	<ol style="list-style-type: none"> 1. Count of participants/encounters – (mentioned above) 2. Other process/implementation measures (e.g. number of items distributed) – (incentives are given and tracked) 3. Surveys of participants – (knowledge and behavior assessments are given pre/post to children and their families) 4. Biophysical health indicators – (pre/post weight, BMI, waist circumference are measured per participant) 5. Assessment of environmental change 6. Impact on policy change or imitation 7. Effects on healthcare utilization or cost 8. Assessment of workforce development 9. Other (specify)
Describe how initiative is evaluated?	<p>Fit4Allkids initiatives (First steps/ Fit4AllTeens) include data collection on knowledge acquisition and behavior change of healthy lifestyles and opportunities for improvement. Knowledge and behavior screens were given pre/posttests to determine if the interventions were effective.</p> <p>Biophysical health indicators are collected, at an individual level, pre and post measures are evaluated for weight, BMI, and waist circumference.</p> <p>Both parents and children are assessment with appropriate knowledge and behavior assessments, aimed at interventions and education provided (such as 9-5-2-1-0 messaging) to track increased knowledge and changed behavior.</p> <p>Attendance is tracked. The program gives a post evaluation of the program for feedback on instructors and overall satisfaction.</p>
Describe outcome of the initiative?	<p>Outcome data goals include: weight maintenance for children, this is only a 6 week program, so maintenance of weight is measured as a success. Knowledge increases for both parents and children is measured and increases have been found following interventions. Measure of positive behavior changes (lifestyle changes) are shown for more of a long term adaption of a healthier lifestyle. Healthier weight thought and positive feelings towards weight management lifestyle are noted. As a continuation of the program, many become involved with the Healthy Steps clinic following the 6-week program.</p>
Describe how the outcome of the initiative addresses community health needs?	<p>As outlined in our CHNA, obesity and diabetes education and awareness can be improved, within the CBSA. Through above mentioned activities, related to nutrition, fitness, and health, occurring at the school (and in the community) children get invaluable opportunities to improve their own healthy lifestyles; which extend to their families and friends. All activities are focused in our CBSA.</p>
Total Cost of Initiative for Current FY (include total dollars, donations, grants)	\$ 154,929

Initiative II: Healthy Start Federal Project

<p>Does this initiative address a need identified in your CHNA?</p>	<p>This initiative addresses the community identified need: Birth Outcomes</p> <p>This program aims to improve perinatal health outcomes and eliminate disparities in infant mortality and adverse perinatal outcomes (i.e., low birth weight, preterm births, maternal morbidity and mortality) among Black/African American women and babies. Black/African American infants in the Project Area are more than three times more likely to die before their first birthday than White infants. The Black/African American population within the CBSA has lower household incomes, higher unemployment, and lower high-school completion than the White population.</p>
<p>When did this begin (mo/yr)? Does it have an end date or trigger event that will end it?</p>	<p>Began: <u>09/14</u></p> <p>This is a five year federal grant (04/01/14-03/31/19). <i>An application to continue program and services in the same area was submitted 11/21/18 for another five year grant cycle (04/01/19-03/31/24).</i></p>
<p>What population does this initiative target? (# of people and describe target population)</p>	<p>The target population for intensive case management provided by Healthy Start includes Black/African American who are pregnant or interconceptional, fathers, and infants age 0-2.</p>
<p>Total Number of People Reached by Initiative</p>	<p>1,300</p> <p>Breakdown 514-plus women, infants and fathers were screened for Healthy Start services. 179 women, infants and fathers were enrolled in case management services. 714 community members received health and safety education.</p>
<p>What category of intervention best fits this initiative?</p>	<p>i. Chronic condition-based intervention ii. Acute condition-based intervention iii. Condition-agnostic treatment intervention iv. Social determinants of health intervention v. Community engagement intervention vi. Other (specify)</p>
<p>Does your hospital work with other groups to deliver this, if so list?</p>	<p>Yes, Florida Department of Health – Pinellas County, Healthy Start Coalition, Operation PAR, Kinship Pinellas, St. Pete Healthy Start Federal, The Next Stepp Center, St Pete College, Bayfront Health Medical Center, Federally Qualified Community Health Centers of Pinellas-Johnnie Ruth Clarke, community OB Practices, Health Navigators, Healthy Start’s Community Action Network, Healthy Families Programs, Nurse Family Practice, Parents as Teachers, Early Steps, other Early Childhood Programs, CareerSource, Pinellas County Urban League, Neighborhood Centers, Next STEPPS, USF St. Petersburg Family Studies Center</p>

<p>Primary Objective</p>	<p>Healthy Start is a federally-funded initiative dedicated to addressing disparities in Maternal and infant health status in high risk communities. Healthy Start serves women during their childbearing years (14-45 years old) in zip code areas 33701, 33705, 33711, 33712 and 33713. This area in Pinellas County was selected as the target area for implementation of Healthy Start due to the high infant mortality rate. Our goal is to work with women to address risk factors (pregnancy intervals, nutrition, substance/alcohol use, psychosocial concerns, family planning and other issues) that impact their health and may affect a future pregnancy.</p> <p>Healthy Start at Johns Hopkins All Children’s was implemented in September 2014 to address an identified gap in the system of maternal and child health services directly linked to health disparities in infant mortality, pre- and inter-conception care.</p> <p>Healthy Start utilizes a life course approach and serves as an important community entry point for women seeking both prenatal and well-woman care and family planning services. Healthy Start focuses on addressing social determinants and reproductive health capacity at the community-level, in addition to individual health and social risk factors. Healthy Start works to assure access to culturally competent, family-centered and comprehensive health and social services for women, infants and their families.</p>
<p>How initiative is delivered?</p>	<p>The target population for intensive case management provided by Healthy Start includes Black/African American women who are pregnant, interconceptional, fathers and infants age 0-2. Healthy Start also provides education on safe sleep, postpartum depression, infant CPR and first aid, nutrition and exercise self-care and stress management. Specific priority groups include:</p> <ul style="list-style-type: none"> ○ Women who have had a previous poor birth outcome (fetal or infant loss, low birth weight baby) ○ Women who had a child as a young teenager (<15 years old) ○ Women of childbearing age (14-45) who do not have a regular source of health care ○ Women with a history of depression or mental health concerns ○ Women who desire/need support ○ Infants who fail to thrive ○ Fathers/men
<p>What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.</p>	<ol style="list-style-type: none"> 1. Count of participants/encounters 2. Other process/implementation measures (e.g. number of items distributed) – (track incentives given- car seats, diapers, pack-and-plays, etc.) 3. Surveys of participants – (demographic information, depression screenings, etc.) 4. Biophysical health indicators 5. Assessment of environmental change 6. Impact on policy change or imitation 7. Effects on healthcare utilization or cost 8. Assessment of workforce development 9. Other (specify)- HRSA required screenings

<p>Describe how initiative is evaluated?</p>	<p>The Healthy Start Program Evaluator and Program Manager, as well as, the Principal Investigator for the grant, decides benchmarks and performance measures (also required by grantor: HRSA), based on national standards. In FY18, Healthy Start’s benchmarks included:</p> <ul style="list-style-type: none"> • Enroll 720 participants (360 prenatal women, 360 infants and interconceptional women); • Enroll 15-30 men in the father services program; • Ensure that 100% of families enrolled read to their child. • Ensure families have <i>health insurance</i>, have discussed a <i>Reproductive Life Plan</i>, the mother has done her <i>Postpartum Visit</i>, there is no need for <i>Medical Home</i>, if there is, they will be connected to services, the mother is receiving her <i>Well Woman Visit</i>, the families is exhibiting <i>Safe Sleep Behaviors</i> and has <i>Initiated breastfeeding</i>, and promotion of <i>Breastfeeding at 6 months</i>, while <i>Abstaining from cigarette smoking prenatally</i> and not conceiving another <i>child within 18 months</i>, that the child/children are receiving their <i>Well Child Visits</i>, and mom and dad are <i>Perinatal Depression Screened & Referral</i> (if necessary), families complete an <i>Intimate Partner Violence</i> screen, tracking <i>Father/Partner Involvement during Pregnancy</i> and <i>Father/Partner Involvement with infant</i>.
<p>Describe outcome of the initiative?</p>	<p>Women referred for JHACH case management: 514 Infants referred for JHACH case management: 179 Women enrolled in Program case management: 139 Infants enrolled in Program case management: 46 Fathers enrolled in Program case management: 17 Total # enrolled and active ongoing women and infant participants: 352 % Women and infant participants without medical insurance: 8.8% Raising your MENTality meetings: 13 average # attendees/ 7 meetings (92 total) # Classes/Events hosted: 17 # Attendees at Classes/Events hosted: 714 # External events Program represented at: 37</p>
<p>Describe how the outcome of the initiative addresses community health needs?</p>	<p>Healthy Start addresses an identified gap in the system of maternal and child health services directly linked to health disparities in infant mortality, pre- and inter-conception care.</p> <p>The Project focuses its efforts on:</p> <ul style="list-style-type: none"> • Improving women’s health before, during and after pregnancy • Promoting quality services with a focus on required core competencies and standardized interventions • Strengthening family resilience by engaging both parents and addressing some of the stress that underlies many disparities in birth outcomes • Achieving collective impact serving as community hubs that drive collective improvements • Increasing accountability through quality improvement, performance monitoring and evaluation <p>Healthy Start focuses on addressing social determinants and reproductive health capacity at the community-level, in addition to individual health and social risk factors. Healthy Start works to assure access to culturally competent, family-centered and comprehensive health and social services for women, infants and their families.</p>

Total Cost of Initiative for Current FY (include total dollars, donations, grants)	\$1,482,050
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Initiative III: Lakewood Health Squad Program

Does this initiative address a need identified in your CHNA?	This initiative addresses the community identified need: Childhood Obesity / Mental Health
When did this begin (mo/yr)? Does it have an end date or trigger event that will end it?	Lakewood High School has participated in Health Squad programming since 2014 and has provided a model of sustainability. JHACH has provided extra funding in FY 18 to the school, to expand programs
What population does this initiative target? (# of people and describe target population)	High school students and their families, school faculty and staff (entire school)
Total Number of People Reached by Initiative	Current active Health Squad participants: Lakewood High School: 100 students Program impact: Lakewood High School: 1,300 students + faculty and staff
What category of intervention best fits this initiative?	i. Chronic condition-based intervention ii. Acute condition-based intervention iii. Condition-agnostic treatment intervention iv. Social determinants of health intervention v. Community engagement intervention vi. Other (specify)
Does your hospital work with other groups to deliver this, if so list?	Pinellas County Schools, Kohls, Feeding Tampa Bay, JHACH Adolescent Medicine Physicians and Nurses, City of St. Pete, American Heart Assoc.
Primary Objective	The Health Squad is a school-wide, student-led health and wellness program offered to all students. The purpose of the program is to provide age-appropriate and specific resources, information, and opportunities related to health to the entire student body. In FY 18, there was one high school in Pinellas County engaged in Health Squad programming: Lakewood High School. (FY 19- expand programs to a second school)
How initiative is delivered?	Assisted students in providing school-wide awareness efforts <ul style="list-style-type: none"> • Monthly lunch and learn seminars on various health topics with guest speakers and community leaders • School lunch taste testing • Free after-school fitness classes for students offered by a certified personal trainer • Student networking and volunteer opportunities in the community • Freshmen health assessment (blood pressure, Body Mass Index, BMI) • Exam stress management with a licensed mental health counselor • School-wide assembly on mental health • Sport specific nutrition education seminars • Healthy culinary classes • School-wide field days • Health and wellness social media PSAs/videos

<p>What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.</p>	<ol style="list-style-type: none"> 1. Count of participants/encounters 2. Other process/implementation measures (e.g. number of items distributed) 3. Surveys of participants 4. Biophysical health indicators 5. Assessment of environmental change (created fitness room at school for fitness classes; support garden on campus, run by students) 6. Impact on policy change or imitation 7. Effects on healthcare utilization or cost 8. Assessment of workforce development 9. Other (specify)
<p>Describe how initiative is evaluated?</p>	<p>These efforts started with grant funding and research program efforts. The grant funding ended in 2016 and the program efforts though on a smaller scale continued at the school due to continued interest from the students and the school program champions who lead these efforts. This program sustainability is a measure of success.</p>
<p>Describe outcome of the initiative?</p>	<p>Outcomes include first-time student involvement in school programs, keeps students and their families educated on current research and best practices for nutrition or various health topics; keeps kids busy and involved and off the streets. Creates a bond throughout the school, a safe haven for students seeking extracurricular and/or clubs.</p>
<p>Describe how the outcome of the initiative addresses community health needs?</p>	<p>As outlined in our CHNA, obesity and diabetes education and awareness can be improved in the CBSA. Through all of the activities mentioned above, related to nutrition and health, occurring at the school students get invaluable opportunities to improve their own healthy lifestyles; which extend to the students families and friends outside of the school environment. The location is optimal, as the school is located in the middle of our CBSA. This model and program have been sustained by the school for the past few years, which can speak to its necessity.</p>
<p>Total Cost of Initiative for Current FY (include total dollars, donations, grants)</p>	<p>\$10,000</p>