



20 AdventHealth 22 Shawnee Mission

Community Health Needs Assessment

Extending the Healing
Ministry of Christ

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Letter From Leadership

At AdventHealth Shawnee Mission, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our walls and into the communities we serve. Our commitment is to address the health care needs of our community with a wholistic focus — one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk to and work with community organizations, public health experts and people like you, who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth Shawnee Mission, we know that a healthy community is not a “one size fits all” proposition and believe everyone deserves a whole-health approach that meets them where they are and supports their individual health journey.

This work would not have been possible without the partnership of public-health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborations, AdventHealth Shawnee Mission will continue to create opportunities for better health in all the communities we serve.

In His service,

Michael Knecht
 CEO / President
 AdventHealth Shawnee Mission



Executive Summary

Shawnee Mission Medical Center d/b/a AdventHealth Shawnee Mission will be referred to in this document as AdventHealth Shawnee Mission or “the Hospital”. AdventHealth in Shawnee Mission, Kansas conducted a Community Health Needs Assessment from August 2021 to May 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community’s health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023 to 2025 Community Health Plan based on the needs prioritized in the assessment process.

Community Health Needs Assessment Committee

To ensure broad community input, AdventHealth Shawnee Mission created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met six times in 2021. They reviewed the primary and secondary data and helped to identify the top-priority needs in the community.

A list of CHNAC members can be found in Priorities Selection.

Hospital Health Needs Assessment Committee

AdventHealth Shawnee Mission also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospital would address because of the findings in the assessment. The HHNAC made this decision by reviewing the priority needs selected by the CHNAC and the internal hospital resources available. With this information, the HHNAC was able to determine where the Hospital could most-effectively support the community.

A list of HHNAC members can be found in Priorities Selection.

Data

AdventHealth Shawnee Mission, in collaboration with the AdventHealth Corporate team, collected both primary and secondary data. The primary data included stakeholder and community surveys. Secondary data included internal hospital utilization data (inpatient and emergency department). This utilization data showed the top diagnoses for visits to AdventHealth Shawnee Mission from 2019 to 2021. In addition, publicly available data was utilized from state and nationally recognized data sources. Primary and secondary data was compiled and analyzed to identify the top 10 issues.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a community asset inventory. This inventory was designed to help the CHNAC and the HHNAC understand existing community efforts to address the 10 identified issues from aggregate primary and secondary data and to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The CHNAC and HHNAC used a priority selection exercise that utilizes clearly defined criteria to select the top issues to address.

See Priorities Selection for more.



The priority selection criteria included:

Alignment: Does this issue align with our mission, strategy, public-health or community goals?

Impact on Community: What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?

Resources: Are there existing, effective interventions and opportunities to partner with the community to address this issue?

Outcome Opportunities: Can an impact on this issue be made in a demonstrable way, and will interventions have an impact on other health and social issues in the community?



Priority Issues to be Addressed

The priority issues to be addressed are:

1. Behavioral health: mental health and drug misuse
2. Nutrition and healthy eating
3. Preventative care and screenings

See *Priorities Addressed for more information.*

Approval

In December 2022, the AdventHealth Shawnee Mission Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2022.

Next Steps

AdventHealth Shawnee Mission will work with the CHNAC and the HHNAC to develop a measurable implementation strategy called the 2023 to 2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

About AdventHealth

AdventHealth Shawnee Mission is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 80,000 skilled and compassionate caregivers serve 4.7 million patients annually. From physician practices, hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, wholistic care at 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in research, new technologies and the people behind them to redefine medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of

the world's top two percent of scientists. These critical thinkers are changing medicine and shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation, recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. AdventHealth was recognized for its innovative digital front-door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentations and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its workplace culture, having been recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" three years straight. This recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth.

About AdventHealth Shawnee Mission

AdventHealth Shawnee Mission is at the core of AdventHealth's connected system of care in the Kansas City area. Throughout this report, we will refer to our facility as AdventHealth Shawnee Mission or the Hospital. Originally built in 1962, Shawnee Mission has grown from a small community hospital (Shawnee Mission Center) to a 504-bed acute care facility, with the busiest emergency department in Johnson County. Employing over 3,600 team members, including over 2,000 nurses, physicians and medical staff, the team at Shawnee Mission offers comprehensive care for all stages of life.

- The only hospital in Johnson County to receive the prestigious Baby-Friendly® designation
- One of only six hospitals in Kansas to achieve a CMS 5-Star Rating from the Centers of Medicare & Medicaid Services
- First hospital in a five-state area to use the da Vinci surgical robot — providing minimally invasive procedures that promote shorter recovery times
- The only certified member of MD Anderson Cancer Network®, a program of MD Anderson Cancer Center, delivering cancer care based on MD Anderson best practices and national standards
- For the 17th consecutive time, The Leapfrog Group, an independent national watchdog organization, awarded AdventHealth Shawnee Mission an "A" Hospital Safety Grade for achieving the highest national standards in patient safety. The Leapfrog Group assigns an "A", "B", "C", "D" or "F" grade to all general hospitals across the country.





COMMUNITY OVERVIEW

Community Description

Located in Johnson County, KS, AdventHealth Shawnee Mission identifies its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes 34 zip codes across Johnson, Wyandotte and Leavenworth counties.

According to the 2020 Census, the population in the Shawnee Mission Primary Service Area has grown 11.4% in the last ten years to 716,574 people. This is almost four times the amount of growth in the State of Kansas since the last Census. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention, unless indicated otherwise. Data are reported for the PSA, unless listed for a specific county.



Community Profile

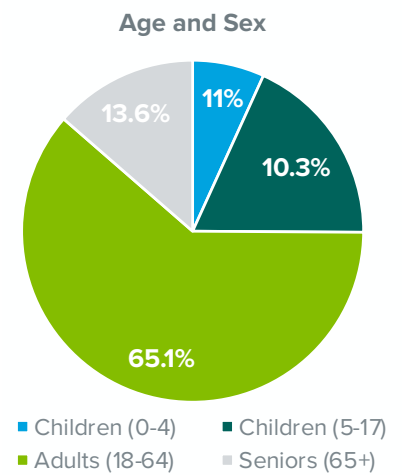
Age and Sex

The median age in the Hospital's community is 36.9, slightly lower than that of Kansas which is 37.2 and the US, 38.2.

Females are the majority, representing 50.9% of the population. Middle-aged women, 40-64 are the largest demographic in the community at 16.2%.

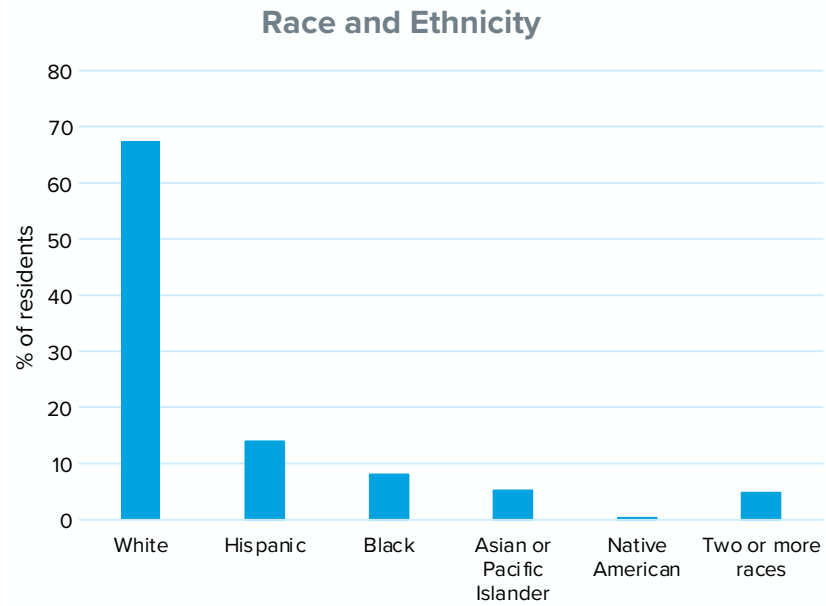
Children are 25.1% of the total population in the community. Infants, those zero to four, are 6.8% of that number. The community birth rate is 52.7 births per 1,000 women aged 15-50, this is higher than the US average of 50.4, but lower than that of the Kansas, 62.2. In the Hospital's community, 11% of children aged 0 to 4 and 10.3% of children aged 5 to 17 are in poverty.

Seniors, those 65 and older, represent 13.6% of the total population in the community. Females are 56.6% of the total senior population.



Race and Ethnicity

In the Shawnee Mission community, 67.4% of the residents are White, 13.9% are Hispanic, 8% are Black. Residents that are of Asian or Pacific Islander descent represent 5.2% of the total population, while .3% are Native American and 4.8% are two or more races.



Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so, when possible, the Hospital could align its work with national efforts when addressing social determinants of health. For the purposes of the CHNA the Hospital will follow this model for reporting any related data.



The Healthy People 2030 place-based framework outlines five areas of SDOH:

- Economic Stability:** This includes areas such as income, cost of living, food security and housing stability.
- Education Access and Quality:** This focuses on topics such as high school graduation rates, enrollment in higher education, literacy and early childhood education and development.
- Health Care Access and Quality:** This includes topics such as access to health care, access to primary care and health insurance coverage.
- Neighborhood and Built Environment:** This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.
- Social and Community Context:** This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability

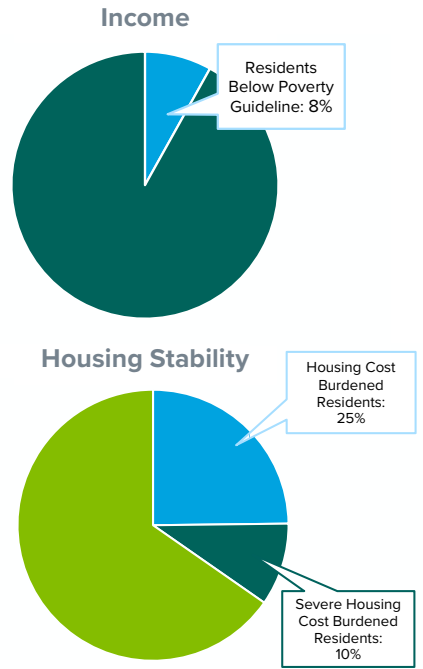
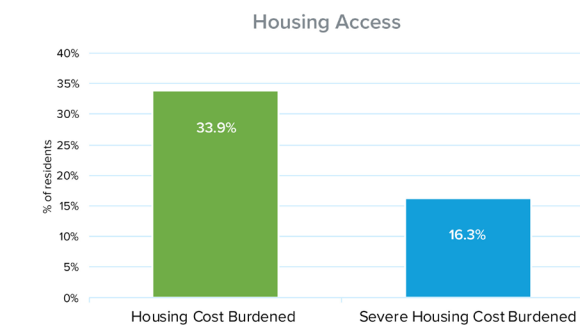
Income

The median household income in the Hospital's PSA is \$87,775. This is above the median for both the state and the US. Although above the median, 8.1% of residents live in poverty, the majority of whom are under the age of 18.

Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.¹ Feeding America estimates for 2020,² showed the food insecurity rate in the Hospital's community as 11.8%.

Increased evidence is showing a connection between stable and affordable housing and health.³ When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more the 50%.



¹ Food Insecurity - Healthy People 2030 | health.gov
² Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
³ Severe housing cost burden | County Health Rankings & Roadmaps

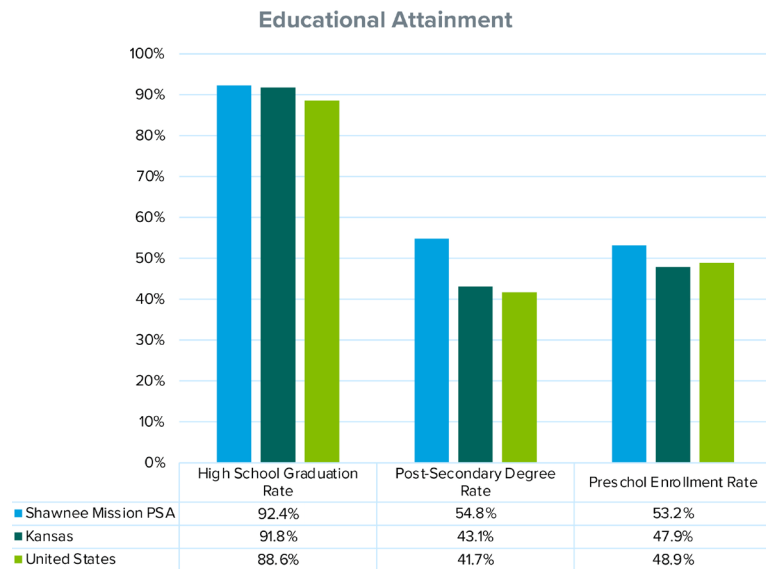
Education Access and Quality

Research shows education can be a predictor of health outcomes, as well a path to address inequality in communities.⁴ Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 92.4% high school graduation rate, which is higher than both the state and national average. The rate of people with a post-secondary degree is also higher in the Hospital's community than in both the state and nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs show that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.⁵

In the Hospital's community, 53.2% of 3–4-year-olds were enrolled in preschool. Although higher than both the state (47.9%) and the national (48.9%) average, there is still a large percentage of children in the community who may not be receiving these early foundational learnings.



⁴ The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

⁵ Early Childhood Education! Health Impact in 5 Years | Health System Transformation | AD for Policy | CDC

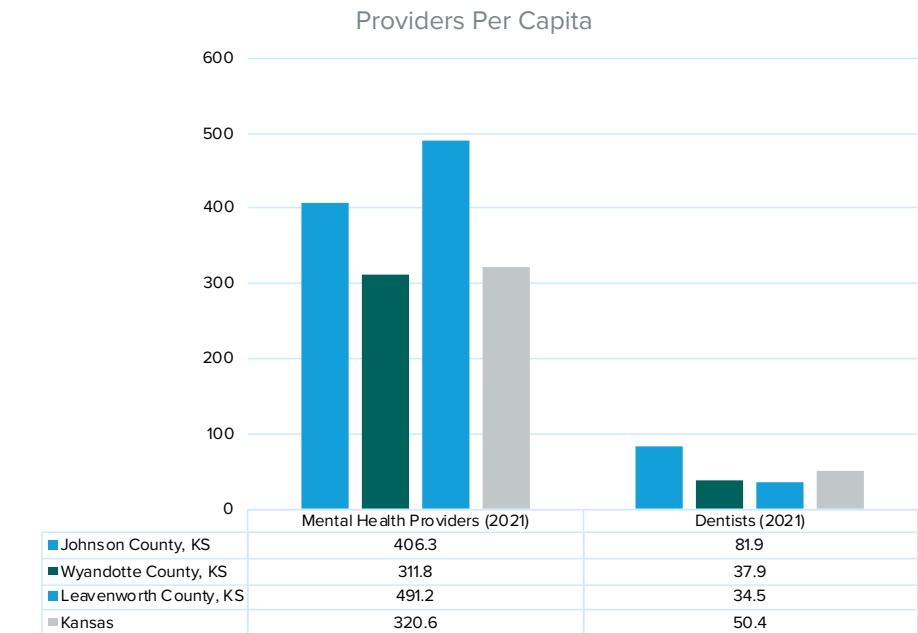
Health Care Access and Quality

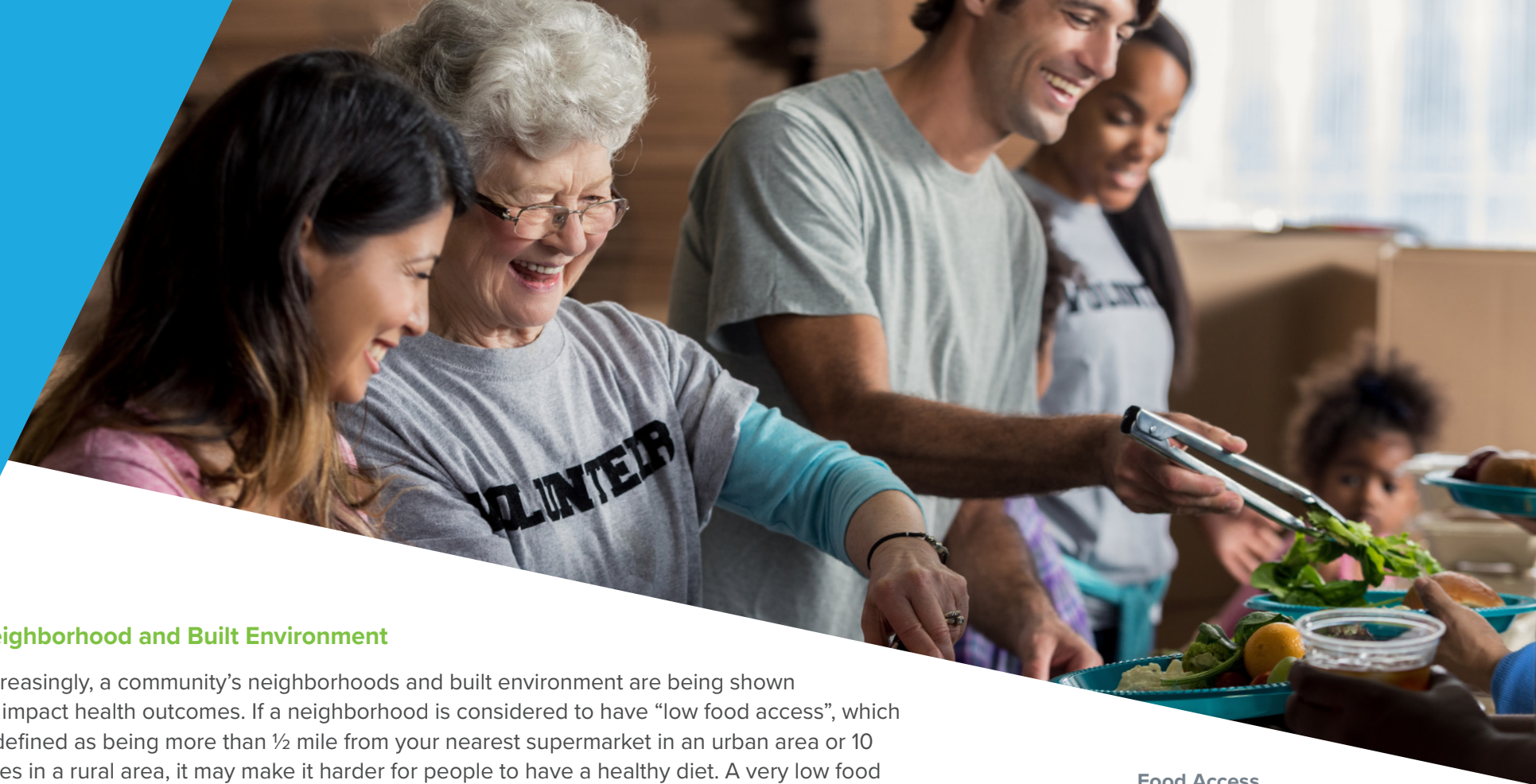
In 2019, 13.6% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person's ability to access care, there are other potential barriers that can delay care for many people.⁶

Accessing health care requires more than just insurance, there also need to be available health care professionals to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the counties that the Hospital serves, Johnson County has the most care providers available, higher than the state average.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 75.3% of people report visiting their doctor for routine care.

⁶ Health Insurance and Access to Care (cdc.gov)





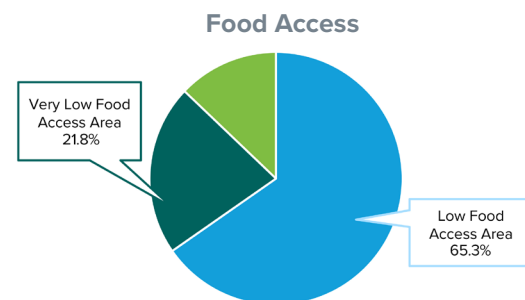
Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have "low food access", which is defined as being more than ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person's diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet.⁷ In the Hospital's PSA, 65.3% of the community lives in a low food access area, while 21.8% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and maintaining employment. In the Hospital's community, 4.4% of the households do not have an available vehicle.

⁷ A Neighborhood's Built Environment May Have Numerous Effects on Its Residents' Health - RWJF



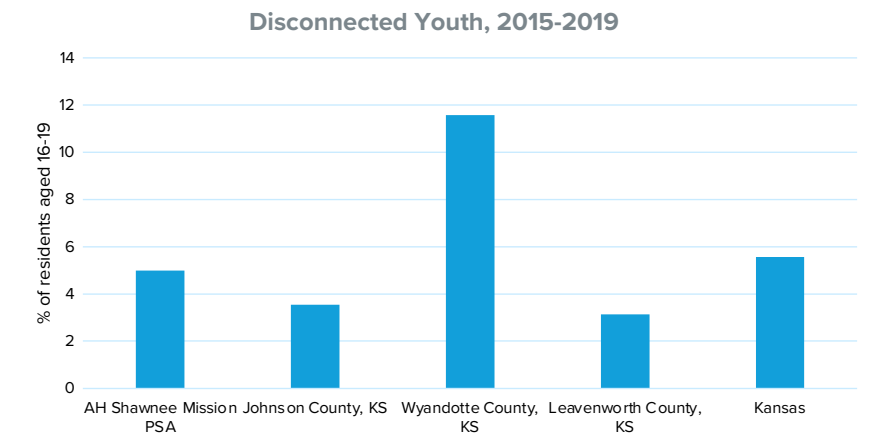
Social and Community Context

People's relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being.⁸ When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don't have connections to create them or there are barriers like language between groups.

In the Hospital's community, 4.9% of youth aged 16-19 were reported as disconnected, this means they were neither enrolled in school nor working at the time. The percentage of disconnected youth was highest in Wyandotte County at 11.6%.

Also, in the Hospital's community, 26.2% of seniors (age 65 and older) report living alone and 3.2% of residents report having limited English proficiency. Both these factors can create barriers to feeling connected in the community.

⁸ Social and Community Context - Healthy People 2030 | health.gov





Process, Methods and Findings

■ Process and Methods

The Process

The health of people living in the same community can be very different because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, the Hospital solicited input directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. The Hospital, aided by the AdventHealth Corporate team, also collected publicly available data and internal Hospital utilization data for review.

The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members, to form a Community Health Needs Assessment Committee (CHNAC) to guide the assessment process. During data review sessions, community members of the CHNAC provided insight on how health conditions and areas of need were impacting those they represented. The CHNAC used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2022 CHNA.

Community Input

The Hospital collected input directly from the community and from community stakeholders, individuals working in organizations addressing the needs and interests of the community. Input was collected through two different surveys, the community health survey and the stakeholder survey.

Community Health Survey

- Provided in both English and Spanish to anyone in the community and accessible through weblinks and QR codes.
- Links and QR codes were shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to electronic mailing lists, they maintained and when possible shared on their own social media channels.
- Paper surveys were given to partners to place at their organizations with the goal of reaching those who might not have access otherwise and experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.

Stakeholder Survey

- Participants were asked to provide input on health and barriers to health that they were seeing in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that work to improve the health and wellbeing of the community.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, underrepresented, lower income and/or who are more likely to be impacted by the social determinants of health.

Public and Community Health Experts Consulted

A total of 43 stakeholders provided their expertise and knowledge regarding their community. This included five members of the CHNAC whose names are bolded.

Name	Organization	Services Provided	Populations Served
Matt Martinek, VP Development	American Cancer Society	Research, education and programs for the prevention and treatment of cancers	Greater Kansas City Metro Community
Laura Lopez, Executive Director	American Heart Association	Research, education and programs advancing cardiovascular health	Greater Kansas City Metro Community
Mary Glover, Facility Supervisor	AMR Medical Transport	Transportation for health care and public health services	Those lacking transportation in the greater Kansas City metropolitan community
Julie, EMT	AMR Medical Transport	Transportation for health care and public health services	Those lacking transportation in the greater Kansas City metropolitan community.
Kristin Riott, Executive Director	Bridging The Gap, Inc.	Environment and sustainability through education and volunteer action	Greater Kansas City Metro Community
Anna Slocum, Director of Parks and Recreation	City of Merriam	Community recreation, fitness and wellness programming	Residents of all ages in Merriam, Kansas
Lindsey Constance, President	Climate Action KC	Climate resilience planning, solutions, education and advocacy	Greater Kansas City Metro community
Molly Gotobed, Program Director	Community Health Council of Wyandotte County	Health access through advocacy, collaboration and education	Vulnerable populations primarily in Wyandotte County
Carolina Biagi, Program Coordinator	Community Health Council of Wyandotte County	Health access through advocacy, collaboration and education	Vulnerable populations in Wyandotte County and neighboring counties
Larry White, Pastor	Community Impact Church	Faith organization	Ministry serving low income and Hispanics
Justin Gust, Director of Community Health	El Centro	Education, Community Health, Health Navigation, Food Assistance, Economic Empowerment, Advocacy	Latino individuals and families living in Johnson, Wyandotte and surrounding counties
Terrie VanZandt-Travis, Retiring Executive Director	Growing Futures Early Education Center, Inc.	Head Start early education at home and center-based and comprehensive family services	Low income and vulnerable families living in Johnson County
Jill Gaikowski, Executive Director	Happy Bottoms	Diaper Assistance and Potty Training Education	Low-income parents of infants and small children

Name	Organization	Services Provided	Populations Served
Jessica Kejr, Director of Programs	Harvesters—The Community Food Network	Food assistance, nutrition education and advocacy	Low-income individuals and families needing food assistance
Sondra Wallace, Dir. of Mental Health Programs	JFSKC (Jewish Family Services of Greater Kansas City)	Mental health, food assistance, older adult services, family life education and social work services	Individuals and families living in Greater Kansas City with an emphasis in supporting low income and vulnerable populations
Barbara Mitchell, Community Health Division Director	Johnson County Department of Health and Environment	Health care/public health; Leads County Community Health Assessment and the Community Health Network	Individuals and families living in Johnson County
Megan Foreman, Program Manager	Johnson County Department of Health and Environment	Health care/public health	Individuals and families living in Johnson County
Renee Bryant, Food Policy and Advocacy Coordinator	Johnson County Health and Environment	Health care/public health	Individuals and families living in Johnson County
Jeff Stewart, Executive Director	Johnson County Park and Recreation District	County parks and community activity and education programs	Individuals and families living in Johnson County
Carinda Trowbridge, QA/QI Manager	Kansas City Kansas Fire Department	Emergency Response	Families and individuals living in Kansas City, Kansas
Suzanne Robinson. APRN at Shawnee clinic	Mercy & Truth Medical Missions	Health services for the uninsured and low-income individuals	Low-income and vulnerable individuals and families living in Johnson and Wyandotte Counties
Cordelia Whitlatch, Family Physician	Mercy & Truth Medical Missions	Health services for the uninsured and low-income individuals	Low-income and vulnerable individuals and families living in Johnson or Wyandotte Counties
Geoffrey Kigenyi, CEO	Mercy and Truth Medical Missions	Health services for the uninsured and low-income individuals	Low-income and vulnerable individuals and families living in Johnson or Wyandotte Counties
Suzanne Wheeler, Executive Director/CEO	Mid-America LGBT Chamber of Commerce	LGBTQ+ Business Chamber	LGBTQ+ Community in the greater Kansas City
Marlene Nagel, Community Development Director	Mid-America Regional Council	Aging, health, early learning, economy, environment, safety and security planning and coordination and transportation	Bi-State Kansas City Region (9 Counties)

Name	Organization	Services Provided	Populations Served
Tom Jacobs, Director, Environmental Programs	Mid-America Regional Council	Aging, health, early learning, economy, environment, safety and security planning and coordination and transportation	Bi-State Kansas City Region (9 Counties)
Karen Clawson, Principal Planner/ Air Quality	Mid-America Regional Council (MARC)	Aging, health, early learning, economy, environment, safety and security planning and coordination and transportation	Bi-State Kansas City Region (9 Counties)
Julie Donelon, President & CEO	MOCSA	Sexual abuse / assault advocacy, counseling, prevention and education	Individuals experiencing (or at risk) of sexual abuse or assault
John Yost, Board Chair	Pharmacy of Grace, Inc	Affordable and sustainable prescription medication; and RX education	Uninsured and low-income individuals and families
Carla Gibson, Vice President of Programs	REACH Healthcare Foundation	Funding to support the health coverage divide, close the health equity gap, strengthen safety net, policy and advocacy	Vulnerable populations in the greater Kansas City metro
Kimberly Paul, Director of Community Programs	Safehome	Domestic violence support by providing shelter, counseling, legal support and community programs	Women experiencing in domestic violence
Abby Morgan, Shawanoë Principal	Shawanoë Elementary School	Education administration – Title 1 School	Elementary students and their families
Sylvia Terry, President/CEO	Shawnee Community Services	Food pantry, clothing assistance and financial support for immediate needs	Low-income individuals in northeast Johnson County and Wyandotte County
John McKinney, Director Family Services	Westside Family Church	Education/youth services, Food assistance, Financial support, Mental/behavioral health care, Employment assistance, Housing	Students and families of Shawnee Mission School District
Darla Denny, School Nurse	Shawnee Mission School District	Health and social services	Middle School Students
Shelby Rebeck, Director of Health Services	Shawnee Mission School District	Children and youth health services	Children, youth and families of Shawnee Mission School District
Laurie Eckert, School RN	Shawnee Mission School District	Health and social services –Title 1 School	Students and families living in a low-income neighborhood
Nicole Gawer, Social Worker	Shawnee Mission School District Shawanoë Elem.	Social services for students and families- Title 1 School	Students and families living in a low-income neighborhood
Paula Cutter-Mark, Constituent Services and Outreach Representative	The office of Representative Sharice Davids	Government	Individuals and families residing in Johnson and Wyandotte Counties

Name	Organization	Services Provided	Populations Served
Wesley McKain, Manager, Policy & Development	Unified Government of Wyandotte County / KCKS Public Health Dept	Health care/public health	Residents living in Wyandotte County and Kansas City, Kansas
Matt Adams, Pastor	Westside Family Church	Education/youth services, Food assistance, Financial support, Mental/behavioral health care, Employment assistance, Housing	Low-income and vulnerable individuals and families
Mary Beth Gentry, CEO, Executive Director	Young Women on the Move	Education/youth services, Mental/behavioral health care, Food assistance	Low-income middle and high school girls in Wyandotte County
Michelle Robin, Chief Wellness Officer	Your Wellness Connection	Chiropractic care, health and wellness,	Greater KC Metro Community

Secondary Data

To inform the assessment process, the Hospital collected existing health related and demographic data about the community from publicly available sources and Metopio¹, a web-based data platform. This included data on health conditions, social determinants of health and health behaviors.

The most current public data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Centers for Disease Control and Prevention
- Feeding America
- County Health Rankings
- The State Health Department

Hospital utilization data for 2019-2021 was also used in the assessment. Data was for uninsured or self-pay patients who visited the hospital for emergency department, inpatient or outpatient services. The top ten diagnosis codes were provided by the AdventHealth finance team.

¹Metopio – Ridiculously easy data tools to understand places and populations.



The Findings

Throughout the assessment process there were several themes from community input that rose to the top, which were mentioned across numerous issues and health needs, including:



Increasing Access: A need for more accessible entry points to care in the community, including for primary and mental health care, as well as social service supports, particularly for individuals who are undocumented.



Increasing Awareness: Better communication in the community on the care and services available.



Transportation: The barrier that a lack of transportation presents to accessing services in community.



Climate: Climate change and how it is impacting the environmental health of the community.



Discrimination: An increasing awareness that individuals in the community may or do receive unjust or prejudicial treatment on the grounds of race, ethnicity, age, sex or disability.



Childcare Subsidies: The rising cost of childcare and the impact on standard of living for individuals who are low-income.



Impact of Medicaid Expansion: A need to increase access to Medicaid to provide more health care coverage for individuals in need.



Economic Barriers: An increasing cost barrier to accessing care, products and services regardless of insurance and employment status.

When reviewing the data for prioritization, the CHNAC considered these themes and their impact on the communities whose interests they represented.

The areas of significant need identified in the assessment process were around:



Food Insecurity: Food insecurity exists when people do not have physical and economic access to sufficient safe and nutritious food that always meets their dietary needs and food preferences. Food insecurity has been linked to negative health outcomes in children and adults, as well as potentially causing trouble for children in schools.



Housing: Where people live and how people live directly affects their well-being. Research shows that individuals experiencing housing instability have limited access to preventive care and are more likely to have infectious diseases and chronic health conditions like diabetes, cardiovascular disease and chronic obstructive pulmonary disease. Homeless individuals also have a shorter lifespan.



Housing stability is another factor of housing, where housing instability can mean having housing with poor sanitation, heating and cooling; exposure to allergens or pests; and substandard housing structures.



Health Insurance and Health Care Access: Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications), and medical debt is common among both insured and uninsured individuals.



Transportation: Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities. Because transportation touches many aspects of a person's life, adequate and reliable transportation services are fundamental to healthy communities.



Asthma: Asthma is a disease that affects your lungs. It causes repeated episodes of wheezing, breathlessness, chest tightness and nighttime or early morning coughing. Asthma can be controlled by taking medicine and avoiding the triggers that can cause an attack. You must also remove the triggers in your environment that can make your asthma worse.



Cancer: Cancer is a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body. Cancer can start almost anywhere in the human body, which is made up of trillions of cells. Normally, human cells grow and multiply (through a process called cell division) to form new cells as the body needs them. When cells grow old or become damaged, they die and new cells take their place.

Sometimes this orderly process breaks down and abnormal or damaged cells grow and multiply when they shouldn't. These cells may form tumors, which are lumps of tissue. Tumors can be cancerous or not cancerous (benign).





Cardiovascular Disease: Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as those that affect your heart's muscle, valves or rhythm, also are considered forms of heart disease.



Diabetes: Diabetes is a group of diseases characterized by high blood sugar. When a person has diabetes, the body either does not make enough insulin (type 1) or is unable to properly use insulin (type 2). When the body does not have enough insulin or cannot use it properly, blood sugar (glucose) builds up in the blood. Prediabetes is a condition in which blood sugar is higher than normal but not high enough to be classified as diabetes.

People with diabetes can develop high blood pressure, high cholesterol and high triglycerides (a type of fat in the blood). High blood sugar, particularly when combined with high blood pressure and high triglycerides, can lead to heart disease, stroke, blindness, kidney failure, amputations of the legs and feet and even early death. Diabetes is also associated with increased risk of certain types of cancer, such as liver, pancreas, uterine, colon, breast and bladder cancer. High blood sugar also increases a person's chance of developing dementia and Alzheimer's disease.



Mental Health and Mental Health Disorders: Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day.

Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.



Pregnancy and Maternal Health: Women in the United States are more likely to die from childbirth than women living in other developed countries. Some women have health problems that start during pregnancy, and others have health problems before they get pregnant that could lead to complications during pregnancy.



Obesity: Obesity is a medical condition in which excess body fat has accumulated to an extent that it may have a negative effect on health. Obesity is measured by an individual's body mass index (BMI). The prevalence of obesity continues to increase in the United States. Obesity is common, serious and costly. This epidemic is putting a strain on American families, affecting overall health, health care costs, productivity and military readiness. Moreover, obesity can have negative health outcomes since obesity can lead to type 2 diabetes, heart disease and some cancers.



Substance Misuse – Alcohol & Drug: Substance use disorders can involve illicit drugs, prescription drugs or alcohol. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.



Tobacco Use: Smoking leads to disease and disability and harms nearly every organ of the body. Additionally, smoking causes cancer, heart disease, stroke, lung diseases, diabetes and chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Smoking also increases risk for tuberculosis, certain eye diseases and problems of the immune system, including rheumatoid arthritis. Secondhand smoke causes stroke, lung cancer and coronary heart disease in adults. Children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, middle ear disease, more severe asthma, respiratory symptoms and slowed lung growth.



Physical Health & Activity: Being physically active means movement of the body to get to and from places, for work or for leisure. Regular physical activity is proven to help prevent and manage noncommunicable diseases such as heart disease, stroke, diabetes and several cancers. It also helps prevent hypertension, maintain healthy body weight and can improve mental health, quality of life and well-being.



Preventative Care – Screenings: Prevention means intervening before health effects occur, through measures such as screenings, vaccinations, altering risky behaviors (poor eating habits, tobacco use) and banning substances known to be associated with a disease or health condition.



Nutrition & Healthy Eating: Nutrition is considered something that is taken into the body as food, influencing health, while healthy eating means eating a variety of foods that give you the nutrients you need to maintain your good health. Many people in the United States do not eat a healthy diet, which could be because some people do not have the information needed to choose healthy foods or do not have access to healthy foods or can not afford to buy enough food. People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes and other health problems.





PRIORITIES SELECTION

■ Prioritization Process

The Community Health Needs Assessment Committee through data review and discussion, narrowed the health needs of the community to a list of the top 10 priorities. Community partners on the CHNAC were looked to represent the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community. During Fall 2021 and Summer 2022 the CHNAC met six times to review and discuss the collected data and identify the top community needs to prioritize.

Members of the CHNAC included:

Community Members:

- Julie Brewer, Executive Director, United Community Services of Johnson County
- Susan Caman, CHIP Coordinator, Unified Government of Wyandotte County and Kansas City, Kansas
- Jill Chalfie, City of Shawnee Council Member and Trailridge Middle School PTA
- Stewart Curtright, Community Justice Program Coordinator, Church of the Resurrection
- Shalese Clay, Program Manager, Community Health Council of Wyandotte County (Cradle KC and Every Baby to 1)
- Amy Falk, CEO, Health Partnership Clinics (FQHC)
- Justin Gust, Director, Health Programs, El Centro

- Geoffrey Kigeny, CEO, Mercy & Truth Medical Missions (Safety Net Clinics)
- Donna Martin, Public Health Senior Planner / Project Manager for Double Up Food Bucks, Mid-America Regional Council
- Barbara Mitchell, Division Director, Johnson County Department of Health and Environment
- Shelby Rebeck, Director, Health Services, Shawnee Mission School District
- Catherine Rice, Vice President, Health Partnership Clinics
- Pam Shernuk, Chair, Johnson County Commission on Aging
- Sondra Wallace, Director of Mental Health Programs, Jewish Family Services of Kansas City

AdventHealth Team Members:

- Jeanette Metzler, Community Benefit Lead
- David Kennedy, Executive Director, Mission



Public Health Experts:

To identify the top needs the CHNAC took part in a prioritization activity. During the activity, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community and the resources available to address it. CHNAC members ranked the need based on established criteria through an online survey.

- Barbara Mitchell, Division Director, Johnson County Department of Health and leader of the Johnson County Community Health Assessment, Community Health Implementation Plan and the Community Health Network with over 100 community organizations
- Susan Carman, CHIP Coordinator, United Government of Wyandotte County and Kansas City, Kansas

After a list of 10 of the top health needs of the community had been selected by the CHNAC, a Hospital Health Needs Assessment Committee (HHNAC) met to review the top needs that had been chosen. The HHNAC reviewed the data behind the selected needs and the available resources to address them in the community. The HHNAC also considered the Hospitals current resources and strategies to find ways to address the needs most effectively.

Members of the HHNAC included:

- David Kennedy, Executive Director, Mission
- Molly Haase, Director, Advocacy
- Lisa Cummings, Manager, Community Wellness
- Laurie McCormack, Administrative Director, AdventHealth Foundation
- Julie Jenks, Project Coordinator, Human Resources
- Rennie Schuler-McKinney, Administrative Director, Behavioral Health Services
- Jimmy Bolanas, Regional Director Strategy
- Juliet Santos, Director, Population Health and Care Coordination

- Robin Harrold, Vice President, Network Strategy
- Doug Spear, Executive Director Marketing and Strategic Engagement
- Tricia Rausch, Perinatal Bereavement Coordinator, Birthing Center
- Connie Woods, Administrative Director, Oncology and Breast Centers



The needs found in the assessment were evaluated and scored by the CHNAC and the HHNAC on a scale of 1 to 5 (1=lowest, 2=low, 3=moderate, 4=high, 5=highest) using the criteria below:

- **Alignment:** Does this issue align with our mission, strategy, public health or community goals? (15%)
- **Impact on Community:** What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now? (25%)
- **Resources:** Are there existing, effective interventions and opportunities to partner with the community to address this issue? (30%)
- **Outcome Opportunities:** Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community? (30%)

The following needs rose to the top during the CHNAC’s discussion and prioritization activity:

Identified Issues	Alignment (15%)	Impact on Community (25%)	Resources (30%)	Outcome Opportunities (30%)	Total Ranking
Mental Health	4.75	4.92	3.58	4.50	4.37
Health Insurance and Access	4.64	4.91	3.09	4.45	4.19
Preventative Care — Screenings	4.50	4.58	3.58	4.08	4.12
Nutrition and Healthy Eating	4.42	4.58	3.58	4.00	4.08
Diabetes	4.25	4.42	3.50	4.17	4.04
Food Insecurity	4.18	4.18	3.64	4.00	3.96
Pregnancy and Maternal Health	4.25	3.83	3.42	4.25	3.90
Drug Misuse	4.25	4.33	3.08	4.17	3.90
Cardiovascular Disease: Hypertension	4.08	4.08	3.42	4.00	3.86
Housing	4.18	4.73	2.82	3.91	3.83

The HHNAC followed the same process as the CHNAC for prioritization, narrowing down the list to the top four priority needs:

Identified Issues	Alignment (15%)	Impact on Community (25%)	Resources (30%)	Outcome Opportunities (30%)	Total Ranking
Mental Health	4.91	4.91	4.27	4.27	4.53
Nutrition and Health Eating	4.91	4.82	3.82	4.45	4.42
Drug Misuse	4.27	4.55	3.55	4.18	4.10
Preventative Care — Screenings	4.45	4.18	3.64	3.91	3.98



Available Community Resources

As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the HHNAC chose which priorities to address. CHNAC members contributed to this review. Hospital resources are shown in green.

Top Ten Issues and Community Goals	Community Based Organizations and Coalitions	Current AdventHealth Programs & Support	Initiatives Under Development or Early Stages and Other Considerations
Mental Health	HPC Behavioral Health Vibrant Behavioral Health JC Mental Health Centers Prairie Ridge Psychiatric Hospital Cottonwood Springs Osawatomie Mental Health Greater KC Mental Health Coalition Jewish Family Services Young Women on the Move JC Suicide Prevention Coalition Black Health Care Coalition Good Faith Network Good Faith Network Doing justice in Johnson County, KS (fire.glass)	Behavioral health services Patient assessments for at risk patients crisis call line Feel Whole Community classes	SAMHSA releases toolkit for 988 crisis line partners AHA News KC Mental Health Coalition — Raising KC

Top Ten Issues and Community Goals	Community Based Organizations and Coalitions	Current AdventHealth Programs & Support	Initiatives Under Development or Early Stages and Other Considerations
Health Insurance and Health Care Access	Clinics: Health Partnership Clinics Vibrant Health County Health Departments, Mercy & Truth Clinics Jay-Doc Wy-Jo Care Duchesne Clinic Care Beyond the Boulevard (Mobile Clinic) Other: KC Medicine Cabinet	HealthFund Solutions (HFS) Nurse Line Bridge Care ED Financial Assistance Transportation vouchers	Pharmacy of Grace Home — Pharmacy Of Grace
Preventive Care — Screenings	Health clinics listed above Internal Medicine and Family Physicians Black Health Care Coalition	AH Medical Group, Cancer Center Mercy & Truth Saturday Clinics	Kansas Cancer Partnership currently finalizing 2022-2026 goals and implementation strategies
Nutrition and Healthy Eating	KC Healthy Kids Coalition Weighing In Coalition (CMH) CMH-Weighing-In, Am. Heart Association-Healthy Living On-Line Series Young Women on the Move	Whole Health Institute AH Community Wellness Programs AH dietitians	AH Plantwise (Promotes plant-centered eating) Food Is Medicine (AH FWD) (Includes screenings and education in food distribution and measures outcomes) PCRM — Healthy Food in Hospitals tool kit and consulting (Plant Centered Eating) Johnson County Save The Food (food waste) Temporarily on hold

Top Ten Issues and Community Goals	Community Based Organizations and Coalitions	Current AdventHealth Programs & Support	Initiatives Under Development or Early Stages and Other Considerations
Diabetes	American Diabetes Association Most hospitals provide diabetes education programs and support services Black Health Care Coalition	Diabetes Support Groups Stop Diabetes Before It Starts Whole Health Institute	Division of Diabetes Translation CDC CHWs of JCDHE (recently certified and looking to pilot a diabetes management program in Spanish)
Food (Nutrition) Insecurity	Harvesters & Food Pantries JC Service Centers CMH Weighing-In JC Food Policy Council Health Departments WIC Dotte Mobile Grocer Crosslines Community Outreach, Catholic Charities, Farmer's Markets Giving Grove KC Community Gardens After the Harvest (gleaning)	CHP Strategies targeted to Shawnee and KCKS neighborhoods Patient Insecurity Screenings and Referrals	Johnson County Transportation grant for food access linked with Health Care Grant. Hospitals and food insecurity AHA Trustee Services
Pregnancy & Maternal Health	Cradle KC Coalition FIMR Review Boards Uzazi Village (KCMO) New Birth Company, County prenatal services Fourth Trimester March of Dimes Black Health Care Coalition	Inpatient/ outpatient behavioral Education classes and support groups Parent call-line (24/7) Post-partum support Parent Care	CHC Council — Maternal Health Community Health Workers recently received word of additional grant funding Plans underway for CHC to provide AHSM with CHW for Medicaid Moms

Top Ten Issues and Community Goals	Community Based Organizations and Coalitions	Current AdventHealth Programs & Support	Initiatives Under Development or Early Stages and Other Considerations
Drug Misuse	Health Partnership Substance Abuse Program Behavioral Health Group Drug Enforcement Agency(DEA) DCCCA — Naloxone Program; Cottonwood Springs; Pharmacies JC Suicide Prevention Coalition Opioid Response Network https://opioidresponsenetwork.org/	Inpatient/ outpatient behavioral health services AHSM Pharmacy RX disposal service	JJC Mental Health — Community Collaboration: Opioid Use Prevention — (1st meeting 4/21/2022)
Chronic Disease: Hypertension AHSM-CHP (Chronic Disease)	Health clinics and physician groups (screening and treating) Stand-Alone Blood Pressure Stations (Drug stores and pharmacies) Black Health Care Coalition	Community wellness programs (nutrition, stress management, chronic disease specific) Move 4 Life CPR Programs (includes prevention)	
Housing	United Community Services JC and WC Housing Authorities Catholic Charities Weatherization Assistance Program (ECKAN) Johnson County Interfaith Hospitality Network Hillcrest Transitional Housing COR Housing & Construction Ministry KS Homeowners Assistance Fund Good Faith Network Good Faith Network Doing justice in Johnson County, KS (fire.glass)		Partnering with Health Systems on Affordable Housing Investments (planning.org) How Can Hospitals Invest in Affordable Housing? (managedhealthcareexecutive.com) Investing in Community Health_Toolkit.pdf (centerforcommunityinvestment.org)



Priorities Addressed

Because of the connection between mental health disorders and drug use, the Hospital made the decision to address both needs together under the priority of Behavioral Health.



Priority 1: Behavioral Health: Mental Health and Drug Misuse:

In the Hospital's community, 19.3% of residents have a prevalence of depression, while 12.7% of the residents report poor mental health. According to community survey respondents more than 25% have been diagnosed with a depressive order and more than 26% have been diagnosed with an anxiety disorder. Almost 60% of the community and stakeholders surveyed do not believe

the community is good at treating mental health. There is also a need to address drug misuse in the community. According to the Hospital's community survey, 36.8% of respondents reported taking prescription medication for non-medical reasons, while 33.3% believe that people in the community are addicted to street drugs.

Awareness of and the need to address mental health disorders, as well as a growing fentanyl crisis, has been increasing in the country. By addressing mental health and drug misuse as a priority, the Hospital can align to local, state and national efforts for resources to create better outcomes opportunities over the next three years.



Priority 2: Nutrition and Healthy Eating:

More than 41% of community survey respondents reported eating fruits and vegetables less than two days a week. Nutrition is known to be a critical influencer of health. Healthy eating improves maternal health and health at every stage of life. It builds stronger immune systems, lowers the risk of chronic diseases like diabetes and cardiovascular disease, while increasing longevity. By addressing nutrition and healthy eating, the Hospital hopes to improve the overall health of the community. This will impact the multiple health conditions identified in the assessment process as well as food security challenges.



Priority 3: Preventative Care and Screenings:

According to community survey respondents, 33.5% are not aware of what preventative screenings are needed. Public data shows that less than 40% of community seniors are up to date on necessary core preventative services. Preventative care has been shown to reduce the risk of disease, disabilities and death. Preventative care also improves health outcomes, quality of life and can decrease an individual's cost of care over time through early detection.

The Hospital will address preventative care and screenings through efforts that will have impacts on other issues identified in the assessment process including hypertension, pregnancy and maternal health and health care access and insurance.



Priorities Not Addressed



Health Insurance and Access:

In the Hospital's community, 13.6% of residents had no health insurance, according to public data. Of community survey respondents, 6% were uninsured. A need for increasing access to available services was heard from community and stakeholder survey respondents as well.

The Hospital believes that other organizations are better positioned in the community to address this and will support those efforts when able in the Community Health Plan through the preventative care and screenings priority.



Food Insecurity:

More than 11% of the residents in the Hospital's community are food insecure according to Feeding America and 65.3% live in a low food access area. According to community survey respondents, 46.1% received SNAP benefits last year, while 40.8 felt they ate less than they should have due to cost.

The Hospital believes that other organizations are better positioned in the community to address this need directly and will support those efforts when able in the Community Health Plan through the nutrition and healthy eating priority.



Cardiovascular Disease – Hypertension:

Thirty percent of residents in the Hospital's community have been told they have hypertension per public data. The number of community survey respondents reporting hypertension is even higher at 35.3% and hypertension related conditions are shown to be one of the top ten codes in Hospital visits by uninsured patients.

The Hospital did not select hypertension as a priority, as it is not positioned to directly address this in the community at large. The Hospital did choose nutrition and healthy eating however knowing that how individual eats is an integral step in treating hypertension and hopes to have an indirect impact through these efforts.



Diabetes:

Diabetes is shown to impact 8.7% of residents in the Hospital's community according to public data, while 25.9% of community survey respondents report having diabetes. Diabetes related conditions are also shown to be one of the top ten codes in Hospital visits by uninsured patients.

The Hospital did not select diabetes as a priority, as it is not positioned to directly address this in the community at large. The Hospital did choose nutrition and healthy eating however knowing that how individual eats is a factor in diabetes and hopes to have an indirect impact on diabetes through these efforts.



Pregnancy and Maternal Health:

In Wyandotte County, only 70.1% of mothers who give birth receive prenatal care in the first trimester and the premature birth rate is at 12.9%, higher than in the rest of the country. There is also a higher infant mortality rate in Wyandotte County than in the US.

The Hospital did not select pregnancy and maternal health as a priority but will support other community partners where possible in their efforts.

The Hospital did choose preventative care and screenings, however, knowing that preventive care is an important factor in maternal health and maternal health outcomes and hopes to have an indirect impact through these efforts.



Housing:

In the Hospital's community, 24.8% of residents are housing cost-burdened paying over 30% of their income to housing costs per public data. According to community survey respondents 44.1% report being worried they would not have stable housing in the next two months. More than 70% of the community and public health experts surveyed do not consider housing in the area affordable.

The need for safe and affordable housing in the community is significant, however the Hospital did not perceive the ability to have a measurable impact on the issue within the three years allotted for the for the Community Health Plan with the current resources available to the community and the Hospital at this time.





COMMUNITY HEALTH PLAN

Next Steps

The CHNAC will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the hospital board annually.

A link to the Community Health Plan will be posted on [AdventHealth.com](https://www.adventhealth.com) prior to May 15, 2023.



2020 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a brief summary of progress made on our most recent plan. The full summary is available upon request.

Lack of Resources to Meet Community Mental and Behavioral Health

In the 2019 CHNA, the Hospital selected the Lack of Resources to Meet Community and Behavioral Health as a priority. During the assessment, survey data showed the community believed mental health was of high importance but didn't believe it was treated like it. Data showed that 8.6% of residents in Johnson County and 13.4% of residents in Wyandotte County indicated that their mental health was "not good" on 14+ days in the past month. Suicide rates in both counties were higher than the Healthy People 2020 goal of 10.2 per 100,000.

Since adopting this plan, the Hospital has worked with numerous partners to increase program referrals, provide education and training on mental health, as well as provide assessments and connect residents to needed resources and support. Some of the results of these efforts include, 13 clients referred for Medical Assistance Treatment; almost 1300 adults and students trained in programs on how to identify and support mental health needs; more than 800 assessments to evaluate suicide safety risk; and support and connection to resources for more 3,000 individuals through a crisis line.

Rising Health Care Costs and Lack of Health Insurance

Rising Health Care Costs and Lack of Health Insurance was also a priority. Survey respondents in the assessment ranked "Health Insurance for All" of the highest importance in the community, but with the lowest satisfaction. The rate of uninsured adults in Wyandotte County was 22.3% and 7.85% in Johnson County. When asked, 25% of residents in Johnson County said they were worried or stressed about paying their medical bills.

The Hospital has focused their efforts on increasing access to health insurance for community members and establishing residents with medical homes. Since the adopting the plan, the Hospital has signed up 31 residents for health care coverage and provided the resources for signing up to 425 families. The Hospital has also connected 100 residents with medical homes and provided over \$123,000 in funding to local safety net clinics to increase capacity.

Chronic Disease Health Disparities in Communities of Color

The Hospital selected Chronic Disease Health Disparities in Communities of Color as the third priority. Data collected for the 2019 CHNA found hospital admission rates for diabetes, stroke, heart disease and congestive heart failure were significantly higher for Blacks than Whites. Because chronic disease can be closely linked to lifestyle behavior and food, the Hospital included increasing access to healthy food as a strategy to address the priority.

The Hospital has focused its efforts on the one-mile area around the intersection of 31st and Minnesota. To date, over 400 refugee families in the area have received resources to sign-up for food assistance and 125 families have received meal kits. The Hospital has also provided classes on health nutrition and healthy lifestyle choices to 811 residents.

Poor Pregnancy Outcomes in Wyandotte County

Poor Pregnancy Outcomes in Wyandotte County was the fourth priority. The 2019 assessment found that 27% of expecting mothers in Wyandotte County received no or late prenatal care, while 8.5% smoked during their pregnancy. The Hospital delivers more than 5,000 babies a year and has excellent prenatal and parental resources that could be used.

The Hospital has focused efforts on providing education and support to new moms and families in the community. Some of the results include identifying 552 new moms experiencing postpartum depression and connecting them to the support that was right for them, for some this was in support groups, for others via individual phone conversations. The Hospital also provides a free 24-7 phone number for new and expecting parents with questions to call when they need support, which served almost 1,200 people in 2021.



■ 2020 Community Health Plan Comments

We posted a link to the most recently conducted CHNA and most recently adopted 2020 Community Health Plan on our hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.





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CHNA Approved by the Hospital Board on: December 15, 2022

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