

ASCENSION ST. VINCENT'S RIVERSIDE CHNA

Developed in collaboration with The Jacksonville Nonprofit Hospital Partnership

Prepared by Blue Zones, LLC

2025



Scott Kashman, MHA, FACHE
President and CEO
Ascension St. Vincent's Riverside

I am honored to serve as the President and CEO of Ascension St. Vincent's Riverside hospital. Deeply rooted in our community for over 100 years, the Daughters of Charity founded our hospital in 1916. Since then, our Ministry of the Catholic Church has served our neighbors, with special attention to those struggling most.

St. Vincent's Riverside is a destination for award-winning specialty care. This includes heart and vascular, stroke, brain and spine, lung health, cancer, orthopedics, weight-loss surgery, and women's health. We offer a wide range of minimally-invasive procedures, imaging and lab tests, all on one campus. We're humbled to consistently be recognized for our quality and safety measures. This year, we were named a top-15 health system by Fortune/PINC AI and a Best Regional Hospital by Newsweek. These recognitions are a testament to our physicians' and care teams' commitment to our patients and a reflection of our devotion to our Ministry's values and our commitment to delivering personalized care through listening and compassion. We will continue to expand these services to meet the growing needs of our community.

Our commitment to Northeast Florida goes well beyond the walls of our hospital. We are blessed to be able to support local organizations such as JAXUSA, Feeding Northeast Florida and Jacksonville Civic Council. These partnerships are an integral part of our broader mission to enhance the health of our neighbors. However, our most significant commitment is to the most vulnerable members of Northeast Florida. Our initiatives, including the Mobile Health Outreach Clinic, Dispensary of Hope, and our various community benefit and outreach initiatives, are a testament to this commitment. We value each member of our community and strive to impact their lives positively.



Ascension St. Vincent's Riverside

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Executive Summary

The Community Health Needs Assessment (CHNA) represents a significant commitment by nonprofit hospitals to improve health outcomes in the communities they serve through rigorous assessment of the community's health status, incorporation of stakeholders' perspectives, and adoption of related implementation strategies to address priority health needs. The CHNA is conducted not only to meet federal requirements of the Affordable Care Act of 2010 ("ACA") and of Section 501(r)(3) of the Internal Revenue Code, but also to guide community investments of nonprofit hospitals that will have a sustainable impact on community health and well-being.

For its 2025 CHNA, Ascension St. Vincent's Riverside collaborated with the Jacksonville nonprofit Hospital Partnership (JNHP). Comprised of the five non-profit health systems serving Northeast Florida, JNHP selected an approach that would align with and deepen what is already known about the communities they serve. This approach began with a framework that included twelve categories of community health needs commonly identified within the social determinants of health literature, organized across three domains – People, Places and Equity. Each health needs category had several sub-categories, or drivers, associated with it. Using a deductive interview approach, input was gathered from those representing the broad interests of the communities served, including local public health representatives, community-based organizations, and medical providers. Input was also gathered from under-resourced populations and community members experiencing health needs through intercept surveys conducted in the five-county region.



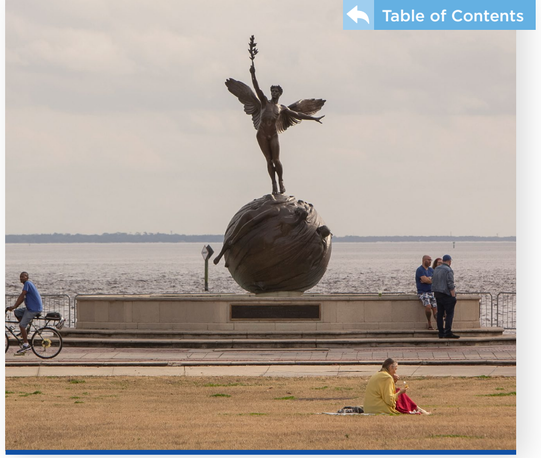
Using the primary data collected from the interviews and the community members as well as secondary data sources, a prioritization analysis was conducted across all twelve health needs categories and their drivers to determine the most significant health needs. The four health needs categories scoring the highest, along with the highest scoring drivers for each are:

1. Access to Care
- Health Insurance
- Transportation

2. Housing
- Housing Cost Burden
- Homelessness

3. Mental Health
- Access to Mental Health Care

4. Food Environment
- Access to Healthy Food
- Food Insecurity



In the remainder of this report, you will find information and details related to:

- The Jacksonville Nonprofit Hospital Partnership, Ascension St. Vincent's Riverside, and the communities they serve (Section I)
- The Community Health Improvement Strategies implemented following the prior CHNA (Section II)
- A Deep Dive into the top four prioritized significant health needs (Section III)
- The process used to determine the prioritized significant health needs (Section IV)



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ADDITIONAL RESOURCES

A linked document throughout the report which includes the impact evaluation of the implementation strategies, the resources to meet health needs, and the list of the readout participants.



Ascension St. Vincent's Riverside

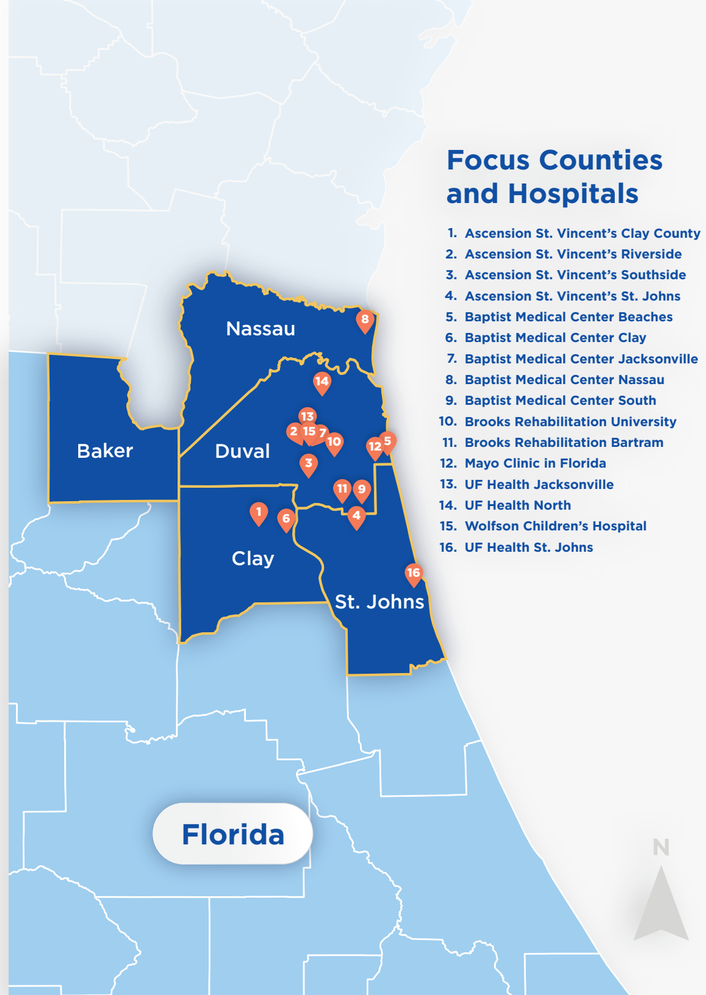
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Section I

About Us

About the Jacksonville Nonprofit Hospital Partnership

The Jacksonville Nonprofit Hospital Partnership (JNHP) is comprised of the comprehensive network of nonprofit hospitals and health systems in Northeast Florida, which is a key region in Florida's healthcare landscape. The region comprises five counties: Baker, Clay, Duval, Nassau, and St. Johns and includes the top-rated healthcare systems of Ascension St. Vincent's, Baptist Health, Brooks Rehabilitation, Mayo Clinic in Florida, and University of Florida Health. Collectively, the health systems operate sixteen hospitals in the region (see map), with the newest being UF Health St. Johns. UF Health acquired Flagler Health+ in 2023, renaming it UF Health St. Johns. The JNHP added UF Health St. Johns to its partnership in August 2024, allowing for the alignment of the CHNA process and timing with all UF Health hospitals.



Focus Counties and Hospitals

1. Ascension St. Vincent's Clay County
2. Ascension St. Vincent's Riverside
3. Ascension St. Vincent's Southside
4. Ascension St. Vincent's St. Johns
5. Baptist Medical Center Beaches
6. Baptist Medical Center Clay
7. Baptist Medical Center Jacksonville
8. Baptist Medical Center Nassau
9. Baptist Medical Center South
10. Brooks Rehabilitation University
11. Brooks Rehabilitation Bartram
12. Mayo Clinic in Florida
13. UF Health Jacksonville
14. UF Health North
15. Wolfson Children's Hospital
16. UF Health St. Johns



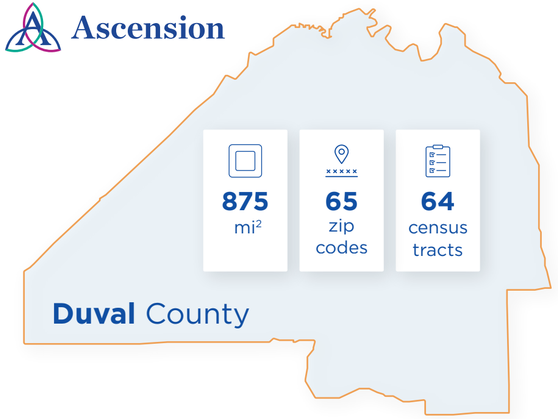
This robust network of hospitals ensures that residents have access to a wide range of services, from primary care to emergency services and specialized medical treatments. The presence of leading institutions such as the strong academic and clinical research focus UF Health highlights the region's commitment to advanced health care provision and cutting-edge medical research. The health care infrastructure of the region not only supports local communities but also attracts patients from across the United States, contributing significantly to the region's economy and positioning Northeast Florida as a hub for medical excellence.

About Ascension St. Vincent's Riverside

Ascension St. Vincent's Riverside (ASV Riverside) is a faith-based, not-for-profit hospital that serves the people of Jacksonville, Florida. It serves the 65 zip codes and 64 census tract areas with 875 square miles of Duval County. It was founded in 1916 by the Daughters of Charity and is part of Ascension, the largest Catholic and non-profit healthcare system nationwide. The hospital is the first in the county to be accredited by the National Accreditation Program for Breast Centers. Ascension St. Vincent's Riverside also has a partnership with Mayo Clinic through which it provides cancer care to residents. It provides 24/7 emergency care, as well as advanced surgical care for serious and life-threatening injuries and illnesses. Specialty services include heart and vascular care, advanced care for respiratory illness and sleep apnea, neurologic specialty care, and emergency care services. The hospital also provides a range of primary care services such as physicals, screening tests, urgent care, and treatments for existing health conditions.

Duval County, located in the northeastern part of Florida, is home to approximately 1,040,655 people. It is made up of five key communities – Jacksonville, Jacksonville Beach, Atlantic Beach, Neptune Beach, and Baldwin. It is a predominantly urban area and includes Jacksonville, the largest city by landmass in the continental U.S. The coastline of the county provides access to several public beaches, and activities such as boating, seaside dining, bicycling, and surfing are common in the county.

Ascension



HEART AND VASCULAR CARE

ADVANCED CARE FOR RESPIRATORY ILLNESS AND SLEEP APNEA

NEUROLOGIC SPECIALTY CARE

EMERGENCY CARE SERVICES

PHYSICALS

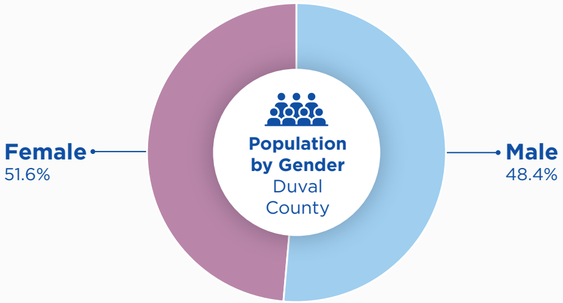
SCREENING TESTS

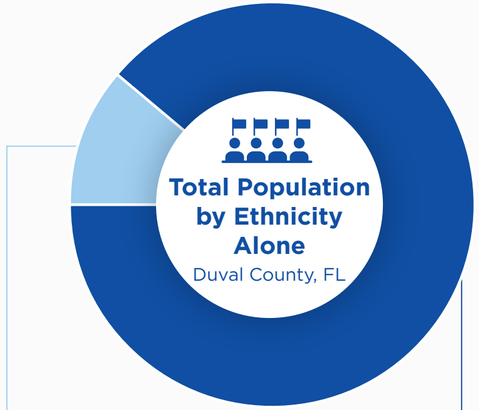
NEUROLOGY

OTHERS

Who We Serve

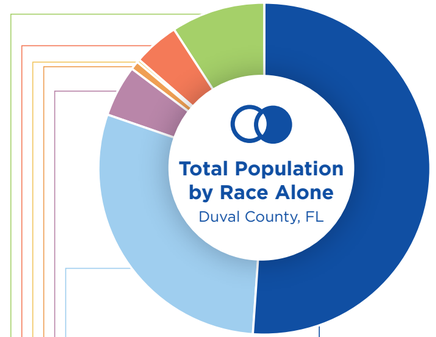
ASV Riverside serves Duval County with its population of over 1 million people across 875 square miles. This populations is 48% male and 52% female (nonbinary or gender-nonconforming were not choices in the 2020 census), with just over 21% under 18 years of age. From a race and ethnicity perspective, just over 50% of the population identifies as white and 89% as non-Hispanic.





11.3% **Hispanic or Latino Population**

88.7% **Non-Hispanic Population**



51.7% **White**

29.4% **Black**

5.0% **Asian**

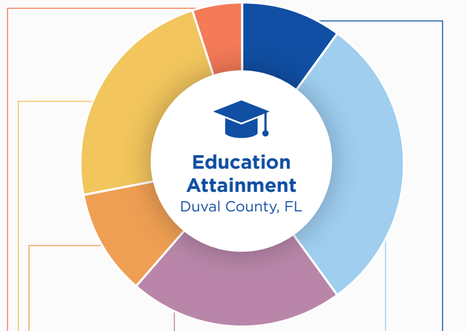
0.4% **American Indian / Aslaska Native**

0.1% **Native Hawaiian / Pacific Islander**

4.5% **Some Other Race**

9.0% **Multiple Races**

Data Source: US Census Bureau, American Community Survey, 2018-22



- 9.3% **No High School Degreee**
- 27.9% **High School Only**
- 20.9% **Some College**
- 9.7% **Associate's Degree**
- 21.5% **Bachelor's Degree**
- 10.8% **Graduate or Professional Degree**

36.6 yr.
DUVAL
MEDIAN AGE

12.98%
DUVAL
POPULATION WITH ANY DISABILITY

65+ years
14.73%
DUVAL
POPULATION OVER 65

14.34%
DUVAL
POVERTY RATE

SNAP
14.95%
DUVAL
HOUSEHOLDS RECEIVING SNAP BENEFITS

$65,579
DUVAL
MEDIAN HOUSEHOLD INCOME

Data Source: US Census Bureau, American Community Survey. 2018-22

JNHP Hospitals' Service Areas

For reference, the specific Northeast Florida counties served by each hospital in the JNHP is set forth in the table below. Notably, the specialty hospitals - Brooks Rehabilitation Hospital and Wolfson Children's Hospital – serve all five counties as regional referral centers.

Hospitals	Hospital Campus Service Areas				
	Clay	Duval	St. Johns	Nassau	Baker
Ascension St. Vincent's Clay County	✓				
Baptist Medical Center Clay	✓				
Ascension St. Vincent's Riverside		✓			
Ascension St. Vincent's Southside		✓			
Baptist Medical Center Jacksonville		✓			
UF Health Jacksonville		✓			
Baptist Medical Center South		✓	✓		
Baptist Medical Center Beaches		✓	✓		
Mayo Clinic in Florida		✓	✓		
Ascension St. Vincent's St. Johns		✓	✓		
UF Health North		✓		✓	
Baptist Medical Center Nassau				✓	
UF Health St. Johns			✓		
Wolfson Children's Hospital	✓	✓	✓	✓	✓
Brooks Rehabilitation (2 campuses)	✓	✓	✓	✓	✓

Health Status of Service Areas

The following data demonstrates the state of health of the service area population. The leading causes of death indicate not only the mortality from these diseases, but they also largely indicate the underlying disease prevalence leading to death. The leading causes of deaths and hospitalizations are further provided with a race and ethnicity view so disparities may be brought to light. The specific cancer deaths reflect the top three types of cancer by incidence.

Report Area	2022 Total Deaths	% Change from 2019	2022 Leading Causes of Death									
Florida	**238,953**	**15%**	Heart Disease **20.86%**	Cancer **19.66%**	Unintentional Injury **7.17%**	Stroke **6.85%**	COVID-19 **5.09%**
Baker County	**330**	**26%**	Heart Disease **25.15%**	Cancer **20.30%**	Unintentional Injury **9.70%**	Chronic Lower Respiratory Disease **5.76%**	COVID-19 **4.55%**
Clay County	**2,336**	**21%**	Cancer **19.82%**	Heart Disease **17.51%**	Unintentional Injury **7.11%**	Chronic Lower Respiratory Disease **5.44%**	Stroke **5.14%**
Duval County	**9,879**	**13%**	Cancer **19.18%**	Heart Disease **17.59%**	Unintentional Injury **8.63%**	Stroke **6.16%**	COVID-19 **4.99%**
Nassau County	**1,156**	**24%**	Cancer **21.02%**	Heart Disease **18.94%**	Unintentional Injury **7.70%**	Chronic Lower Respiratory Disease **5.62%**	Stroke **5.62%**
St. Johns County	**2,622**	**24%**	Cancer **22.01%**	Heart Disease **18.92%**	Stroke **5.64%**	Unintentional Injury **5.45%**	COVID-19 **4.61%**

Chronic Diseases Indicator	Baker County Age-Adjusted per 100,000 Pop.	Clay County Age-Adjusted per 100,000 Pop.	Duval County Age-Adjusted per 100,000 Pop.	Nassau County Age-Adjusted per 100,000 Pop.	St. Johns County Age-Adjusted per 100,000 Pop.	Florida Age-Adjusted per 100,000 Pop.
Heart Disease Deaths	**267.7**	**166**	**158.3**	**162.1**	**121.4**	**146.9**
White	291.2	167.8	154.3	164	119.9	144.3
Black	124.5	216.5	179.9	108.6	158.9	166.2
Hispanic	0	96	85.7	153.8	87.3	112.9
Non-Hispanic	272.6	166.9	160.1	161.3	123.5	154.6
Stroke Deaths	**47.6**	**50.8**	**57**	**49**	**36.1**	**47.6**
White	38.1	49.6	51	51	36.2	45.4
Black	0	70.3	79.8	17.7	51.4	65.1
Hispanic	0	26.8	50.6	47	37.2	46.9
Non-Hispanic	34.4	52.1	57.3	49.2	36.2	47.9
Cancer Deaths - Female Breast	**19.5**	**20.2**	**18.9**	**21.6**	**19.8**	**19**
White	14.5	22.7	20.1	23.4	19.5	18.2
Black	0	16.4	31.7	0	38	22.7
Hispanic	640.6	58.6	19	77.5	9.4	15
Non-Hispanic	13.1	17.2	18.9	20.8	19.8	20.1
Cancer Deaths - Lung	**55.8**	**39.6**	**34.8**	**37.5**	**23.9**	**29.7**
White	60.8	40.3	37.5	38.4	24.6	30.6
Black	25.4	16.9	27.1	16.3	25.8	24.2
Hispanic	0	17.4	26.7	18.6	3.5	18.8
Non-Hispanic	56.9	41	35.5	37.8	24.9	32.1

Data Source: Florida Charts 2022

Chronic Diseases Indicator	Baker County Age-Adjusted per 100,000 Pop.	Clay County Age-Adjusted per 100,000 Pop.	Duval County Age-Adjusted per 100,000 Pop.	Nassau County Age-Adjusted per 100,000 Pop.	St. Johns County Age-Adjusted per 100,000 Pop.	Florida Age-Adjusted per 100,000 Pop.
Cancer Deaths - Prostate	**23.4**	**22**	**22.3**	**19.4**	**17.7**	**17.4**
White	20.4	20.1	17.1	17.2	17	15.8
Black	0	17.6	44	96.1	55.9	35
Hispanic	244.6	8.2	14.2	119.3	34.6	18.2
Non-Hispanic	18.4	22.6	22.8	17.9	17.1	17.2
Hospitalizations from or with Heart Failure	**1,824.70**	**1,698.90**	**1,848.00**	**1,381.30**	**1,014.80**	**1,349.30**
White	1,752.50	1,588.20	1,473.20	1,359.50	942.7	1,150.70
Black	2,118.50	2,534.10	2,713.70	1,588.40	1,980.70	2,119.10
Hispanic	1,040.50	847.7	920.3	602.8	523.6	1,057.50
Non-Hispanic	1,784.80	1,714.20	1,879.20	1,351.50	1,013.20	1,408.00
Hospitalizations from or with Diabetes	**2,978.30**	**2,775.50**	**2,909.80**	**1,944.00**	**1,336.00**	**2,218.40**
White	2,815.00	1,803.00	2,225.20	1,850.70	1,198.60	1,803.00
Black	3,966.20	3,736.50	4,377.00	3,222.70	3,092.50	3,736.50
Hispanic	2,422.80	1,747.50	1,700.00	963.5	962	2,162.10
Non-Hispanic	2,914.10	2,785.00	2,944.30	1,925.30	1,318.30	2,212.00
Hospitalizations from or with Hypertension	**5,961.50**	**6,064.70**	**6,054.40**	**4,699.50**	**3,500.90**	**4,742.30**
White	5,783.30	5,748.00	5,098.80	4,570.60	3,302.20	4,103.70
Black	6,814.40	7,449.90	8,005.70	5,821.40	5,613.80	6,790.00
Hispanic	4,769.30	3,044.80	3,027.00	2,068.50	1,853.90	3,858.50
Non-Hispanic	5,814.50	6,125.40	6,145.00	4,625.40	3,469.60	4,907.70

Data Source: Florida Charts 2022





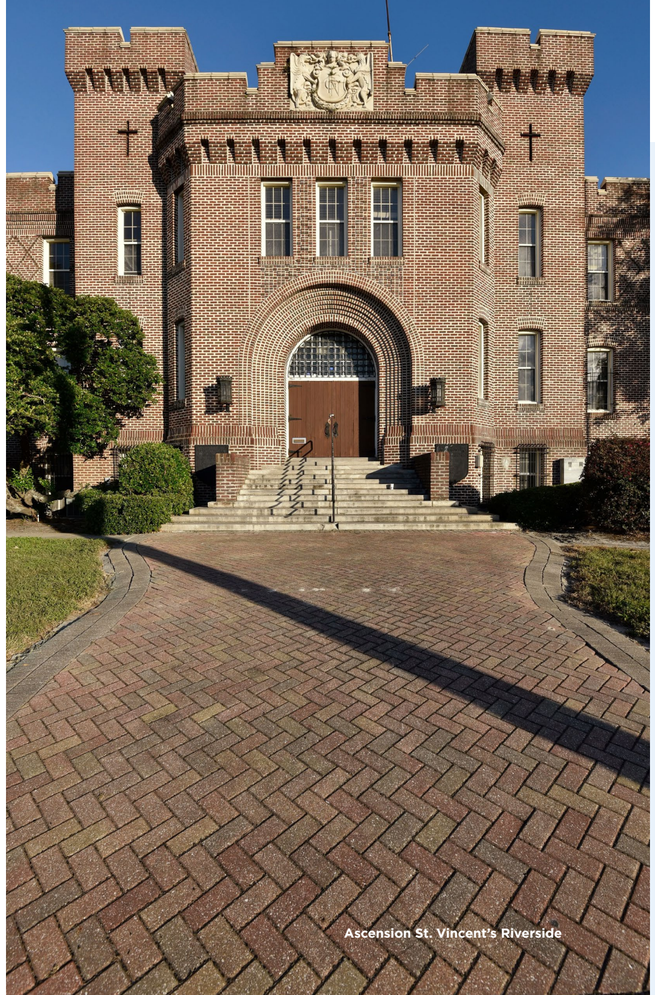
Section II

Prior CHNA Successes and Impacts

Before we look ahead, it's helpful to gain perspective by looking back at the 2021 CHNA (conducted 2021-2022) prioritized health needs to understand what has been accomplished over the last three years. Nine themes emerged from the 2021 CHNA, with mental health, access to care and poverty prioritized as the top three, respectively. Once the health needs were prioritized, each health system and its affiliated hospitals determined the health needs each would respond to and identified associated implementation strategies.

Of the nine significant health needs, the JNHP hospitals collectively responded to seven of them, with each responding to at least one of the top three prioritized health needs. For purposes of this review, several strategies were categorized to the theme that most closely aligned to it based on social determinants of health categories and sub-categories. For example, the strategy "increase access to healthy food, e.g., screening, SNAP, food" was categorized under poverty, recognizing that income is often a component of healthy food access.

Collectively, the sixteen hospitals implemented, supported or continued over 100 unique strategies. A sample of the strategies the JNHP hospitals implemented is provided below, followed by impact highlights of several of the strategies implemented by Ascension St. Vincent's. For a full listing of the Ascension St. Vincent's strategies by health need theme, please see Additional Resources Appendix.



Ascension St. Vincent's Riverside

2022 CHNA Examples of Response Strategies Across all JNHP Hospitals

Mental Health

Offer **Mental Health First Aid.**

Implement **Calm Classroom.**

Offer family education on **Lethal Means Safety.**

Provide Senior-to-Senior **Friendly Callers** program.

Fund **Rethreaded,** which provides support and resources to survivors of human trafficking.

Access to Care

Provide **virtual care visits.**

Implement **Findhelp** agency referral system.

Operate **School Health Centers.**

Partner with organizations who provide access to care for those **without insurance.**

Supplement staff for **Volunteers in Medicine** clinic, including cardiology, gastroenterology, gynecology, and internal medicine.

Poverty / Economic Stability

Increase Access to **healthy food** (screening, SNAP, food).

Increase employment opportunities focusing on low life expectancy zip codes.

Ensure **seniors have access** to in-home and other supports for health and well-being, including **food**.

Chronic Disease

Provide **asthma education** to children with asthma.

Provide a **food pharmacy** program to address diabetes, obesity & hypertension.

Provide **Community Benefit Programming** to address the lack of services available to individuals with a differing ability.

Maternal & Child Health

Bring **Think First** (brain & spinal cord injury prevention program) training to the children of northeast Florida.

Partner with the Northeast Florida **Healthy Start Coalition** to address needs of moms and babies.

Ascension St. Vincent's Riverside

Ascension St. Vincent's Impact Highlights

Ascension St. Vincent's Clay County, St. Johns, Riverside, and Southside worked to **improve access to medical care by increasing virtual office** visits and allowing patients who have difficulty with transportation, mobility, childcare needs, etc. to visit with a medical provider. This access specifically targeted not only Ascension Medical Group patients, but those who are medically under resourced, resulting in a quarterly range of approximately 5% - 7.5% of patients being seen virtually. Although this is less than the anticipated goal of 12%, it still reflects thousands of patients receiving virtual visits.

Ascension St. Vincent's also worked to connect unattached (people without a primary care provider) emergency department patients to an outpatient provider for continuity of care. This initiative required the implementation of an **ED Concierge Program**, beginning with ASV Riverside and ASV Southside. Through ASV's partner Care Continuity, over 2,124 patients were offered assistance through the ED Concierge program during its first year of operation, and 163 (7.7%) of them were connected to an outpatient provider. This is over 1,000 patients more than the program goals of offering assistance to 1,100 patients in its first year.

2,123
Assited Patients
ED Concierge

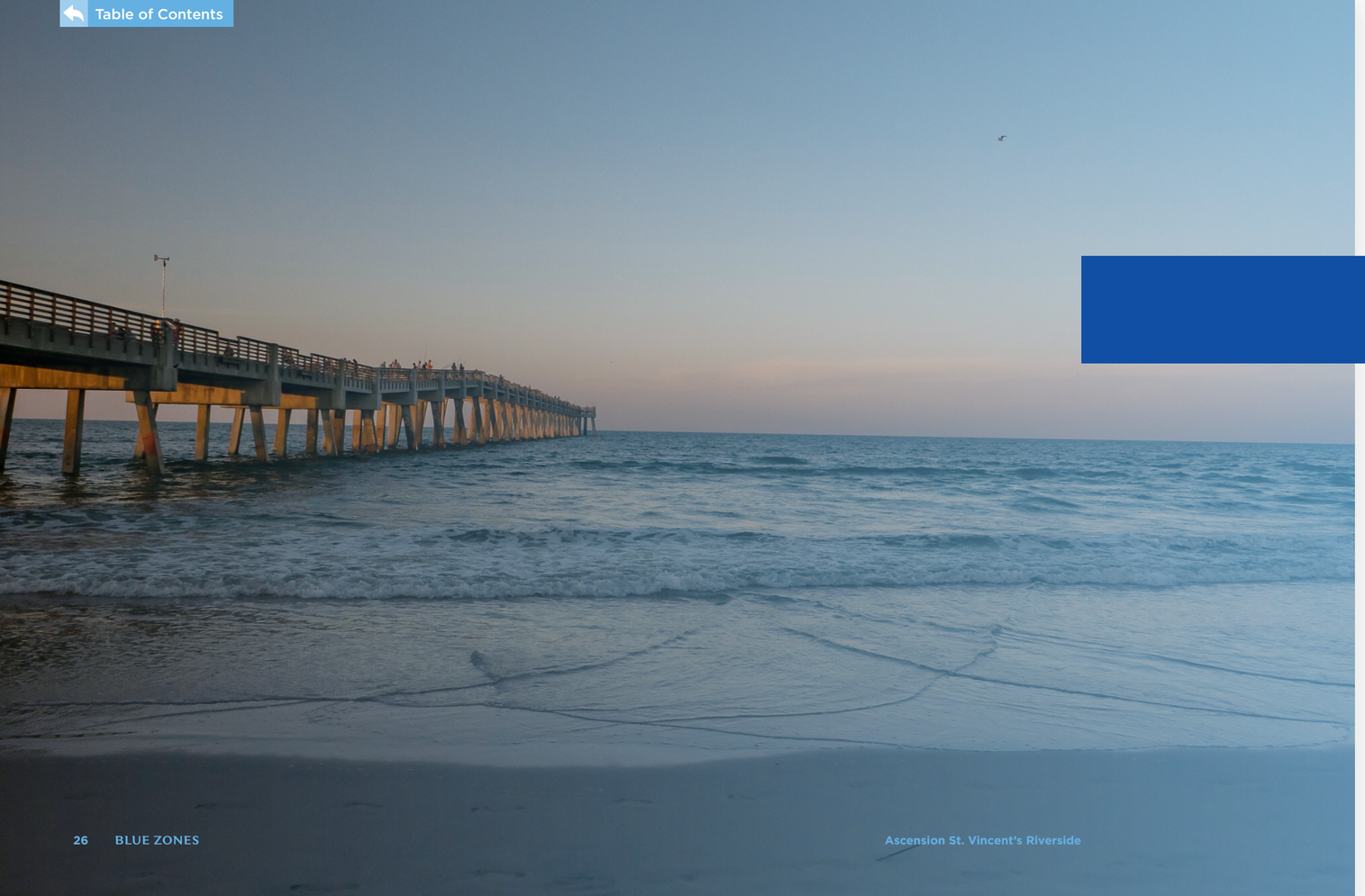
163 (7.7%)
patients connected to an outpatient provider

Impact results reflect Years 1-2 (fiscal years 2023-2024 of the three-year cycle. At the time of this report publication, Year 3 (fiscal year 2025) was not complete.

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Ascension St. Vincent's Riverside



Section III

Prioritized Significant Health Needs

Primary and Secondary Data Overview

The Community Health Needs Assessment was developed using four separate sources of primary and secondary data. This mixed methods approach is considered a preferred practice for needs assessments because it allows for the greatest understanding of community needs from the broadest range of perspectives. Primary data refers to data collected and analyzed specifically for this project, while secondary data refers to data compiled and analyzed by external groups and used here.

Qualitative primary data collection involved group listening sessions with local service providers and individual key stakeholder interviews with local leaders. These were conducted in-person and virtually. Additional qualitative primary data was collected with community members experiencing health needs through intercept surveys across the five-county region. These community conversations were conducted in person. Secondary data was amassed and analyzed across an extensive number of data sets by the University of Missouri Center for Applied Research and Engagement System (CARES) and accessed through its SparksMap online platform.

The JNHP team identified service providers and community-based organizations who work with vulnerable populations to ensure that the voices of those with chronic disease or low income, who are unhoused or are veterans, who identify as LGBTQ+, or who are otherwise under resourced were heard.

In total, we offered 21 key stakeholder interview appointments and 27 group listening sessions from April 9, 2024 through May 13, 2024. Despite the JNHP's best efforts, attendance was lower than anticipated. Of those 48 key stakeholder interview or group listening session opportunities, 31 or 65% were attended. Four of the group listening sessions were attended by just one person and we re-classified those as key stakeholder interviews. We also conducted 72 community conversations in the form of intercept surveys across the five counties from May 7, 2024 through May 10, 2024.

Given that the total sample size was just over 200 and we reached a saturation point of the same needs emerging from all interviews, we are confident that the qualitative data is reflective of the region. This is further reinforced by the fact that, although a majority of organizations participated in interviews held in Duval County, many of them have a regional or multi-county focus and spoke on behalf of more than one county.

Group Listening Sessions (GLS)

- Twenty-seven (27) offered, fifteen (15) attended
- One Hundred Nine (109) people participated

Group listening comments and input were gathered during in-person and virtual sessions, typically running 60 minutes.

Key Stakeholder Interviews (KSI)

- Twenty-one (21) offered, sixteen (16) attended

During the 60-minute interview, key stakeholders shared their greatest concerns regarding health needs, health equity, and social determinants of health for those they serve.

Community Conversations (CC)

- Seventy-two (72) conversations

Input was gathered through structured conversations held over 15-20 minutes.

Participant Attendance

County	TOTAL	KSI	GLS	CC
Duval	**126**	7	89	30
St. Johns	**15**	2	5	8
Clay	**31**	6	7	18
Baker	**7**	1	0	6
Nassau	**22**	4	8	10
	201	20	109	72



Participating Organizations

- Ability Housing
- Agape Health and Wellness Center, Inc.
- Ascension St. Vincent's St. Johns
- Baptist Medical Center - Beaches
- Baptist Medical Center - Clay
- Baptist Medical Center - Jacksonville
- Baptist Medical Center - Nassau
- Baptist Medical Center - South
- Barnabas Center
- Blue Zones
- Brooks Rehabilitation
- Center for Independent Living Jax
- Challenge Enterprise / Food for Clay
- Changing Homelessness, Inc. (CHI)
- City of Jacksonville
- Clay County (Board of County Commissioners)
- Council on Aging of St. Johns County
- Daniel Memorial Baptist Church
- Duval County Public Schools
- ElderSource
- Family Promise
- Family Support Services (FSS)
- Fernandina Beach Pride
- First Coast News
- First Coast YMCA
- Flagler Health
- Florida Department of Health - Baker
- Florida Department of Health - Nassau
- Homeless Veteran Reintegration Program (HVRP)
- Hubbard House
- Impact Church & Revitalize Arlington
- Jacksonville Area Sexual Minority Youth Network (JASMYN)
- Jacksonville Housing Authority (JHA)
- Jacksonville Speech & Hearing Center
- Jacksonville Transportation Authority
- Jax Care Connect
- Jewish Family and Community Services
- Lift Jax
- Local Initiative Support Corporation (LISC)
- Mayo Clinic in Florida
- Micah's Place
- Nassau County Council on Aging
- Northeast Florida Healthy Start
- Northeast Florida Women Veterans
- Presbyterian Social Ministries, Inc. (PSM)
- Starting Point Behavioral Health
- Sulzbacher
- THE PLAYERS Center for Child Health
- The Way Clinic
- The Women's Center of Jacksonville
- UF Health Jacksonville
- UF Health Jacksonville - Urban Health Alliance
- Vision is Priceless
- Volunteers in Medicine
- Volunteers of America of Florida
- Walmart Health
- WeCare Jax

Community Conversation Locations

- Duval County – Sulzbacher Center, Brooks Rehabilitation Clinics
- Clay County – Mission of Dirt Road, Clothes Closet, Salvation Army Food Pantry
- Nassau County – YMCA
- Baker County – Florida Department of Health Clinics, Waffle House
- St. Johns County – Strip Mall / Store Fronts

Significant Health Needs

Based on mathematical analysis of the primary and secondary data, six of the twelve initial health needs were first determined to be significant, and then prioritized in order using a priority index scoring methodology (see Section IV for full prioritization methodology). This ranking was affirmed by the JNHP team and invited community members following a presentation and discussion of the data and methodology held on June 18, 2024. For a list of those who participated, please see the Additional Resources Appendix.

High Priority Needs		
1	**Access to Care**	Drivers of ranking were health insurance and transportation.
2	**Housing**	Drivers of ranking were housing cost burden and homelessness.
3	**Mental Health**	Driver of ranking was access to mental health care.
4	**Food Environment**	Drivers of ranking were healthy food access and food insecurity.
Lower Priority Needs		
5	**Built Environment**	With just 0.84% of the population using public transit to commute to work (U.S. is 3.79%) and a road network density score of 4.33 (U.S. is 1.64), it is understandable that many people spoke to the need for public transit. People also spoke to the need for an increase in walkability and accessibility, citing the need for benches and shade structures.
6	**Community Safety**	People spoke to crime in certain areas, primarily in Duval County. This perception is supported by the data – property crime and violent crime (assault, rape, robbery) rates are all worse than both the state and the U.S., with Duval County largely driving the regional rate.

Ascension St. Vincent's Riverside



Ascension St. Vincent's Riverside



PRIORITY 1

Access to Care

Health Insurance and Transportation

Access to health care was identified as a health need in every key stakeholder and group listening session, and 60% of the people we spoke to in the community conversations also identified it as such. Despite other sub-categories of access to care being available for identification as a health need, such as primary care, dental care, hospitals, specialty care, etc., the two areas that were identified repeatedly as barriers to accessing health care were health insurance and transportation.

Ascension St. Vincent's Riverside

Health Insurance

In Duval County, 21% of the population has Medicaid. Although slightly higher than Florida (19.96%), it is lower than the U.S. (22.34%). This is not necessarily a good thing when considered within the context of those who are uninsured. The uninsured adult population is Duval County is nearly 16% (U.S. is 12%). This means that over 96,000 adults living in Duval County are without insurance. Similarly, 7.4% of children are uninsured (U.S. is 5.3%). When broken down by gender, adult males are the most uninsured at 13.32%, compared to females at 10.24% (U.S. comparison is 9.72% and 7.67% respectively). This current state of uninsured people in Duval County is, in part, a result of the convergence of two factors - that Florida did not expand its Medicaid coverage under the Affordable Care Act and over 320,000 people in Duval County are living below 200% of the federal poverty limit, putting them at higher risk of not being able to afford health insurance.

In addition to the lack of health insurance and its affordability, many people spoke to the limited coverage offered by many of the lower cost Marketplace plans, and the complicated nature of health insurance applications and policies – especially for those with limited education and language proficiency.

Duval County Medical Uninsured Population

96,373
uninsured adult population
15.89% Duval | 12% U.S.

17,017
uninsured children
7.43% Duval | 5.3% U.S.

Data Sources: See pages 42 and 43.

Transportation

Similarly, the issue of transportation as a barrier to accessing health care came up in resounding measure. Although Duval County has a public transit system with 38.9% of the population living within a half-mile of public transit, this still leaves over 650,000 people with even a longer distance to public transit access. To some, it may seem reasonable to access public transit if a person lives within a half-mile of it, but that is not the case for those with any disability, prohibitive health condition or any other variety of issues that makes a half-mile walk impossible. Additionally, those we spoke to also commented on the infrastructure around the bus stops – the need for shade structures, seating on the way and at the stops, the challenge in getting to the places they need to go, etc. – which contribute to the felt need that the public transit system in Duval County remains problematic.

38.9%
POPULATION within
0.5mi
of PUBLIC TRANSPORT

36.89% Florida
34.76% U.S.

Data Source: See page 46.

This problematic nature of public transit not only affects access to health care but also affects accessing healthy food - a critical factor in achieving optimal health. In Duval County, nearly 300,000 people, or 29.38% are living with low food access, which is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest grocery store. This compares poorly to both the state (25.07%) and the U.S. (22.2%). When so many people with low food access also do not have a public transit system, those conditions layer upon each other, creating an increased risk of poor health outcomes.



Ascension St. Vincent's Riverside

Ascension St. Vincent's Riverside

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Primary Data Source Comments

Health Insurance

"Insurance doesn't cover prescription costs and they stop taking medications or ration it because they can't afford it."

"I think the [health care] marketplace is still pricing people out."

"The insurance barriers, particularly as it relates to Medicaid, is huge, and that prevents folks from getting into timely care."

"I also want to bring up a huge issue that's new in our community around insurance. There are some really bad new insurance companies that are coming on board that are using fraudulent ways to enroll people in insurance."

"Even if you've got ACA insurance for example, sometimes the deductibles are so high that you can't do it. And then Florida has never implemented the Medicaid component."

"If I'm underinsured or no insurance, I can't get somewhere. Yeah, I can get to a free clinic maybe for primary care, but who's gonna do my hip? And then so, yeah, who's gonna do my hip or who's gonna take out my gallbladder unless I go to the emergency room and it's forced, right?"

"We see all these families that their insurance inhibits where they can see that specialty care."

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Transportation

"We're 900 square miles. And if you try to get from one side of town to an appointment on the other side of town, it could be two and a half hours plus a bus transfer if you can get to transportation."

"But in transportation, I hear about being a challenge for people. You know, they don't have the transportation to get to the health care."

"And I know there's people out in Clay County that can't get transportation to come here to Jacksonville for the rehabilitation pieces that they need."

"I've had elderly people. How about get to the bus stop? Say there's no bench at the bus stop. It's just the sign that's out. And you have to get to the bus stop if you're in a wheelchair or a walker. And no sidewalk."

"So, there aren't too many transportation companies in Jacksonville, Nassau, that, you know. Well, they vary, and there's like one."

"We're so spread out, but so I would say more public transit because we're so spread out. We have a lot of room for improvement in our public transit transportation system."

"Yeah. We have a terrible history here. We used to have incredible public transportation to all the neighborhoods, but it was by rail car. Trolley car. And there were in the 60s and 70s, there was this move that no, no, no, everyone should have their own car. So they dismantled all that and ended up leaving pockets of neighborhoods completely disconnected."

Secondary Data Summary

INSURANCE

Population Receiving Medicaid

This indicator reports the percentage of the population with insurance enrolled in Medicaid (or other means-tested public health insurance). This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

Percent of Insured Population Receiving Medicaid



0% 25%

Northeast Florida	18.17%
Florida	19.96%
United States	22.34%
Duval County	21.41%

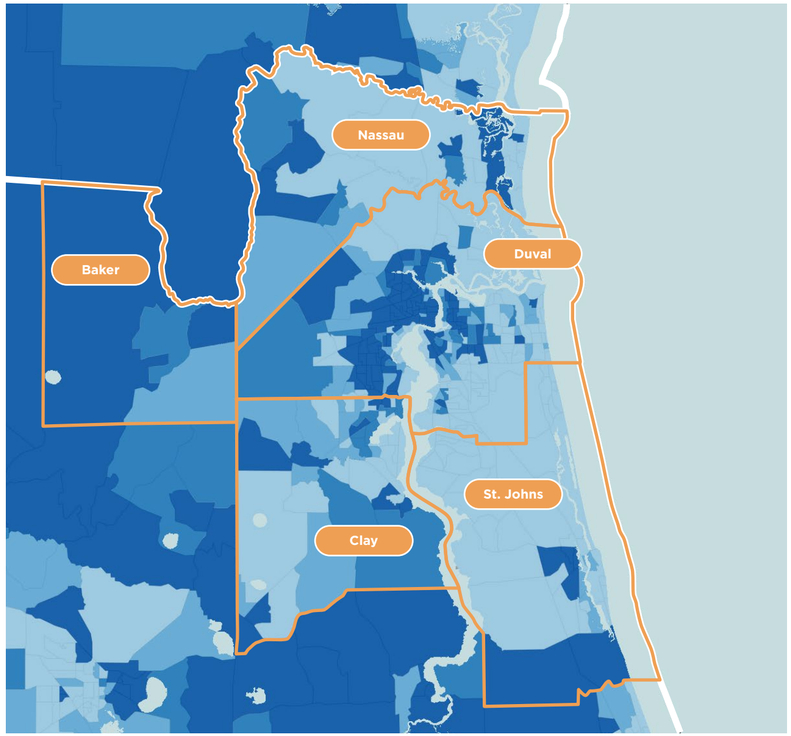
Report Area	Total Population (For Whom Insurance Status is Determined)	Population with Any Health Insurance	Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid
Northeast Florida	1,579,772	1,417,214	257,555	18.17%
Baker County, FL	24,868	22,063	5,285	23.95%
Clay County, FL	215,982	197,099	31,590	16.03%
Duval County, FL	971,845	857,940	183,672	21.41%
Nassau County, FL	90,308	83,169	13,730	16.51%
St. Johns County, FL	276,769	256,943	23,278	9.06%
Florida	21,300,363	18,679,638	3,727,882	19.96%
United States	326,147,510	297,832,418	66,532,218	22.34%

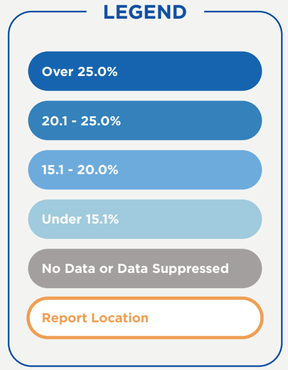
Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey, 2018-22

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Insured, Medicaid / Means-Tested Coverage

Percent by Census Tract, ACS 2018-22





INSURANCE

Uninsured Adults

The lack of health insurance is considered a key driver of health status.

This indicator reports the percentage of adults age 18 to 64 without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to health care access including regular primary care, specialty care, and other health services that contribute to health status.

Percent Population Age 18-64 Without Medical Insurance



Report Area	Total Population Age 18-64	Population Age 18-64 w/ Insurance	Population Age 18-64 w/ Insurance (%)	Population Age 18-64 w/o Insurance	Population Age 18-64 w/o Insurance (%)
Northeast Florida	979,393	837,421	85.50%	141,972	**14.50%**
Baker County, FL	15,388	13,017	84.59%	2,371	15.41%
Clay County, FL	134,427	116,838	86.92%	17,589	13.08%
Duval County, FL	606,633	510,260	84.11%	96,373	15.89%
Nassau County, FL	54,002	47,195	87.39%	6,807	12.61%
St. Johns County, FL	168,943	150,111	88.85%	18,832	11.15%
Florida	12,583,091	10,343,074	82.20%	2,240,017	17.80%
United States	197,133,424	173,254,919	87.89%	23,878,505	12.11%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, Small Area Health Insurance Estimates, 2021

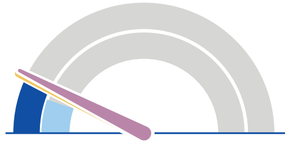
INSURANCE

Uninsured Children

The lack of health insurance is considered a key driver of health status.

This indicator reports the percentage of children under age 19 without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to health care access including regular primary care, specialty care, and other health services that contribute to health status.

Percent Population Under Age 19 Without Medical Insurance



Report Area	Total Population Age 0-18	Population Age 0-18 w/ Insurance	Population Age 0-18 w/ Insurance (%)	Population Age 0-18 w/o Insurance	Population Age 0-18 w/o Insurance (%)
Northeast Florida	377,034	350,535	92.97%	26,499	**7.03%**
Baker County, FL	7,056	6,510	92.26%	546	7.74%
Clay County, FL	53,858	50,437	93.65%	3,421	6.35%
Duval County, FL	229,133	212,116	92.57%	17,017	7.43%
Nassau County, FL	19,503	18,074	92.67%	1,429	7.33%
St. Johns County, FL	67,484	63,398	93.95%	4,086	6.05%
Florida	4,420,732	4,098,168	92.70%	322,564	7.30%
United States	75,979,898	71,938,607	94.68%	4,041,291	5.32%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, Small Area Health Insurance Estimates, 2021

INSURANCE

Uninsured Population by Gender

This indicator reports the uninsured population by gender. Please note that the 2020 census limited gender choices to male and female; it did not include choices such as nonbinary or gender-nonconforming.

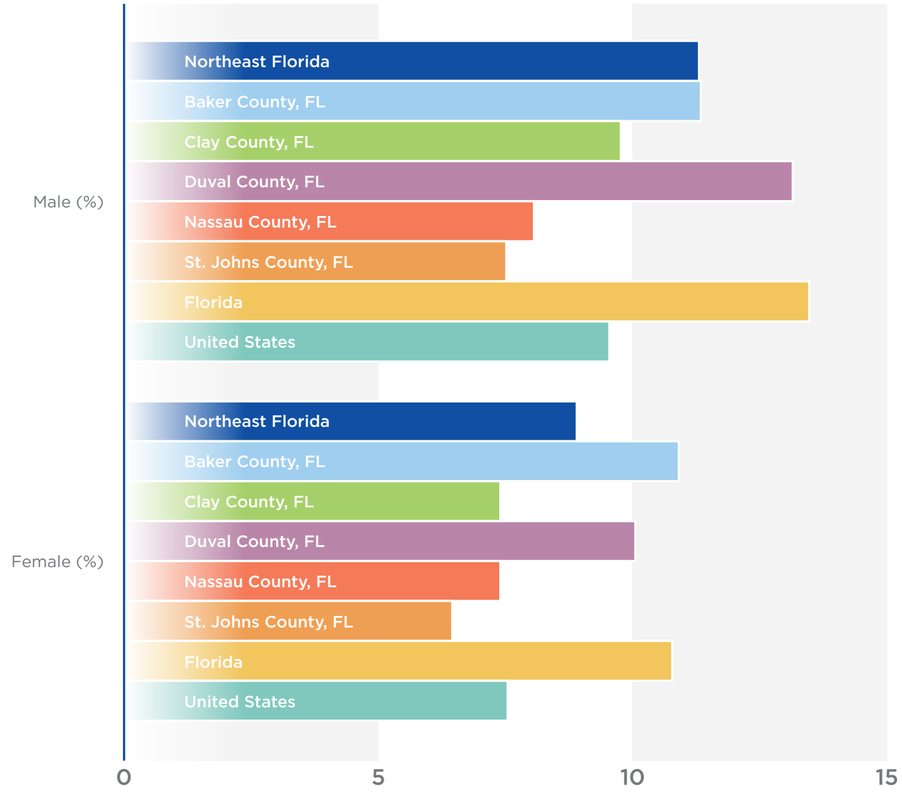
The percentage values could be interpreted as, for example, *"Of all the male population within the report area, the proportion without health insurance coverage is (value)."*

Report Area	Male	Female	Male (%)	Female (%)
Northeast Florida	88,325	74,233	11.53%	9.12%
Baker County, FL	1,421	1,384	11.52%	11.04%
Clay County, FL	10,546	8,337	9.95%	7.58%
Duval County, FL	62,260	51,645	13.32%	10.24%
Nassau County, FL	3,674	3,465	8.28%	7.55%
St. Johns County, FL	10,424	9,402	7.68%	6.66%
Florida	1,424,476	1,196,249	13.69%	10.98%
United States	15,616,252	12,698,840	9.72%	7.67%

Data Source: US Census Bureau, American Community Survey, 2018-22.

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Uninsured Population by Gender



TRANSPORTATION

Distance to Public Transport

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit services in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Percentage of Population within Half Mile of Public Transit



Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Northeast Florida	1,475,386	377,322	25.57%
Baker County, FL	27,785	0	0%
Clay County, FL	207,291	4,508	2.17%
Duval County, FL	924,229	359,937	38.94%
Nassau County, FL	80,578	0	0%
St. Johns County, FL	235,503	12,877	5.47%
Florida	20,598,139	7,598,336	36.89%
United States	322,903,030	112,239,342	34.76%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, Small Area Health Insurance Estimates, 2021

FOOD ENVIRONMENT

Low Food Access

This indicator reports the percentage of the population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the 2019 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Percent Population with Low Food Access



Report Area	Total Population (2010)	Population with Low Food Access	Percent Population with Low Food Access
Northeast Florida	1,345,596	421,957	31.36%
Baker County, FL	27,115	15,066	55.56%
Clay County, FL	190,865	66,319	34.75%
Duval County, FL	864,263	253,891	29.38%
Nassau County, FL	73,314	32,237	43.97%
St. Johns County, FL	190,039	54,444	28.65%
Florida	18,801,310	4,712,762	25.07%
United States	308,745,538	68,611,398	22.22%

Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas, 2019



PRIORITY 2

Housing

Housing Cost Burden and Homelessness

Housing Cost Burden

Housing was identified in all but one of the Key Stakeholder Interviews and Group Listening Sessions. It was typically brought up multiple times in each, with the cost of housing and the associated cost burden of it being identified the most frequently. Although the 31 secondary measures associated with housing did not overall perform poorly at the regional (five-county rolled-up) level when compared to Florida or the U.S., many measures did perform poorly at the county level. For example, the median household income (a factor that contributes to housing cost burden) in Duval County is less than the state and the U.S. When viewed from a race and ethnicity perspective, the lowest median household income is among black householders in Duval County, at $47,536, which is not only below the overall Florida and U.S. income levels, but is also below the median income levels of black householders in Florida and the U.S. Most of the households making up the lower half of the median income level are located in the Jacksonville urban core.

Many people also spoke of the working poor or ALICE (Asset Limited, Income Constrained, Employed) in relation to the level of housing cost burden, recognizing the increase in housing costs and citing the inability for many people to live close to their work (Amelia Island in Nassau County and Ponte Vedra in St. Johns County). The recency of this effect is well known despite the data lag. News such as *"Florida leads nation in number of cost-burdened renters"* and *"As of late May 2024, the median Florida home price (which includes single family homes and townhomes/condos) is $399,944 which is 11.3% above the national average home price of $359,240"* supports this felt need. With 2022 data showing nearly 135,000 Duval County residents cost burdened at the 30% level and 61,000 cost burdened at the 50% level, the burden of the cost of housing remains a core concern in Duval County, especially when coupled with the fact that the HUD-assisted housing units in Northeast Florida (311 per 10,000 housing units) are significantly less than the U.S average (414 per 10,000).

311/10,000
HUD-assisted housing units
NORTHEAST FLORIDA

414/10,000
HUD-assisted housing units
UNITED STATES



Homelessness

A growing sense of an increase in homelessness also emerged from the interviews and conversations. In part, because it is known that the increase in the housing cost burden will cascade to an increase in homelessness. The sense of an increase is also believed because of the increase in service requests and the increase in visibility of people who are unhoused. The secondary data from the 2023 HUD annual Homeless Assessment Report does not reflect this increase, which draws from the Point-In Time count and the Housing Inventory Count conducted in January 2023, nearly 18 months from the date of this writing.

Vulnerable Populations and Housing

Similar to the overall homelessness data, homelessness among veterans and children do not reflect an increase in the 2023 data. That said, any person who is homeless, perhaps especially veterans and children, reflect a significant need in any community.

In addition to the concerns around the cost of housing and homelessness, other housing-related indicators are also of concern, especially those around vulnerable populations. For example, the percentage of older adults living alone in Duval County (37.46%) is greater than both the state (34.93%) and the U.S.(37.22%), with nearly 40,000 seniors living alone, creating a risk of isolation and unobserved accidental harm that impacts overall well-being.

40,000
Seniors Living Alone in
Duval County

Data Source: See page 62.

Primary Data Source Comments

"Most people in our field would say that you know housing is health care."

"I know there is significant homelessness and housing issues across all age populations, but even for children too."

"I don't know how to quantify it, but the newly homeless is something I'm seeing now."

"One of the most pressing issues is just, is housing. Availability of affordable housing and making sure that there are ways for people to afford housing that works for them and their families."

"Kind of tent areas kind of popping up in our communities from the homeless population. There's just nowhere for people to live. There's just no affordable housing."

"So I would definitely say that housing is a problem. Housing costs here are high and seem to only be going up. It's hard for anyone to live here that doesn't make good money."

"People can't even afford affordable housing, because it's taking more than 30% of their income is spent on housing."

"I think the housing burden continuing to just like the food I don't know how people get out of those cycles."

"I mean, housing is just impossible here. The rate and the cost. I feel like just even anecdotally, I'm seeing more."

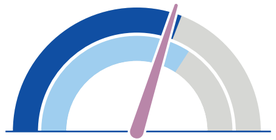
Secondary Data Summary

INCOME

Median Household Income

This indicator is based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income.

Median Household Income



0 110000

Florida	$67,917
United States	$75,149
Duval County	$65,579

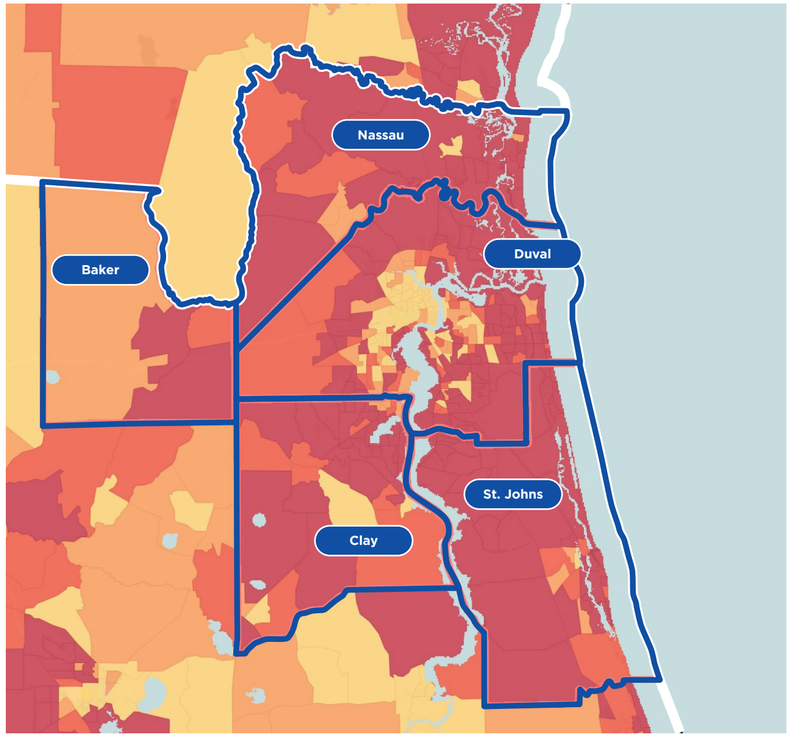
Report Area	Total Households	Average Household Income	Median Household Income
Northeast Florida	632,232	$100,577	No data
Baker County, FL	9,004	$86,352.32	$67,872
Clay County, FL	79,704	$100,854.65	$82,242
Duval County, FL	396,132	$90,665.64	$65,579
Nassau County, FL	36,336	$109,291.34	$84,085
St. Johns County, FL	102,056	$136,985.68	$100,020
Florida	8,353,441	$96,992.32	$67,917
United States	125,736,353	$105,833.04	$75,149

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey, 2018-22

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Median Household Income

by Census Tract, ACS 2018-22



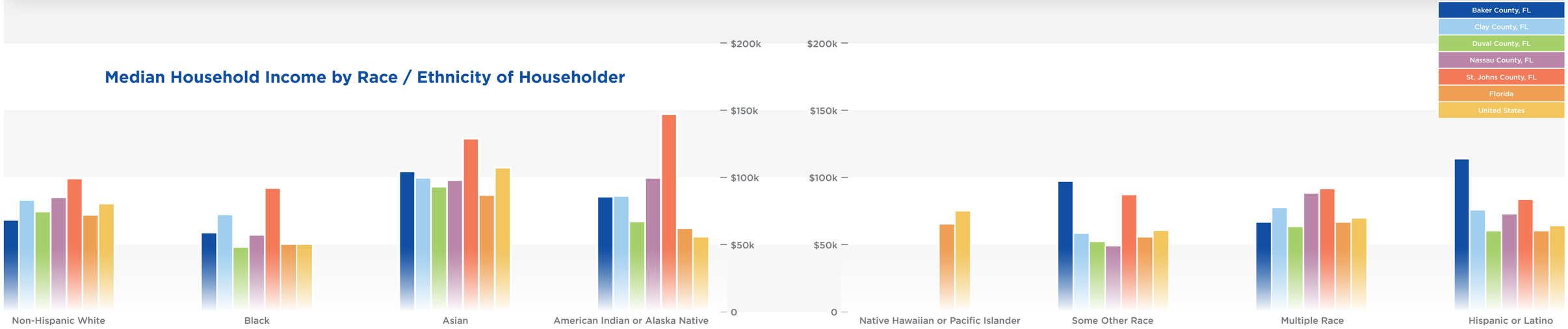
LEGEND

- Over $70,000
- $60,000 - $70,000
- $50,000 - $59,999
- Under $50,000
- No Data or Data Suppressed
- Report Location



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Median Household Income by Race / Ethnicity of Householder



Data Source: US Census Bureau, American Community Survey, 2018-22.

AFFORDABLE HOUSING

Assisted Housing Units

This indicator reports the total number of HUD-funded assisted housing units available to eligible renters as well as the unit rate (per 10,000 total households).

HUD-Assisted Units, Rate per 10,000 Housing Units



Report Area	Total Housing Units (2022)	Total HUD-Assisted Housing Units	HUD-Assisted Units, Rate per 10,000 Housing Units
Northeast Florida	578,620	18,019	311.41
Baker County, FL	8,828	331	374.94
Clay County, FL	75,360	351	46.58
Duval County, FL	369,704	16,816	454.85
Nassau County, FL	33,475	168	50.19
St. Johns County, FL	91,253	353	38.68
Florida	7,931,313	202,640	255.49
United States	123,559,968	5,114,316	413.91

Note: This indicator is compared to the state average.
Data Source: US Department of Housing and Urban Development, 2017-21

HOUSING COSTS

Cost Burden (30%)

This indicator reports the percentage of the households where housing costs are 30% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.

Percentage of Households where Housing Costs Exceed 30% of Income



Report Area	Total Households	Cost-Burdened Households	Cost-Burdened Households, Percent
Northeast Florida	623,232	190,693	30.60%
Baker County, FL	9,004	1,993	22.13%
Clay County, FL	79,704	18,691	23.45%
Duval County, FL	396,132	134,400	33.93%
Nassau County, FL	36,336	8,734	24.04%
St. Johns County, FL	102,056	26,875	26.33%
Florida	8,353,441	2,915,774	34.91%
United States	125,736,353	38,363,931	30.51%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey, 2018-22

HOUSING COSTS

Cost Burden, Severe (50%)

This indicator reports the percentage of the households where housing costs are 50% or more of total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels.

Percentage of Households where Housing Costs Exceed 50% of Income



Report Area	Total Households	Severely Burdened Household	Severely Burdened Households (%)
Northeast Florida	632,232	85,231	13.68%
Baker County, FL	9,004	920	10.22%
Clay County, FL	79,704	7,911	9.93%
Duval County, FL	396,132	61,019	15.40%
Nassau County, FL	36,336	3,896	10.72%
St. Johns County, FL	102,056	11,485	11.25%
Florida	8,353,441	1,395,758	16.71%
United States	125,736,353	17,679,129	14.06%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey, 2018-22

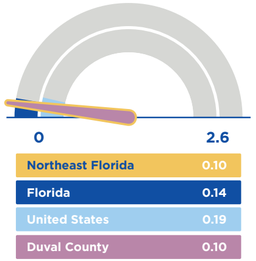
HOMELESSNESS

Homeless Population

This indicator reports the total homeless population as estimated from Point-in-Time (PIT) count in 2023. Data is obtained from HUD's Annual Homeless Assessment Report (AHAR).

Note: This data is reported by Continuum of Care (CoC) region. CoCs are an administrative geographic unit used by HUD to fund and administer services. CoCs may cover one or more counties.

Homeless Rate per 100 Population 2023



Report Area CoC Name	Total Population 2020	Overall Homeless 2023	Homeless Rate per 100 Population
Northeast Florida	1,577,377	1,682	0.10
Jacksonville - Duval, Clay, Nassau Counties CoC	1,304,164	1,247	0.10
St. Johns County CoC	273,213	435	0.16
Florida	21,538,187	30,756	0.14
United States	334,735,155	651,777	0.19

Note: This indicator is compared to the state average.
Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Overall Homeless

Report Area	Overall Homeless 2020	Overall Homeless 2023	Difference	% Difference
Northeast Florida	1,733	1,682	-51	**-2.9%**
Clay, Duval and Nassau County, FL	1,366	1,247	-119	-8.7%
St. Johns County, FL	367	435	68	18.5%
Florida	27,487	30,756	3,269	11.9%
United States	1,160,932	1,306,208	145,276	12.5%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

Population Change 2020-2023: Overall Homeless Veterans

Report Area	Overall Homeless Veterans 2020	Overall Homeless Veterans 2023	Difference	% Difference
Northeast Florida	203	112	-91	**-44.8%**
Clay, Duval and Nassau County, FL	177	84	-93	-52.5%
St. Johns County, FL	26	28	2	7.7%
Florida	2,436	2,558	122	5.0%
United States	74,504	71,148	-3,356	-4.5%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2023.

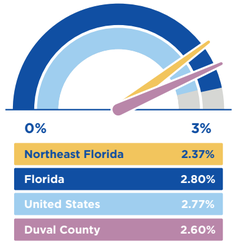
HOMELESSNESS

Homeless Children & Youth

This indicator reports the number of homeless children and youth enrolled in the public school system during the school year 2019-2020. According to the data source definitions, homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Those who are homeless may be sharing the housing of other persons, living in motels, hotels or camping grounds, in emergency transitional shelters, or may be unsheltered. Data are aggregated to the report-area level based on school-district summaries where three or more homeless children are counted.

Note: Data availability for 100.00% schools.

Rate of Homelessness Among Public School Students (in Reported Districts)



Report Area	Students in Reported Districts	Homeless Students	Homeless Students (%)	Districts Reporting	Students in Reported Districts
Northeast Florida	229,900	5,443	**2.37%**	100.00%	100.00%
Baker County, FL	5,047	103	2.00%	100.00%	100.00%
Clay County, FL	38,698	817	2.10%	100.00%	100.00%
Duval County, FL	130,279	3,349	2.60%	100.00%	100.00%
Nassau County, FL	12,248	513	4.20%	100.00%	100.00%
St. Johns County, FL	43,628	661	1.50%	100.00%	100.00%
Florida	2,854,470	79,834	2.80%	97.37%	99.86%
United States	47,386,316	1,311,089	2.77%	86.95%	97.47%

Note: This indicator is compared to the state average.
Data Source: U.S. Department of Education, EDFacts. Additional data analysis by CARES. 2019-2020.

HOUSEHOLD STRUCTURE

Older Adults Living Alone

This indicator reports the percentage of households occupied by a single older adult (age 65+). This indicator is important because older adults who live alone are vulnerable populations who may have challenges accessing basic needs, including health needs.

Report Area	Total Occupied Households	Total Households with Seniors (Age 65+)	Households with Seniors Living Alone	Percentage of Total Households	Percentage of Senior Households
Northeast Florida	623,232	184,966	62,130	9.97%	**33.59%**
Baker County, FL	9,004	2,773	904	10.04%	32.60%
Clay County, FL	79,704	24,736	6,644	8.34%	26.86%
Duval County, FL	396,132	106,181	39,775	10.04%	37.46%
Nassau County, FL	36,336	14,394	3,992	10.99%	27.73%
St. Johns County, FL	102,056	36,882	10,815	10.60%	29.32%
Florida	8,353,441	3,107,758	1,085,585	13.00%	34.93%
United States	125,736,353	38,775,247	14,433,125	11.48%	37.22%

Note: This indicator is compared to the state average.
Data Source: U.S. Census Bureau, American Community Survey. 2018-22.

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PRIORITY 3

Mental Health

Access to Mental Health Care

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Mental Health Providers
(providers/100,000 pop.)

250	314
DUVAL COUNTY	UNITED STATES

Data Source: See page 68.

Mental health in general was identified as problematic in 81% of the interviews conducted. Access to mental health care was identified as the leading sub-category of this significant health need, with 51% of interviews commenting on it. The community conversations revealed more about experienced mental health conditions than access.

Of note is that 86% (19/22) of the mental health secondary measures performed worse than the U.S. Specifically, the availability of mental health providers in Duval County is much lower than the U.S., with 250 providers per 100,000 compared to 314 (U.S). Similarly, the availability of addiction and substance abuse providers is significantly lower than the U.S., with 7.6 providers per 100,000 in Duval County compared to 27.9 (U.S.). Although many people commented on the progress made in mental health care access and stigma reduction, such comments were quickly followed up with the ongoing need for mental health care.

Ascension St. Vincent's Riverside

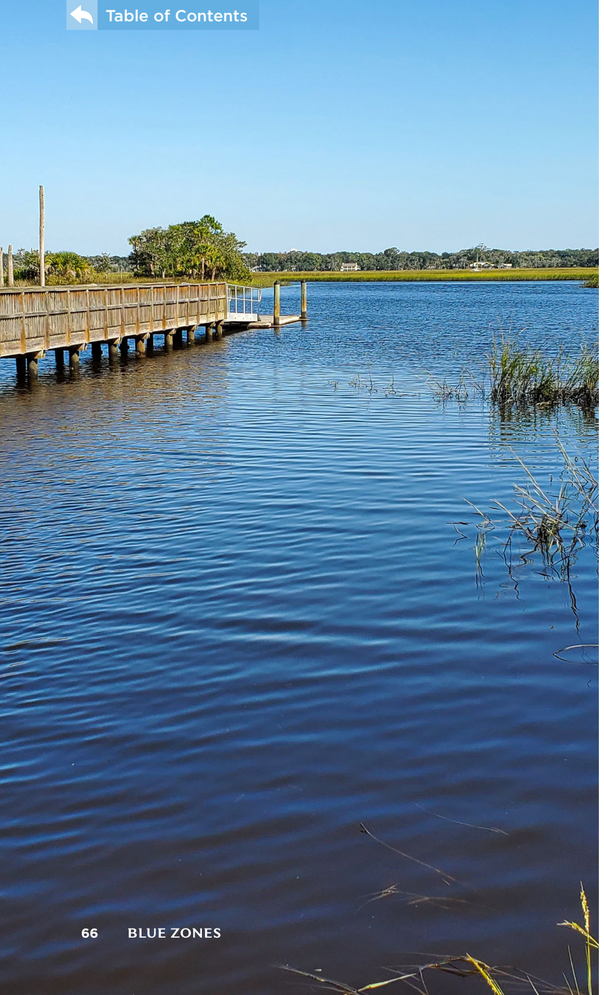
Premature Death Rate
(years lost/100,000 pop.)

11,281	8,299	7,986
DUVAL COUNTY	FLORIDA STATE	UNITED STATES

Data Source: Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via County Health Rankings. 2019-2021.

This ongoing need is evident when considered within the context that people in Northeast Florida are more likely to experience violent crime (assault, rape, robbery), and the resultant mental health risk factors of trauma, anxiety, and stress. This is predominantly a factor in Duval County, which has a violent crime rate per 100,000 population of 633.5, which compares poorly to the state (433.9) and to the U.S. (416).

Duval County residents also experience more deaths of despair, drug overdose mortalities, and opioid overdose mortalities than either the state or the U.S., contributing to Duval County's premature death rate of 11,281 years of potential life lost per 100,000 compared to the state (8,299 years) and the U.S. (7,986 years). Deaths of despair occur disproportionately among males, and among people who are Non-Hispanic White.



Primary Data Source Comments

"So the need continues to grow, even though we're making strides, making impacts, the need continues to outpace the capacity."

"At some point there was a 13-year-old child that said to their parents, I'm sad. They said to their parents, I'm feeling a little anxious. Way before they would be diagnosed as anxiety, well before they would be diagnosed with depression, but there aren't things, there's not enough education as a parent, or even schools aren't even allowed to say, what can we do for this child while it's not an issue?"

"Mental health services have provider shortage, impacting access to care."

"I think the thing is that we're going to see a surge because as people accept it more and are more accepting of services."

"I know things are being addressed. But there is a big need in that area. There is a huge need in mental health."

"You know, these people aren't mentally ill, but they have serious emotional wellness issues because of the stress of an aging person taking care of an aging person."

"I would still say, I think mental health is a big issue. A lot of the patients that we serve here in our clinic, in our group, you know, have challenges with mental health, and you still have so many people that are undiagnosed."

"I have to go with depression and anxiety and trauma. I, working with nonprofits and with kids, it's really given me a fresh perspective on how prevalent that is in this community."

"Under mental health, that isolation, which leads to some of those other issues that people are experiencing when they're isolated, that anxiety, the depression, and then of course the despair."

Secondary Data Summary

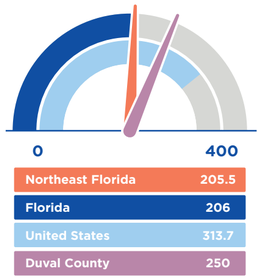
ACCESS TO CARE

Mental Health

This indicator reports the number of mental health providers in the report area as a rate per 100,000 total area population. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care. Data from the 2023 Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file are used in the 2024 County Health Rankings.

Note: Data are suppressed for counties with population greater than 1,000 and 0 mental health providers.

Mental Health Care Provider Rate Per 100,000 Population



Report Area	Estimated Population	Number of Mental Health Providers	Ratio of Mental Health Providers to Population (1 Provider per x Persons)	Mental Health Care Provider Rate (Per 100,000 Population)
Northeast Florida	1,677,458	3,448	486.5	205.5
Baker County, FL	27,857	39	714.3	140
Clay County, FL	227,206	309	735.3	136
Duval County, FL	1,018,000	2,545	400	250
Nassau County, FL	97,826	135	724.6	138
St. Johns County, FL	306,569	420	729.9	137
Florida	22,217,476	45,768	485.4	206
United States	333,191,688	1,045,210	318.8	313.7

Data Source: US Census Bureau, American Community Survey, 2018-22.

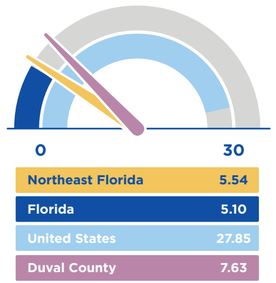
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ACCESS TO CARE

Addiction/Substance Abuse Providers

This indicator reports the number of providers who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The providers include Doctors of Medicine (MDs), Doctors of Osteopathic Medicine (DOs), and other credentialed professionals with Center for Medicare and Medicaid Services (CMS) and a valid National Provider Identifier (NPI). The number of facilities that specialize in addiction and substance abuse treatment are also listed (but are not included in the calculated rate). Data are from latest Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) Downloadable File.

Addiction/Substance Abuse Providers, Rate per 100,000 Population



Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Northeast Florida	1,605,848	36	89	5.54
Baker County, FL	28,259	0	0	0.00
Clay County, FL	218,245	5	4	1.83
Duval County, FL	995,567	24	76	7.63
Nassau County, FL	90,352	0	5	5.53
St. Johns County, FL	273,425	7	4	1.46
Florida	21,538,187	1,413	1,098	5.10
United States	334,735,155	18,293	93,221	27.85

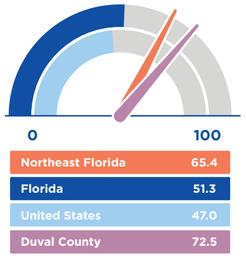
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS – National Plan and Provider Enumeration System (NPPES). May 2024

Death of Despair (Suicide + Drug/Alcohol Poisoning)

This indicator reports average rate of death due to intentional self-harm (suicide), alcohol-related disease, and drug overdose, also known as “deaths of despair”, per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because death of despair is an indicator of poor mental health.

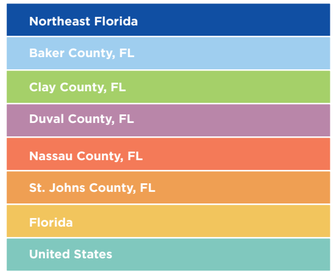
Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Deaths of Despair, Age-Adjusted Death Rate (Per 100,000 Population)

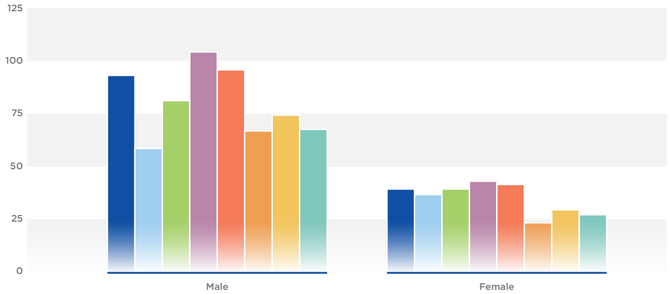


Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Northeast Florida	1,533,060	5,204	67.9	65.4
Baker County, FL	28,670	71	49.5	49.1
Clay County, FL	215,527	656	60.9	59.8
Duval County, FL	947,771	3,564	75.2	72.5
Nassau County, FL	85,783	293	68.3	68.8
St. Johns County, FL	255,309	620	48.6	44.4
Florida	21,221,443	58,785	55.4	51.3
United States	326,747,554	806,246	49.4	47.0

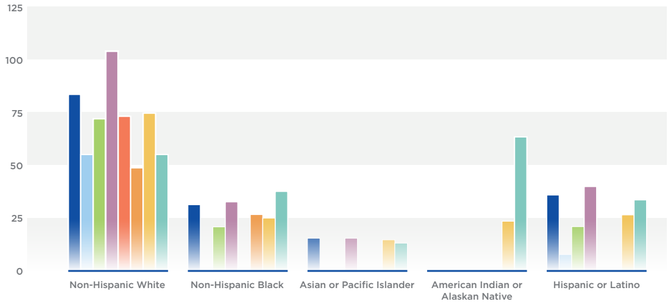
Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC – National Vital Statistics System, Accessed via CDC WONDER, 2016-2020



Deaths of Despair, Age-Adjusted Rate by Gender
(Per 100,000 Pop.)



Deaths of Despair, Age-Adjusted Rate by Race / Ethnicity
(Per 100,000 Pop.)



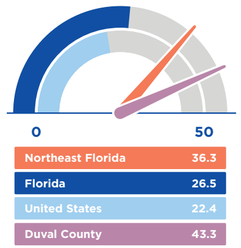
MORTALITY

Drug Overdose (All Substances)

This indicator reports the 2016-2020 five-year average rate of death due to drug overdose of all substances per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Drug Overdose Mortality, Age-Adjusted Death Rate (Per 100,000 Population)



Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Northeast Florida	1,533,060	2,726	35.6	36.3
Baker County, FL	28,670	27	18.8	20.2
Clay County, FL	215,527	322	29.9	32.0
Duval County, FL	947,771	2,060	43.5	43.3
Nassau County, FL	85,783	122	28.4	33.5
St. Johns County, FL	255,309	195	15.3	16.7
Florida	21,221,443	27,013	25.5	26.5
United States	326,747,554	363,665	22.3	22.4

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC – National Vital Statistics System, Accessed via CDC WONDER, 2016-2020

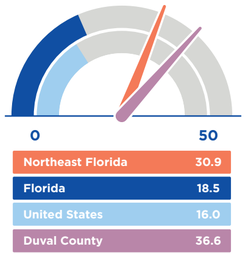
MORTALITY

Opioid Overdose

This indicator reports the 2016-2020 five-year average rate of death due to opioid drug overdose per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

Note: Data are suppressed for counties with fewer than 20 deaths in the time frame.

Opioid Drug Overdose Mortality, Age-Adjusted Death Rate (Per 100,000 Population)



Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
Northeast Florida	1,533,060	2,285	29.8	30.9
Baker County, FL	28,670	17	No Data	No Data
Clay County, FL	215,527	275	25.5	27.7
Duval County, FL	947,771	1,738	36.7	36.6
Nassau County, FL	85,783	101	23.6	28.1
St. Johns County, FL	255,309	154	12.1	13.4
Florida	21,221,443	18,505	17.4	18.5
United States	326,747,554	256,428	15.7	16.0

Note: This indicator is compared to the state average.
Data Source: Centers for Disease Control and Prevention, CDC – National Vital Statistics System, Accessed via CDC WONDER, 2016-2020

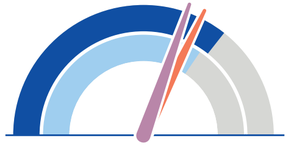
MORTALITY

Life Expectancy

This indicator reports the average life expectancy at birth (age-adjusted to 2000 standard). Data were from the National Center for Health Statistics - Mortality Files (2019-2021) and were used for the 2024 County Health Rankings.

Note: Data are suppressed for counties with fewer than 5,000 population-years-at-risk in the time frame.

Life Expectancy at Birth 2019-2021



50 90

Northeast Florida	75.8
Florida	78.5
United States	77.6
Duval County	74.3

Report Area	Total Population	Life Expectancy at Birth (2019-21)
Northeast Florida	1,494,242	75.8
Baker County, FL	27,482	74.4
Clay County, FL	207,568	75.7
Duval County, FL	919,830	74.3
Nassau County, FL	83,314	76.9
St. Johns County, FL	256,047	81.1
Florida	19,618,187	78.5
United States	307,250,254	77.6

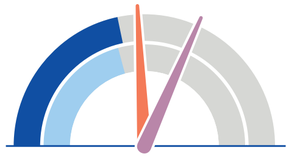
Note: This indicator is compared to the state average.
Data Source: University of Wisconsin Population Health Insitute, County Health Rankings. 2019-2021

VIOLENT CRIME

Total

This indicator reports the combined rate of homicide, rape, robbery, and aggravated assault per 100,000 residents.

Violent Crime Rate (per 100,000 population)



0 1000

Northeast Florida	484.10
Florida	433.90
United States	416.00
Duval County	633.50

Report Area	Total Population	Violent Crimes, 3-year Total	Violent Crimes, Annual Rate (per 100,000 Population)
Northeast Florida	1,489,156	21,629	484.10
Baker County, FL	34,159	397	387.30
Clay County, FL	208,736	1,739	277.70
Duval County, FL	926,305	17,605	633.50
Nassau County, FL	84,226	556	220.00
St. Johns County, FL	235,729	1,332	188.30
Florida	20,754,584	270,212	433.90
United States	366,886,849	4,579,031	416.00

Note: This indicator is compared to the state average.
Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports, Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research, 2015-2017.



PRIORITY 4

Food Environment

Access to Healthy Food and Food Insecurity

Although Food Environment ranked fourth among the significant health needs, it was identified as problematic in 81% of the interviews we conducted, as well as in 40% of the community conversations.

Access to Healthy Food and Food Insecurity

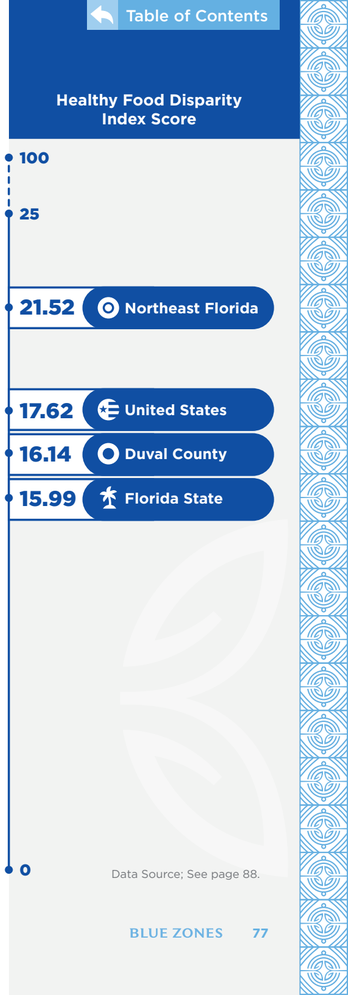
This primary data revealed the drivers of this ranking were healthy food access and food insecurity. Interestingly, many people that we talked with at the Sulzbacher Center did not identify themselves as food insecure, citing instead that they receive all their meals at Sulzbacher. The secondary data corroborated the primary data findings, including that 14.95% of Duval County households receive SNAP benefits (U.S. rate is 11.5%), 29.38% of the population have low food access (U.S rate is 22%), and the grocery store rate is 13.28 per 100,000 population (U.S. rate is 23.38). In terms of numbers of people, this means that over 59,000 Duval County households receive SNAP benefits and that over 250,000 people have low food access.

In addition, 84,225 Duval County residents who have low incomes also have low food access, which has a compounding effect on healthy eating and disease burden. An example of disease burden that is impacted by food and healthy eating can be seen in the most recent aggregated data for Medicare beneficiaries in Duval County, who represent 14.7% of the population. This data shows that diabetes prevalence, heart disease prevalence, and high blood pressure are all higher than the state or the U.S., or both.

Food Disparities

The problematic nature of the food environment is inequitable. Overall, the healthy food disparity index score of 16.14 (0 = perfect equality and 100 = perfect disparity) is higher than the state (15.99), with the disparity falling across racial lines. A higher percentage of people who are Non-Hispanic Black and Hispanic or Latino live in a food desert than people who are Non-Hispanic White.

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Data Source; See page 88.

Primary Data Source Comments

"If folks are living, you know, in an area with a food desert or they are so ill that they can't go to the store, shouldn't be out in the world, they can't run all over town, you know, because there's a sale on bread here and there's, yeah, I can afford, you know, something over here. They don't have that capacity."

"For me, grocery store, a lot of these areas are food deserts, which means that they don't have access to healthy options. So, the result to what they have is typically fast food, unhealthy food, and food of convenience."

"Sometimes you might not live necessarily in a food desert, but you can't really get to the grocery store. Sometimes all of these layer, right? So you have transportation, back in access, but you could actually have a transportation issue to food, right, and not to mention the economic components associated with that. The retailers that take SNAP benefits and then where they are, and then fast food environment is another thing."

"I think what jumps out to me here is, gosh, we do so much work in food security, but food insecurity still kind of jumps out at me. I mean, I know that we're doing more. It just seems like it's still such a huge, huge, huge challenge."

"Within the last month we learned that our provider is currently only serving about 100 individuals with the Meals on Wheels program. There's over 400 individuals on the wait list."

"Yeah, the first area, I will say food insecurity and SNAP. So I personally started a food pantry at the Players Center because we had so many families that were coming from other countries. They would show up at Wolfson's ER and they're not eligible for benefits. They can't get SNAP. So there is a lot of food insecurity."

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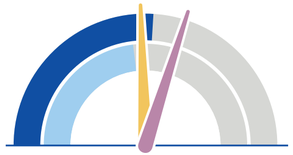
Secondary Data Summary

FOOD ENVIRONMENT

SNAP Benefits - Households Receiving SNAP

This indicator is relevant because it assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; when combined with poverty data, providers can use this measure to identify gaps in eligibility and enrollment.

Percent Households Receiving SNAP Benefits



0% 25%

Northeast Florida	12.22%
Florida	12.98%
United States	11.52%
Duval County	14.95%

Report Area	Total Population	Households Receiving SNAP Benefits	Percent Households Receiving SNAP Benefits
Northeast Florida	623,232	76,137	12.22%
Baker County, FL	9,004	1,739	19.31%
Clay County, FL	79,704	7,338	9.21%
Duval County, FL	396,132	59,219	14.95%
Nassau County, FL	36,336	2,978	8.20%
St. Johns County, FL	102,056	4,863	4.77%
Florida	8,353,441	1,084,253	12.98%
United States	125,736,353	14,486,880	11.52%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey, 2018-22

FOOD ENVIRONMENT

Low Food Access

This indicator reports the percentage of the population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the 2019 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Percent Population with Low Food Access



0% 40%

Northeast Florida	31.36%
Florida	25.07%
United States	22.22%
Duval County	29.38%

Report Area	Total Population (2010)	Population with Low Food Access	Percent Population with Low Food Access
Northeast Florida	1,345,596	421,957	31.36%
Baker County, FL	27,115	15,066	55.56%
Clay County, FL	190,865	66,319	34.75%
Duval County, FL	864,263	253,891	29.38%
Nassau County, FL	73,314	32,237	43.97%
St. Johns County, FL	190,039	54,444	28.65%
Florida	18,801,310	4,712,762	25.07%
United States	308,745,538	68,611,398	22.22%

Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas, 2019

FOOD ENVIRONMENT

Grocery Stores

Healthy dietary behaviors are supported by access to healthy foods, and grocery stores are a major provider of these foods. Grocery stores are defined as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. Delicatessen-type establishments are also included. Convenience stores and large general merchandise stores that also retail food, such as supercenters and warehouse club stores, are excluded.

Grocery Stores, Rate per 100,000 Population



0 30

Northeast Florida	15.63
Florida	17.26
United States	23.38
Duval County	17.88

Report Area	Total Population (2020)	Number of Establishments	Establishments, Rate per 100,000 Population
Northeast Florida	1,605,848	251	15.63
Baker County, FL	28,259	4	14.15
Clay County, FL	218,245	23	10.54
Duval County, FL	995,567	178	17.88
Nassau County, FL	90,352	12	13.28
St. Johns County, FL	273,425	34	12.43
Florida	21,538,187	3,718	17.26
United States	266,610,714	62,329	23.38

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, County Business Patterns, Additional data analysis by CARES, 2021

FOOD ENVIRONMENT

Low Income & Low Food Access

This indicator reports the percentage of the low income populations with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. Data are from the April 2019 Food Access Research Atlas dataset. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Percent Low Income Population with Low Food Access



0% 50%

Northeast Florida	29.94%
Florida	21.98%
United States	19.41%
Duval County	28.18%

Report Area	Total Population	Low Income Population	Low Income Population with Low Food Access	Percent Low Income Population with Low Food Access
Northeast Florida	1,345,596	415,920	124,536	29.94%
Baker County, FL	27,115	8,956	4,631	51.71%
Clay County, FL	190,865	51,695	16,383	31.69%
Duval County, FL	864,263	298,877	84,225	28.18%
Nassau County, FL	73,314	17,742	8,892	50.12%
St. Johns County, FL	190,039	38,650	10,405	26.92%
Florida	18,801,310	6,493,825	1,427,401	21.98%
United States	308,745,538	97,055,825	18,834,033	19.41%

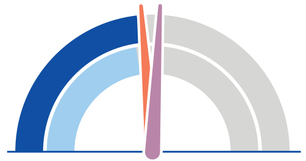
Note: This indicator is compared to the state average.
Data Source: US Department of Agriculture, Economic Research Service, USDA – Food Access Research Atlas, 2019

CHRONIC CONDITIONS

Diabetes Prevalence (Medicare Population)

This indicator reports the number and percentage of the Medicare Fee-for-Service population with diabetes. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for Service program.

Percentage of Medicare Beneficiaries with Diabetes



Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Diabetes	Beneficiaries with Diabetes, Percent
Northeast Florida	168,898	47,597	28.5%
Baker County, FL	3,060	1,108	36.2%
Clay County, FL	27,035	7,997	29.6%
Duval County, FL	87,806	27,196	31.0%
Nassau County, FL	13,562	3,517	25.9%
St. Johns County, FL	35,435	7,779	22.0%
Florida	2,200,536	612,024	27.8%
United States	33,499,472	9,029,582	27.0%

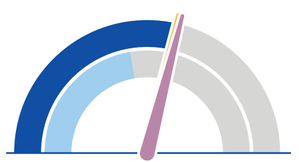
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

CHRONIC CONDITIONS

Heart Disease (Medicare Population)

This indicator reports the number and percentage of the Medicare Fee-for-Service population with ischemic heart disease. Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program.

Percentage of Medicare Beneficiaries with Heart Disease



Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Heart Disease	Beneficiaries with Heart Disease, Percent
Northeast Florida	166,898	57,074	34.2%
Baker County, FL	3,060	1,169	38.2%
Clay County, FL	27,035	9,917	36.7%
Duval County, FL	87,806	30,519	34.8%
Nassau County, FL	13,562	4,114	30.3%
St. Johns County, FL	35,435	11,355	32.0%
Florida	2,200,536	754,304	34.3%
United States	33,499,472	8,979,902	26.8%

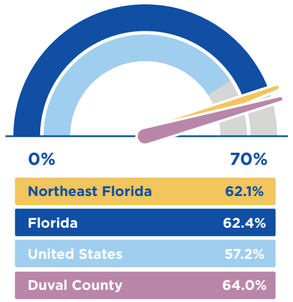
Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

CHRONIC CONDITIONS

High Blood Pressure (Medicare Population)

This indicator reports the number and percentage of the Medicare Fee-for-Service population with hypertension (high blood pressure). Data are based upon Medicare administrative enrollment and claims data for Medicare beneficiaries enrolled in the Fee-for-Service program.

Percentage of Medicare Beneficiaries with High Blood Pressure



Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with High Blood Pressure	Beneficiaries with High Blood Pressure (%)
Northeast Florida	166,898	103,594	**62.1%**
Baker County, FL	3,060	2,015	65.8%
Clay County, FL	27,035	16,200	59.9%
Duval County, FL	87,806	56,160	64.0%
Nassau County, FL	13,562	8,297	61.2%
St. Johns County, FL	35,435	20,922	59.0%
Florida	2,200,536	1,372,692	62.4%
United States	33,499,472	19,162,770	57.2%

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

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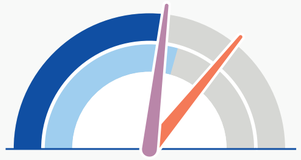
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ACCESS

Healthy Food Access Disparities

This indicator reports the percentage of the report area population living in a food desert by population race and ethnicity. A food desert is defined as a low-income neighborhood (census tract) where a large proportion of the population does not have access to a large grocery store. The disparity index score is a relative measure which expresses the magnitude of disparity in food access across population groups, with a score of 0 representing perfect equality, and a score of 100 representing perfect disparity.

Disparity Index Score



0 30

Northeast Florida	21.52
Florida	15.99
United States	17.62
Duval County	16.14

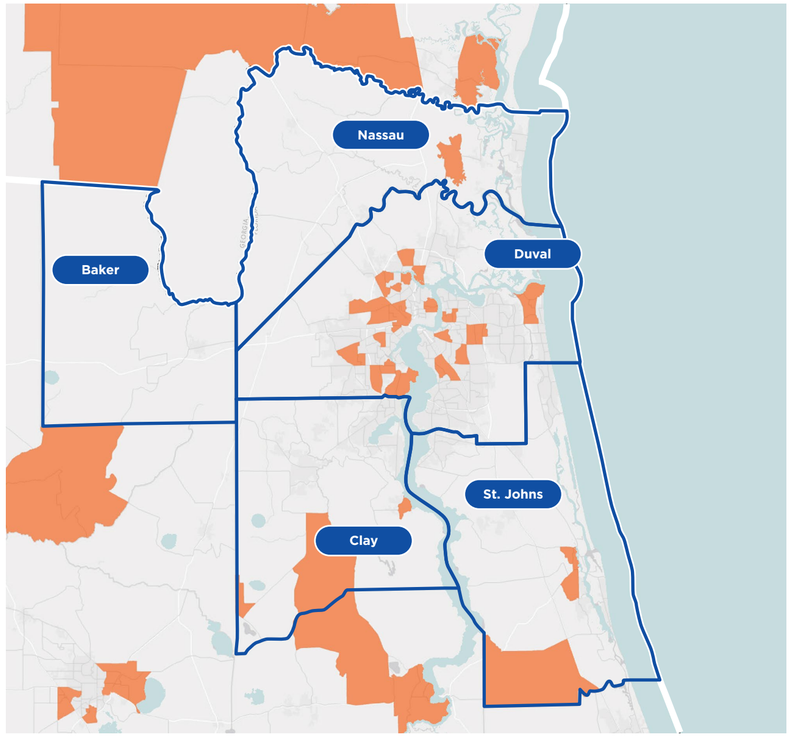
Report Area	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Other Race	Disparity Index Score
Northeast Florida	17.85%	30.98%	52.18%	24.13%	21.52
Baker County, FL	0.00%	0.00%	0.00%	0.00%	No data
Clay County, FL	4.91%	6.75%	6.97%	2.79%	6.71
Duval County, FL	27.48%	41.11%	58.25%	31.73%	16.14
Nassau County, FL	9.00%	6.62%	14.90%	10.00%	3.83
St. Johns County, FL	9.30%	13.04%	29.16%	7.17%	10.98
Florida	20.18%	33.81%	48.46%	25.04%	15.99
United States	18.73%	36.99%	45.91%	22.59%	17.62

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare & Medicaid Services, Centers for Medicare & Medicaid Services - Chronic Conditions. 2018.

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Food Desert Census Tracts

1 Mi / 10 Mi. by Census Tract, USDA - FARA 2019



LEGEND

- Food Desert
- No Data
- Report Location

Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019.



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Section IV

Process and Methods to Conduct the CHNA

Key Stakeholder and Group Listening Sessions Methodology

Our primary data collection began through a deductive interview approach using twelve (12) categories of health needs commonly identified within the social determinants of health literature and frameworks. Specifically, we drew upon:

- Well-Being in the Nation Measurement Framework
- County Health Rankings and Roadmaps
- Healthy People 2030

These 12 categories were organized across 3 domains - People, Places, and Equity. Each of the 12 categories had several sub-categories associated with it also determined through the evaluation of the above frameworks. Throughout our Key Stakeholder Interviews and Group Listening Sessions we presented each domain, seeking input as to needs / barriers / issues within the category and sub-category level, and offering the opportunity to speak to additional sub-categories not otherwise listed.

Vision care, specialty care, dementia, autism, and hypertension, for example, were a few sub-categories mentioned but not listed.

People

Access to Care	Primary Care Mental Health Hospitals Clinics Dental Care	Insurance Transportation Health Literacy Cultural Competency
Health Conditions	Birth Outcomes Obesity Diabetes Heart Disease Asthma	Stroke Cancer Dementia Kidney
Health Behavior	Tobacco Alcohol Drugs Diet	STIs Movement Breastfeeding
Mental Health	Suicide Deaths of Despair Depression Isolation	Stress Anxiety Serious Mental Illness Trauma

Places

Food Environment	Food Insecurity Healthy Food Access Food Deserts	Grocery Store Accessibility SNAP Fast Food
Built Environment	Walkability Park Access Broadband Access Air Quality	Public Transit Liquor Stores Tobacco Retailers
Community Vitality	Social Inclusion Older Adults Living Alone Civic Engagement	Economic Vitality Place Attachment
Community Safety	Arrests Firearm Mortality Violent Crime	Property Crime Disengaged Youth Motor Vehicle Fatalities

Equity

Housing	Housing Cost Burden 50% Affordable Housing Homelessness	Homeless Youth Housing Quality Evictions
Financial Stability	Unemployment Childhood Poverty Median HH Income	Labor Force Debt Housing Cost Burden 30%
Education	Childcare Scarcity Preschool Enrollment	Education Attainment Absenteeism Language Arts Proficiency
Inclusion & Equity	Food Disparities Insurance Disparities Broadband Disparities Education Disparities	Neighborhood Segregation Income Inequality Premature Death Disparities

Health Need Category	Codes Applied
People	
Access to Care	149
Health Conditions	29
Healthy Behavior	28
Mental Health	49
Places	
Food Environment	40
Built Environment	41
Community Vitality	12
Community Safety	22
Equity	
Housing	61
Financial Stability	21
Education	9
Equity	35
Total	**496**

Each key stakeholder interview and group listening session was recorded, transcribed, and uploaded into Dedoose – a qualitative analysis software tool. Each transcript was then coded, applying health needs categories as parent codes and associated sub-categories as child codes to transcript excerpts. After exporting the data, we made adjustments blending or collapsing certain child codes and associated parent codes into areas without much distinction. For example, we added the public transit codes from the built environment category to the transportation codes in the access to care category, ensuring the codes were not otherwise duplicated.

This resulted in the application of 496 codes across 66 child (sub-category) codes, positioning us to make additional calculations such as the percent of interviews that identified the category as problematic, the percent of times the code was applied, as well as further drill-down within each category. The leading health needs categories from this analysis were Access to Care, Housing and Mental Health.

We also asked all interview participants to select the three categories each perceived as the highest need along with an opportunity to share additional comments. For in-person interviews, a scoring tool was distributed and returned with the participants' selections marked. For virtual interviews, we asked participants to put their selections in the chat or we used a polling feature, which similarly provided the virtual participants the same tool to view on-screen.

Of the 129 interview participants, 116 (90%) completed a tally sheet and/or replied in a chat or poll, providing 347 total responses. We counted each instance a category was selected and then calculated the percentage that category was selected as one of the top three categories, positioning us to use the data in later analysis. The findings of the polling were consistent with the coding results, with access to care, housing, and mental health leading the categories.



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Health Need Category	Total Times Selected as Top 3	Percent Selected as Top 3
People		
Access to Care	72	62%
Health Conditions	20	17%
Healthy Behavior	17	15%
Mental Health	57	49%
Places		
Food Environment	25	22%
Built Environment	12	10%
Community Vitality	5	4%
Community Safety	13	11%
Equity		
Housing	71	61%
Financial Stability	30	26%
Education	7	6%
Equity	18	16%

Community Conversations Methodology

For our community conversations, we used an interview sheet and asked each person whether they or people around them were experiencing any of the health needs listed on the sheet, and we documented the conversation as we talked. The interview sheet included the same 12 categories of health needs and associated sub-categories as for the key stakeholder and group listening sessions.

We also conducted a Cantril Ladder assessment on each person, using a visual representation of a ladder and asking them to tell us which rung on a ladder represented their life today, with 0 being the worst possible life and 10 being the best possible life. We did not see any patterns emerge with the Cantril Ladder data (scores ranged from 0-10 overall). It was therefore not used in any of our subsequent data analysis.



Health Need Category	Codes Applied
People	
Access to Care	82
Health Conditions	46
Healthy Behavior	32
Mental Health	47
Places	
Food Environment	37
Built Environment	42
Community Vitality	11
Community Safety	37
Equity	
Housing	69
Financial Stability	38
Education	18
Equity	9
Total	**468**

We then hand-coded the interview sheets ensuring a 1:1 parent-to-child code application (for each child code applied, there is a corresponding parent code). This resulted in the application of 468 codes across the 66 child (sub-category) codes and positioned us to make additional calculations such as the percent of conversations that identified the category as problematic, the percent of times the code was applied, as well as further drill-down within each category.

The community conversations resulted in the same three categories rising to the top as the key stakeholder interviews and group listening sessions: Access to Care, Housing, and Mental Health.



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Secondary Data Methodology

For our secondary data source, we used CARES (The Center for Applied Research and Engagement Systems) based out of the University of Missouri. CARES is a comprehensive community needs dataset using data from 110 data providers and 781 data sets, including the US Census Bureau, American Community Survey (ACS), Centers for Disease Control and Prevention (CDC), United States Department of Agriculture (USDA), Department of Transportation, Federal Bureau of Investigation, and more. Data geographies range from state, county, city, census tract, school district, and ZIP code levels.

Measures associated with each health needs category were identified based on their direct and indirect relationship to the category and sub-categories by using the health measurement frameworks listed above and by reviewing other CHNA models. We also maintained a consistent set of measures reflective of long-term outcomes across all categories. Each measure was then evaluated as to whether it was performing worse (yes) than or better (no) than the state or the U.S. The percentage of measures performing worse than the respective comparison was then calculated for each health need category.

The number of measures per health needs category ranged from 21 to 39. To review the secondary data evaluated for each of the 12 health needs categories please see the appendix.

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Prioritization Methodology

To determine the highest priority health needs, we first determined those health need categories that were significant by applying the following three principles:

1. **Principle:** Incorporate the analysis conducted for the secondary data, the interviews, and the community conversations.

   Application: We chose the following calculations for each of the respective data types:

   - **Secondary Data:** The percent of the selected measures associated with each category that performed poorly as compared to the state and to the U.S.
   - **Interview Data:** The percent of the interviews that identified the respective category as problematic
   - **Community Conversations:** The percent of community conversations that identified the respective category as problematic.

2. **Principle:** Determine a threshold value for each data source based on the range of respective results.

   Application: We selected median for each data type after conducting means, median and percent testing. This means that if any individual data type scored above the median, a health needs category was potentially significant.

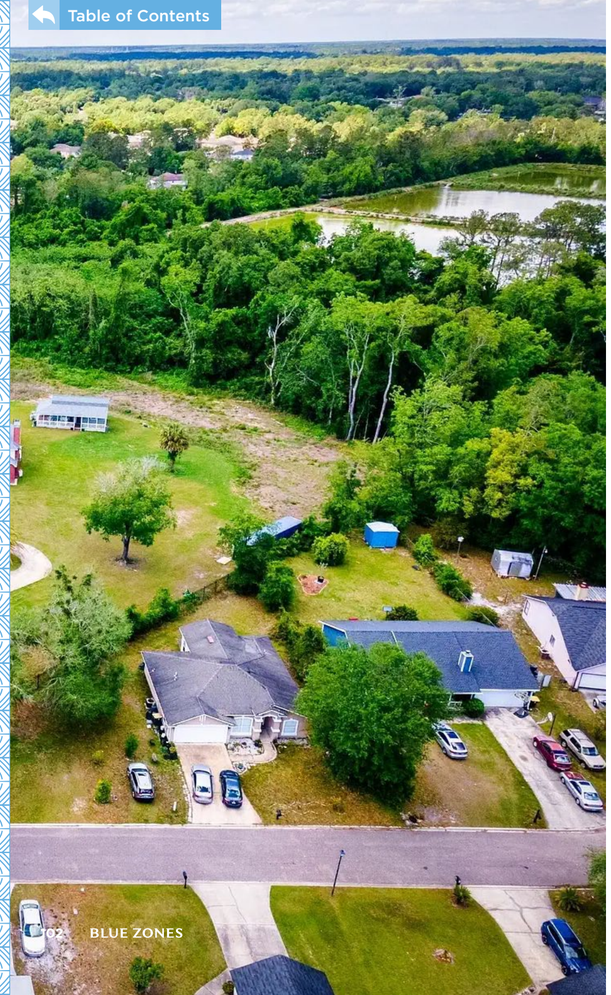
3. **Principle:** Ensure primary data is valued greater than secondary data to ensure primary voices are heard.

   Application: A health need category was determined to be significant if two out of three of the following were true:

   - If the percent of associated measures performing poorly compared to the state or U.S. > median
   - If the percent of interviews that identified the category as problematic > median
   - If the percent of community conversations that identified the category as problematic > median

This methodology resulted in determining that six of the initial twelve health need categories were significant. These include access to care, mental health, food environment, built environment, community safety, and housing.

	Peach Above median of 54%	Yellow Above median of 64%	Blue Above median of 64%	Blue Above median of 33%
Health Need Category	**Percent of associated indicators performing poorly compared to state**	**Percent of associated indicators performing poorly compared to U.S.**	**Percent of interviews that identified category as problematic**	**Percent of community conversations that identified category as problematic**
Access to Care	51%	66%	100%	60%
Health Conditions	63%	86%	56%	31%
Healthy Behavior	67%	82%	44%	32%
Mental Health	59%	86%	81%	29%
Food Environment	56%	68%	81%	39%
Built Environment	47%	50%	85%	44%
Community Vitality	65%	73%	41%	13%
Community Safety	71%	62%	63%	35%
Housing	39%	48%	96%	65%
Financial Stability	44%	47%	59%	42%
Education	48%	55%	33%	18%
Inclusion & Equity	47%	53%	56%	10%



Once certain health needs were determined to be significant, we then turned to prioritizing them by calculating a priority index score for each. To do this, we considered the breadth and intensity of the primary data.

For the breadth, we calculated:

- The percent of all primary source data (interviews and conversations) that identified the respective health need as problematic, and
- The total number of times all primary source data (interviews and conversations) identified the respective health need as problematic - based on the number of associated sub-category codes.

For the intensity, we included:

- The percentage of times the respective health need was selected as a top three, and
- The number of times the respective health need was selected as a top three.

We then re-scaled the breadth and the intensity "number of times" values so that the minimum would be zero and the maximum would be one. Each significant health need's priority index score was then determined by adding the respective four values (the percent values and the rescaled "number of times" values) for each significant health need. Access to Care had the highest priority index score of 3.33, followed by Housing with 2.75 and Mental Health with 1.82.

		Breadth	Breadth		Intensity	Intensity		
	Health Need Category	Percent of all primary data sources that identified health need as problematic	Number of times health need identified as problematic, all sources	Rescaled	Percentage of times health need selected as top three	Number of times health need selected as top three	Re-scaled	Priority Index Score
1	Access to Care	0.71	231	1.00	0.62	72	1.00	3.33
2	Housing	0.74	130	0.41	0.61	71	0.98	2.75
3	Mental Health	0.36	96	0.22	0.49	57	0.75	1.82
4	Food Environment	0.51	77	0.10	0.22	25	0.20	1.03
5	Built Environment	0.56	83	0.14	0.10	12	0.00	0.80
6	Community Safety	0.42	59	0.00	0.11	13	0.02	0.55

Because the intent of conducting the Community Health Needs Assessment is not just to identify and prioritize the significant health needs, but also to respond to them, our final step in analysis was to understand the sub-categories that served as primary drivers of each prioritized significant health need. Addressing the underlying driver(s) is more likely than otherwise to have an overall positive impact on the health need category itself. The shading in the charts below represents the primary driver(s) of each prioritized need.

Access to Care Sub-Categories	Interviews	Conversations	Total
Health Insurance	49	27	**76**
Transportation	33	29	**62**
Dental Care	17	10	27
Specialty Care	13	6	19
Cultural Competency	13	2	15
Primary Care	8	5	13
Health Literacy	11	0	11
Accessibility	4	0	4
Hospitals	0	2	2
Vision Care	1	1	2
	149	82	231

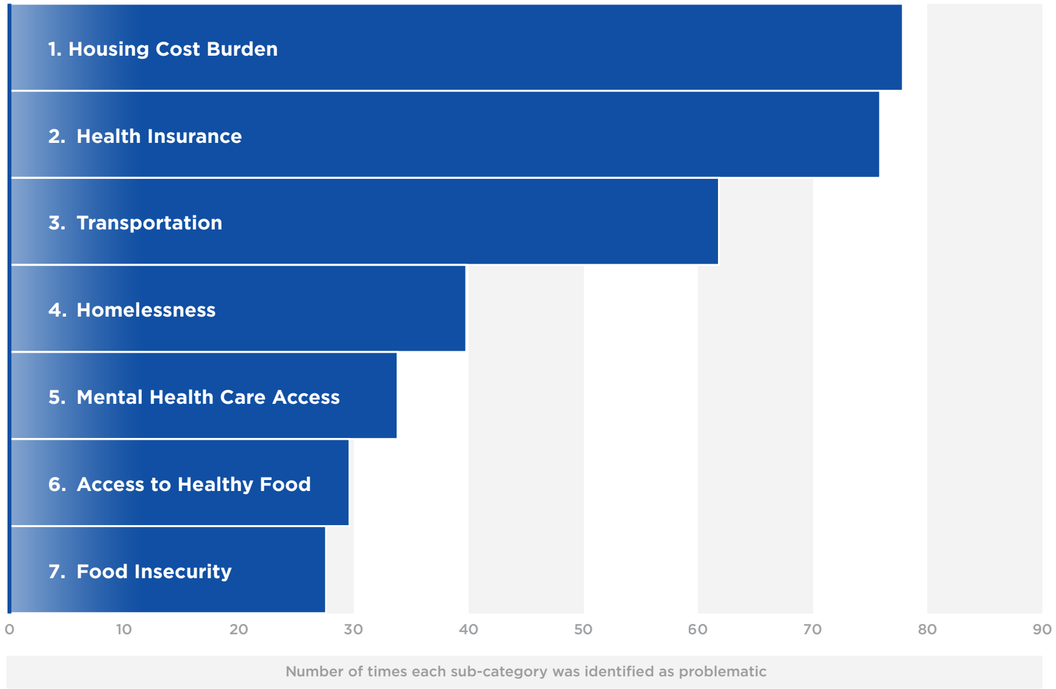
Mental Health Sub-Categories	Interviews	Conversations	Total
Mental Health Access	25	9	**34**
Stress	4	9	13
Depression	3	9	12
Anxiety	4	7	11
Isolation	6	4	10
Suicide	5	1	6
Trauma	2	4	6
Severe Mental Illness	0	2	2
Deaths of Despair	0	2	2
	49	47	96

Housing Sub-Categories	Interviews	Conversations	Total
Housing Cost Burden	38	60	**78**
Homelessness	11	29	**40**
Unstable Housing	7	0	7
Evictions	5	0	5
Quality of Housing	0	0	0
	61	69	130

Food Environment Sub-Categories	Interviews	Conversations	Total
Access to Healthy Food	16	14	**30**
Food Insecurity	14	14	**28**
Food Desert	4	6	10
Fast Food	4	3	7
SNAP	2	0	2
	40	37	77

A re-ordering of the significant health need categories by their most problematic sub-categories resulted in a final prioritization of:

Significant Health Need by Sub-category



Next Steps

The next step in the CHNA process includes the development of an implementation strategy to address the significant health needs identified. Using evidence-based solutions and programs to address the priority needs, each hospital in the JNHP will work to develop its strategy based on the result of this CHNA.

In advance of each hospital selecting its own strategies, the JNHP decided to come together and identify a priority area and an associated initiative that it would work on collectively. Following the presentation of the CHNA findings, the JNHP representatives engaged in a facilitated exercise to do just that.

The facilitated exercise included a “sticky note” exercise for each of the 7 prioritized health needs. Each participant, after review of each health need and prior associated strategies (if any), and group discussion and deliberation, wrote on a sticky note as many strategies as they wanted and placed them on the corresponding large wall Post-it boards.

The group then did a step-back view of the wall boards to read and review the ideas on the sticky notes. Following that, the group did two rounds of a “dot prioritization” exercise to vote (with sticky dots) for the health need they wanted to address. Through this process, transportation, one of the drivers of access to care, was selected.

All the ideas on the transportation board were then reviewed for overlapping ideas and central themes. Four ideas emerged from this process and each was added to a criteria-based decision tool. The JNHP will continue to review potential strategies to address the priority health needs.

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Section V

Acknowledgments

Jacksonville Nonprofit Hospital Partnership Representatives

Throughout the CHNA process, the following representatives of the JNHP not only showed their engagement and shared their unique perspectives, but their passion and commitment to make Northeast Florida a healthier place in which people are born, grow, live, work and age was palpable.

Paula Bides
Director, Community Benefit, Ascension Florida and Gulf Coast

Toni Callahan
Manager, Community Health & Well-Being, Baptist Health

Glenwood Charles, Jr.
Senior Community Partner Coordinator, Baptist Health

Jessica Cummings
Vice President, Community Engagement, Brooks Rehabilitation

Katie Ensign
Vice President, Community Investment and Impact, Social Responsibility, Baptist Health

Ann-Marie Knight
Vice President, Community Engagement & Chief Diversity Officer, UF Health Jacksonville

Ashley Pratt
Community Relations, Mayo Clinic in Florida

CHNA Consultants

This CHNA was conducted on behalf of the JNHP by Blue Zones, LLC. Blue Zones is a company that is dedicated to transforming well-being where people live, work, learn, grow up and grow old. For over 20 years, Blue Zones has been on the ground in hundreds of American cities and organizations co-creating and implementing evidence-informed well-being transformation programs to create sustainable, systems-level solutions that improve population health and economic vitality. Blue Zones partners with public and private sector leaders to increase the well-being of communities leading to greater stability, reduced health care costs and disparities, and increased resilience. Blue Zones partners with organizations and brands that want to make meaningful, sustainable impact for their employees, members, and customers.

The first step in its work in any community is assessing the community. Our community assessments go deep into the community and include policy evaluations of the built environment food systems and tobacco. It includes engaging with community leaders, business leaders, grocery store owners and small business owners. We talk to people throughout the community, including those living in areas most impacted by disparities and inequities. We conduct surveys and draw upon publicly available data. And we observe the environment and the culture. We do this all to lay a foundation for identifying where to start; what policies and initiatives will have the greatest impact on community well-being – our key metric that correlates with living better, longer. We were very pleased to have the opportunity to apply our assessment methods and expertise for this CHNA.

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Resources / Organizations

For resources and organizations potentially available to address the significant health needs, please see the Additional Resources Appendix.

Data Limitations

Group Listening Sessions and Key Stakeholder interviews were conducted solely with volunteers, which could affect how broadly the community was represented. Similarly, the community conversations were not scheduled and were dependent on the willingness of people to participate when asked. Broad scale community engagement is difficult in geographically large, rural communities and large, high-population urban communities. Some of the secondary data sets used demonstrate data lag, which could alter the conclusion if more current data had a significant shift. Despite these limitations, the data provided can be seen as an accurate reflection of the community's health needs.

Written Comments

We value input into the community health needs assessment. Please visit our public website (https://healthcare.ascension.org/chna) to submit your comments.

At the time of this report development, no written comments about the previous CHNA Report or the adopted implementation strategies were received.

Approval

This community health needs assessment was adopted on

_____, by _____.

The final report was made widely available on _____.





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