Community Health Needs Assessment

Mercy Hospital St. Louis

Fiscal Year 2019

Mercy

Your life is our life's work.

Our Mission:

As the Sisters of Mercy before us, we bring to life the healing ministry of Jesus through our compassionate care and exceptional service.

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I. Executive Summary

Mercy Hospital St. Louis (MHSL) is a 979-bed, single-occupancy-room hospital located in St. Louis, Missouri. It is one of five hospitals in Mercy's East Community and the only Level 1 (highest level) trauma center in St. Louis County. MHSL's campus includes Mercy JFK Clinic, which focuses on serving the health needs of individuals who are uninsured or underinsured; Mercy Heart and Vascular Hospital; the David C. Pratt Cancer Center; and Mercy Children's Hospital, the only full-service pediatric hospital in St. Louis County and one of only two hospitals in the state of Missouri to have a Level III (highest level) neonatal intensive care unit.

MHSL's primary service area is St. Louis County. Throughout the county, MHSL operates Mercy Clinic physician offices, outpatient hospital services, and Mercy Urgent Care Centers. In 2015, Mercy also opened the world's first virtual care center, located in St. Louis County. The center addresses critical community health needs, such as transportation barriers to accessing care affecting lower-income and non-ambulatory patients, and provider shortages in the surrounding rural communities comprising MHSL's extended service area.

Mercy's mission is to deliver "compassionate care and exceptional service" to every community member. In dedication to this mission, our work includes the development of a Community Health Needs Assessment (CHNA) during the last year, which included both St. Louis City and County Public Health sectors, a first for our region, as well as traditional and non-traditional partners in both medical and community-based agencies and organizations. To do this, we gathered and analyzed health-related information and statistics from St. Louis, St. Louis County. This information includes interviews with public health experts and those who represent the broad interests of the community served by the hospital, and surveys of community residents and local physicians.

The CHNA identified five top-priorities and of the five, four have been chosen as health needs for the Mercy Hospital St. Louis community. We will strive diligently to address these needs with a Health Equity lens over the next three years:

Access to Care
Behavioral Health/Substance Abuse
Maternal Child Health
Chronic Disease Prevention and Management

Please visit https://www.mercy.net/about/community-benefits/ to learn more about the community benefit work being done at Mercy.

As always, we seek to develop a rich and rewarding network of partnerships with our neighbors. I welcome any thoughts you may have on ways to achieve our goal for a healthier community.

Sincerely,

Steve Mackin
President and Chief Executive Officer
Mercy Hospital St. Louis

Beginning in early 2017, Mercy Hospital South (formerly St. Anthony's) and Mercy Hospital St. Louis joined the **St. Louis Partnership for a Healthy Community (STLPHC)** which is comprised of a broad

range of stakeholders from within the public health system and individual advocates who subscribe to a comprehensive definition of health. The membership of STLPHC is intended to represent the wide range of entities that impact health in the St. Louis region: it includes both the City of St. Louis Department of Health and the St. Louis County Department of Health, area hospital systems, government agencies/departments, coordinated care organizations, community-based organizations, academic institutions, and business partners in the City of St. Louis and St. Louis County.
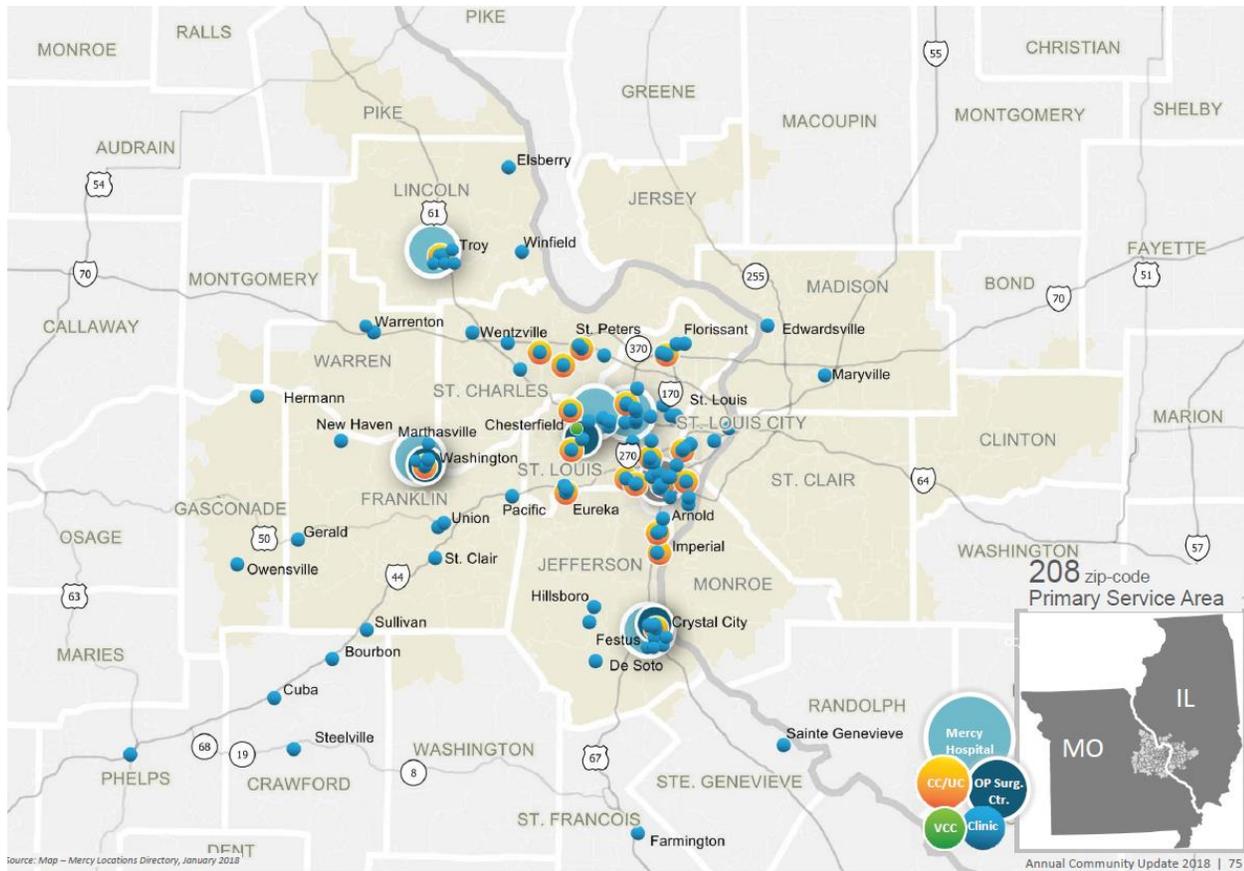
The work of this partnership resulted in the **St. Louis Region Community Health Assessment and Community Health Improvement Plan** completed in August of 2018. Partnering on a needs assessment and joining the membership gave Mercy a chance to align efforts with community partners and contribute to an effort that would eliminate duplication, prioritize needs and enable collaborative efforts. The resulting needs assessment was the main focus of establishing priorities set by Mercy Hospital St. Louis and its governing Community Health Council.

In addition, Mercy Hospital St. Louis (MHSL) collaborated with Barnes-Jewish West County Hospital (BJWCH), Missouri Baptist Medical Center (MBMC), St. Luke's Hospital (SLH), St. Luke's Des Peres Hospital (SLDPH), Mercy Hospital South (MHS) and the St. Louis County Department of Health (STLDOH) on a Key Stakeholder analysis with community leaders in the summer of 2018.

The St. Louis Regional Community Health Assessment and Community Health Improvement Plan, along with the Key Stakeholder analysis done with hospital partners helped to identify and prioritize health problems and risk factors in the Mercy Hospital St. Louis community.

II. Community Served by the Hospital

Mercy Hospital St. Louis' extended service area consists of fourteen counties (194 zip codes) and includes both rural and urban settings

In 2011, representatives from the St. Louis County Department of Public Health met with representatives from the St. Louis County Department of Planning and established five regions within the county to reflect how it is divided in terms of geography and social demographics. These regions were: Central, Inner North, Outer North, South, and West. Taking into account the regional distribution of medically underserved individuals, as well as the hospital's location, MHSL defined its community as the following three regions in St. Louis County during its CHNA process:

- West
- Inner North
- Outer North

In total, these three regions constitute 66% of St. Louis County's total population (1,027,856) and comprised 75% of MHSL's discharges of St. Louis County residents in FY2018.

III. Demographics

St. Louis Community Demographics

Population Demographics	Primary Service Area 2017		Primary Service Area 2022		5-Year Growth	MO 2017	US 2017
Total Population	2,771,653		2,805,304		1%	6,112,609	325,139,271
Age Groups	*Number*	*Percent*	*Number*	*Percent*	*Percent*	*Percent*	*Percent*
0-17	621,496	22%	611,896	22%	-2%	23%	23%
18-44	960,327	35%	960,105	34%	0%	35%	36%
45-64	750,673	27%	721,933	26%	-4%	26%	26%
65+	439,157	16%	511,370	18%	16%	16%	15%
Race & Ethnicity							
Asian & Pacific Is. Non-Hispanic	72,635	3%	82,172	3%	12%	2%	6%
Black Non-Hispanic	509,155	18%	511,365	18%	<1%	12%	12%
Hispanic	88,318	3%	101,744	4%	15%	5%	18%
White Non-Hispanic	2,039,010	74%	2,039,900	73%	<1%	79%	61%
All Others	62,535	2%	70,123	3%	11%	3%	3%

	Primary Service Area 2017	Primary Service Area 2022	MO 2017	US 2017
Language*	*Percent*	*Percent*	*Percent*	*Percent*
Only English at Home	94%	94%	94%	79%
Spanish at Home	2%	2%	2%	13%
All Others	4%	4%	3%	8%
Workforce**				
Armed Forces	<1%	<1%	<1%	<1%
Civilian, Employed	60%	60%	59%	58%
Civilian, Unemployed	5%	5%	54%	5%
Not in Labor Force	34%	34%	37%	36%
Household Income				
<$15K	11%	10%	12%	12%
$15-25K	19%	9%	10%	10%
$25-50K	23%	22%	25%	23%
$50-75K	18%	17%	18%	17%
$75-100K	13%	13%	12%	12%
$100K-200K	20%	22%	18%	19%
>$200K	6%	7%	5%	6%
Families living below poverty level	10%	10%	11%	12%
Education Level*				
Less than High School	3%	3%	4%	6%
Some High School	6%	6%	8%	8%
High School Degree	27%	27%	31%	28%
Some College/Assoc. Degree	34%	34%	32%	31%
Bachelor's Degree or Greater	30%	30%	25%	28%

☐ = largest cohort in demographic category

*Excludes population age <5   **Excludes population age <16   ***Excludes population age <25 and based on highest level achieved
Note: St. Louis Primary Service Area consists of 208 zip codes in Missouri and Illinois
Source: Sg2 Market Demographics; Nielsen zip code data, 2017

CNI (Community Needs Index) scoring also helps to describe the community that Mercy Hospital St. Louis serves. The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community using the 2014 source data. The five barriers are listed below along with the individual 2014 statistics that are analyzed for each barrier:

Income barrier:
- Percentage of households below poverty line, with head of household age 65 or more
- Percentage of families with children under 18 below poverty line
- Percentage of single female-headed families with children under 18 below poverty line

Cultural Barrier
- Percentage of population that is minority (including Hispanic ethnicity)
- Percentage of population over age 5 that speaks English poorly or not at all

Education Barrier
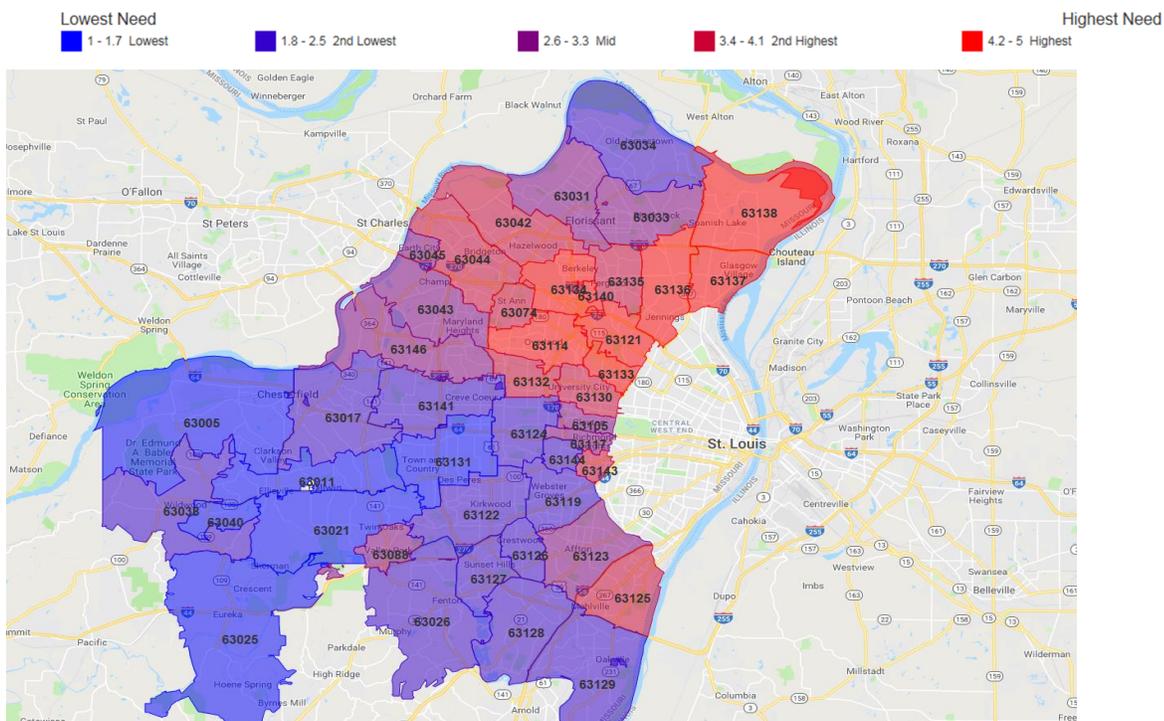- Percentage of population over 25 without a high school diploma

Insurance Barrier
- Percentage of population in the labor force, aged 16 or more, without employment
- Percentage of population without health insurance

Housing Barrier
- Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5 depending upon the ZIP code national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. The zip codes in red are those in highest need. Below is the Community Needs Index (CNI) for St. Louis County:
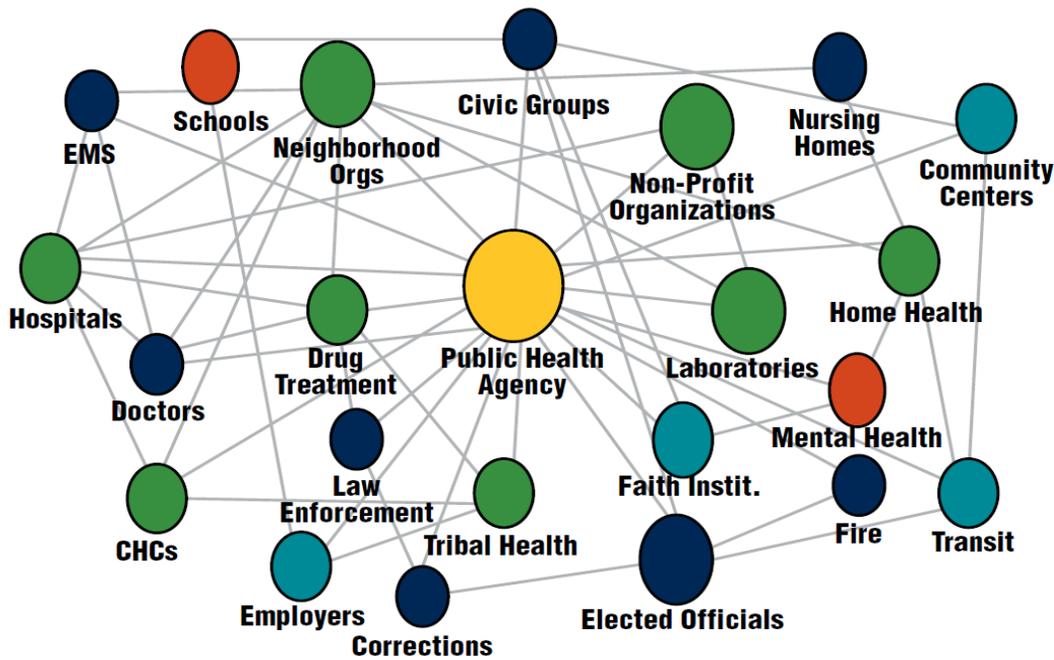

Source: Dignity Heath, Truven Health Analytics Community Needs Index, 2018

See Appendix I for more detail

IV. Community Health Needs Assessment Process

Mercy Hospital Saint Louis sought to identify health priorities by collaborating on the St. Louis Partnership for a Healthy Community (STLPHC) Region Community Health Assessment, collaboration with hospital partners on a Key Stakeholder Analysis and looking at data specific to Mercy Hospital St. Louis.

STLPHC is comprised of a broad range of stakeholders from within the public health system and individual advocates who subscribe to a comprehensive definition of health.[1] The public health system includes any organization, entity, or individual that contributes to or impacts the community's health

The membership of STLPHC is intended to represent the wide range of entities that impact health- it includes both the City of St. Louis Department of Health and the St. Louis County Department of Public Health, area hospital systems, government agencies/departments, coordinated care organizations, community-based organizations, academic institutions, and business partners in the City of St. Louis and St. Louis County. See Appendix A for participating organizations.
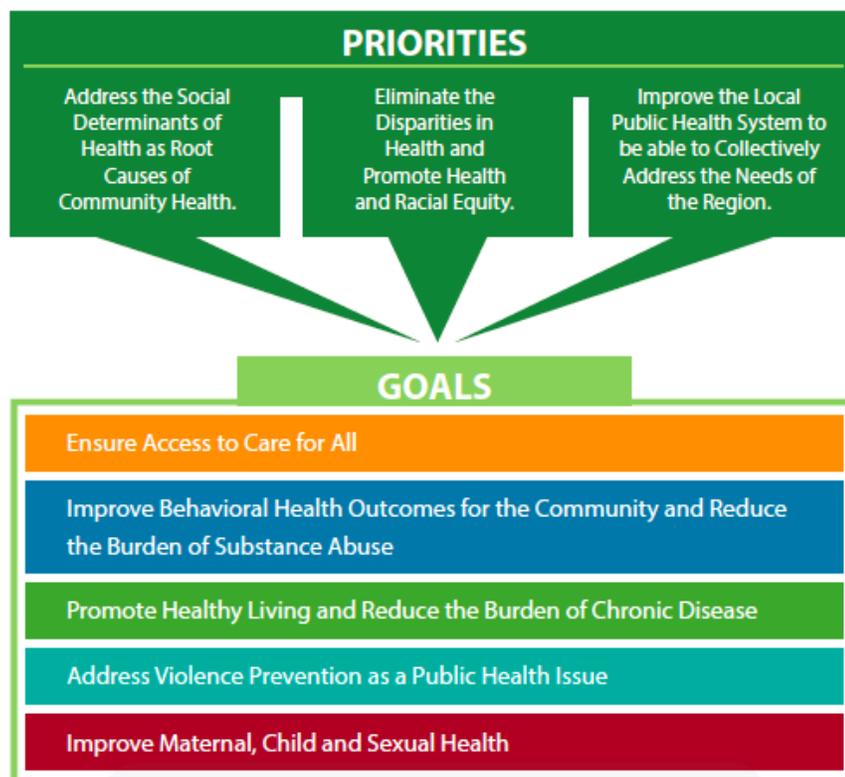
The purpose of STLPHC is to align the efforts of the participants and the residents of the communities they serve to develop and implement a shared community health assessment (CHA) and Community Health Improvement Plan (CHIP) across the City of St. Louis and St. Louis County. STLPHC aims to eliminate duplicative efforts, prioritize needs, and enable collaborative efforts to implement and track improvement activities across the region. This collaborative approach enables an effective and sustainable process; strengthens relationships between communities, organizations and government; creates meaningful community health needs assessments; and results in a platform for collaboration around regional health improvement plans and activities, leveraging collective resources to improve the health and wellbeing of our communities.

V. STLPHC St. Louis Regional Community Health Assessment & Community Health Improvement Plan

STLPHC tailored the Mobilizing for Action through Planning and Partnerships (MAPP) model to conduct the CHA and CHIP. MAPP is a community-driven strategic planning process for improving community health. It is an interactive process that helps communities prioritize public health issues and identify resources to address them.

Beginning in early 2017, partners convened to determine the shared vision and guiding values for the process. Following the development of the shared vision and guiding principles, the four MAPP assessments were conducted over the course of 2017 and analyzed together to identify strategic issues and priorities.

The final CHIP (Community Health Improvement Plan) structure is depicted in the figure below, with three priorities and five goals. The goals represent the strategic issues that the CHIP will address over the next five years. The three priorities underpin all the CHIP work, explicitly recognizing the need to address the social determinants of health, promote health and racial equity, and support regional infrastructure in all the CHIP goals. The priorities were identified as a commitment and intentional approach to improve public health outcomes while also recognizing limited infrastructure and the need to strengthen multi-sector (i.e., community development, transportation) collaboration in the local public health system to address social and structural determinants of health.

PRIORITIES

| Address the Social Determinants of Health as Root Causes of Community Health. | Eliminate the Disparities in Health and Promote Health and Racial Equity. | Improve the Local Public Health System to be able to Collectively Address the Needs of the Region. |

GOALS

- Ensure Access to Care for All
- Improve Behavioral Health Outcomes for the Community and Reduce the Burden of Substance Abuse
- Promote Healthy Living and Reduce the Burden of Chronic Disease
- Address Violence Prevention as a Public Health Issue
- Improve Maternal, Child and Sexual Health

St. Louis Region Community Health Assessment & Community Health Improvement Plan, 2018

See Appendix II for more detail

VI. Key Stakeholder Analysis

In the Patient Protection and Affordable Care Act (PPACA) passed in March 2010, non-profit hospitals were mandated to conduct a community-based health needs assessment (CHNA) every three years. As a part of that process, each hospital is required to solicit input from those who represent the broad interests of the community served by the hospital as well as those who have special knowledge and expertise in the area of public health and underserved populations.

Several St. Louis County hospitals have chosen to work together on this part of the assessment process, even though they are on different time lines for completing their CHNAs. They include Barnes-Jewish West County Hospital, Missouri Baptist Medical Center, Mercy Hospital St. Louis, Mercy Hospital South (formerly St. Anthony's Medical Center) and St. Luke's Hospital. For the first time this year, St. Luke's Des Peres was also included in the process. Many of these hospitals have been working together since the initial stakeholder assessment, conducted in 2012, followed by a second in 2015.

The hospitals continue to be on different timelines with this iteration of the needs assessment. The assessments of Mercy Hospital South, Mercy St. Louis, St. Luke's Hospital and St. Luke's Des Peres are due at the end of June 2019. Those of Barnes-Jewish West County and Missouri Baptist Medical Center are due at the end of December 2019. However, all hospitals continue to cooperate on soliciting the community feedback to be incorporated into each individual assessment.

VII. Rating of Needs

Participants rerated the needs identified in the 2018 assessment on a scale of 1 (low) to 5 (high), based on their **perceived level of community concern** and the **ability of community organizations to collaborate around them**.

The issues of **access to care** and **access to insurance** were rated the highest in terms of level of concern and ability to collaborate, followed by **violence** and **mental health**. **Substance abuse** and **maternal/child health** were not far behind.

The table on the next page shows the actual ratings for each need that was evaluated.
Average Scores

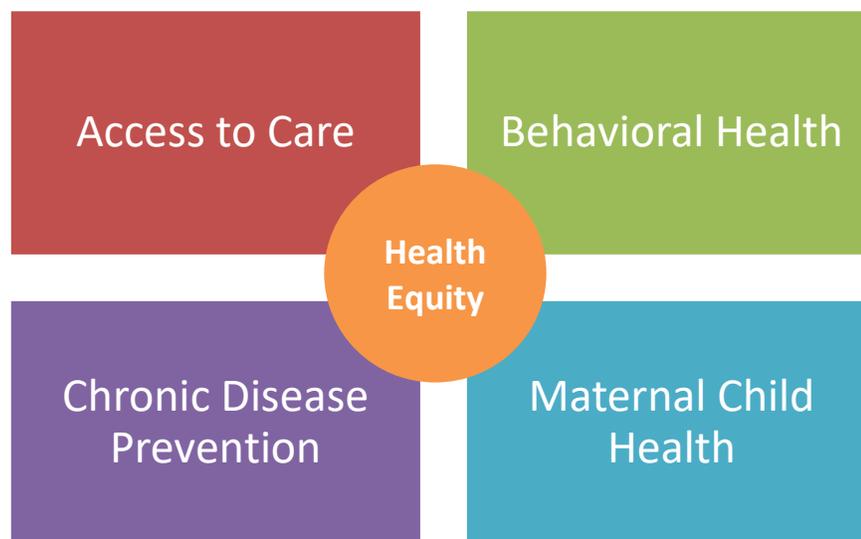| Health Need	Level of Concern	Ability to Collaborate
Access to care	4.7	4.6
Access to insurance	4.7	4.4
Violence	4.6	4.4
Mental health	4.6	4.3
Substance abuse	4.4	4.4
Maternal/child health	4.3	4.3
Cultural competence/health literacy	4.2	4.0
Senior health care	4.2	3.9
Diabetes	4.2	4.1
Heart/vascular disease	4.2	3.9
STIs	4.0	3.5
Obesity	3.9	3.6
Cancer: breast	3.7	3.2
Cancer: colorectal	3.6	2.9
Cancer: lung	3.4	2.9
Cancer: skin	3.4	2.9
Cancer: head and neck	3.3	2.9

See Appendix III for more detail

VIII. Community Health Needs Identified in the Assessment

The MHSL Community Outreach team reviewed results from the STLPHC Community Health Assessment, the Key Stakeholder assessment and data pertaining to our defined community-St. Louis County, the portion of St. Louis County that immediately surrounds Mercy Hospital St. Louis.

Using these sources, members identified needs based on the following criteria: *the severity of the need*, *resources currently available or unavailable in the community to address the need*, and *the ability to make long-term impact on the health of our community*.

It is not surprising that in our research, the majority of community concerns closely mirrored the needs that we identified in our 2016 needs assessment. While groundwork has been laid to address these concerns, further work on these initiatives is needed. The following were chosen as MHSL four main priorities in improving the health of our community for 2020-2022:

Access to Care	Behavioral Health
Health Equity	
Chronic Disease Prevention	Maternal Child Health

The Community Health Council (Appendix IV), led by the hospital's president, guided the CHNA process. The Community Health Council is accountable for ensuring that community benefit activities meet mission, compliance, and IRS guidelines. The council meets quarterly and includes a MHSL board member, the chief medical officer, and co-workers from finance, care management, philanthropy, Mercy's integrated physician group (Mercy Clinic), mission, and other key areas.

Co-workers in Mercy's Community Health & Access Department also serve on the Council and were the primary leads for the 2016 CHNA. These priorities will be what guide our subsequent Implementation Plan. Through the established priorities, MHSL will seek to increase access and improve health status, especially for the most vulnerable and unserved individuals in our community.

IX. Need(s) that will not be addressed

In any case of prioritization, there will be some areas of needs that are identified that are not chosen as a priority. Because MHSL has limited resources, not every community need will be addressed. Throughout the CHNA process, the following need arose as a community concern. However, it will not be addressed as a top priority because other organizations are more appropriate to address this need.

- Violence in the Community

Infectious disease physicians at Mercy will continue to address this issue through collaborative work. Mercy will not, however, take a lead role on this issue as there are some limitations to the organization's partnerships in this area as a Catholic Health System.

- Sexually Transmitted Infections

While these needs listed will not be specifically addressed in our priorities, they will most likely be impacted indirectly through the work in our other community outreach priorities.

Challenges and Limitations
Data was collected and reviewed from a variety of sources, including the St. Louis Regional Community Health Assessment, Key Stakeholder analysis, published data and hospital-specific data. Challenges and limitations to data collection include relative age of publicly available data and government-sourced public health data, relative lack of county specific data especially as it relates to mental and behavioral health and difficulty reaching some community residents for input.
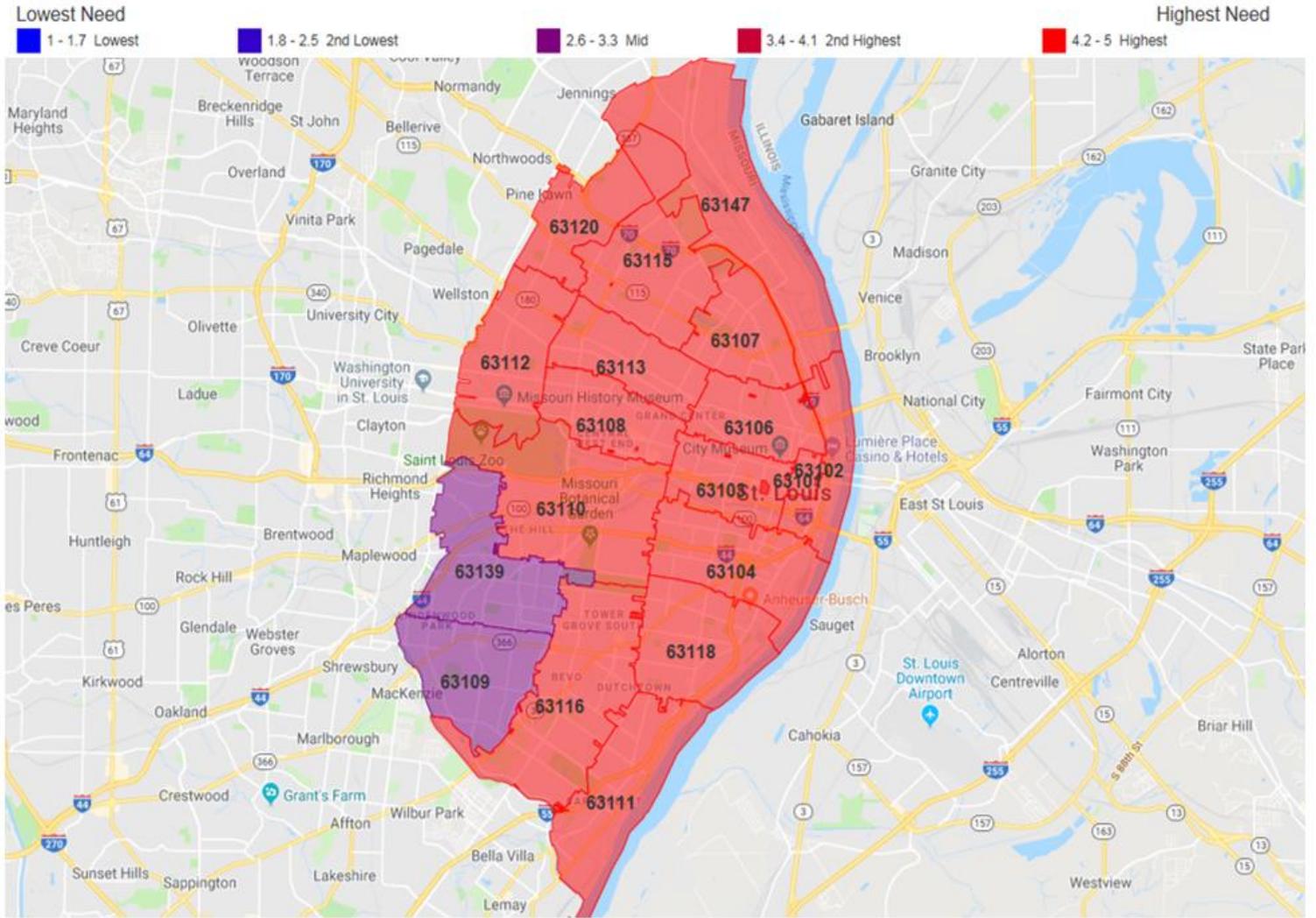
Next Steps
After carefully reviewing the data and mapping existing resources, MHSL is developing an implementation plan with evidence-based strategies. The plan will be submitted to a committee of appointed members from Mercy Hospital St. Louis, for their approval. The final version of the CHNA and Implementation Plan will be available to the public on the Mercy Hospital St. Louis website, www.mercy.net/communitybenefits.

X. Appendices

Appendix I

Community Needs Index
St. Louis City

Source: Dignity Heath, Truven Health Analytics Community Needs Index, 2018

Mean(zipcode): 4.5 / Mean(person): 4.4   CNI Score Median: 4.7   CNI Score Mode: 5

Zip Code	CNI Score	Population	City	County	State
63101	4.6	3457	Saint Louis	St. Louis City	Missouri
63102	4.6	2451	Saint Louis	St. Louis City	Missouri
63103	4.6	8545	Saint Louis	St. Louis City	Missouri
63104	4.6	18821	Saint Louis	St. Louis City	Missouri
63106	5	11762	Saint Louis	St. Louis City	Missouri
63107	5	11579	Saint Louis	St. Louis City	Missouri
63108	4.4	21033	Saint Louis	St. Louis City	Missouri
63109	3.2	26202	Saint Louis	St. Louis City	Missouri
63110	4.2	17878	Saint Louis	St. Louis City	Missouri
63111	5	19427	Saint Louis	St. Louis City	Missouri
63112	4.8	19246	Saint Louis	St. Louis City	Missouri
63113	5	12479	Saint Louis	St. Louis City	Missouri
63115	4.8	19623	Saint Louis	St. Louis City	Missouri
63116	4.2	42846	Saint Louis	St. Louis City	Missouri
63118	5	26122	Saint Louis	St. Louis City	Missouri
63120	5	9402	Saint Louis	St. Louis City	Missouri
63139	3	21920	Saint Neuis	St. Louis City	Missouri
63147	4.8	10752	Saint Louis	St. Louis City	Missouri

Source: Dignity Heath, Truven Health Analytics Community Needs Index, 2018

Zip Code	CNI Score	Population	City	County	State
63005	1.6	18816	Chesterfield	St. Louis	Missouri
63011	1.6	35812	Ballwin	St. Louis	Missouri
63017	1.8	41216	Chesterfield	St. Louis	Missouri
63021	1.6	57618	Ballwin	St. Louis	Missouri
63025	1.2	16184	Eureka	St. Louis	Missouri
63026	2.4	45354	Fenton	St. Louis	Missouri
63031	2.6	47736	Florissant	St. Louis	Missouri
63033	3.2	42834	Florissant	St. Louis	Missouri
63034	2	18656	Florissant	St. Louis	Missouri
63038	1.8	7246	Glencoe	St. Louis	Missouri
63040	1.4	9803	Grover	St. Louis	Missouri
63042	3.4	19667	Hazelwood	St. Louis	Missouri
63043	2.8	22677	Maryland Heights	St. Louis	Missouri
63044	3.4	10624	Bridgeton	St. Louis	Missouri
63045	3	8	Earth City	St. Louis	Missouri
63074	4	15208	Saint Ann	St. Louis	Missouri
63088	3	8554	Valley Park	St. Louis	Missouri
63105	2.6	18026	Saint Louis	St. Louis	Missouri
63114	4.2	35954	Saint Louis	St. Louis	Missouri
63117	2.8	9135	Saint Louis	St. Louis	Missouri
63119	2.2	33533	Saint Louis	St. Louis	Missouri
63121	4.6	25945	Saint Louis	St. Louis	Missouri
63122	2	39916	Saint Louis	St. Louis	Missouri
63123	2.8	49404	Saint Louis	St. Louis	Missouri
63124	2.2	10449	Saint Louis	St. Louis	Missouri
63125	3.6	32340	Saint Louis	St. Louis	Missouri
63126	1.8	14951	Saint Louis	St. Louis	Missouri
63127	2	5184	Saint Louis	St. Louis	Missouri
63128	1.8	29331	Saint Louis	St. Louis	Missouri
63129	1.8	54423	Saint Louis	St. Louis	Missouri
63130	3.8	30050	Saint Louis	St. Louis	Missouri
63131	1.4	16007	Saint Louis	St. Louis	Missouri
63132	3.8	13968	Saint Louis	St. Louis	Missouri
63133	4.8	8406	Saint Louis	St. Louis	Missouri
63134	4.6	13370	Saint Louis	St. Louis	Missouri
63135	4	20729	Saint Louis	St. Louis	Missouri
63136	4.6	47708	Saint Louis	St. Louis	Missouri
63137	4.4	20089	Saint Louis	St. Louis	Missouri
63138	4.4	19802	Saint Louis	St. Louis	Missouri
63140	4.4	427	Saint Louis	St. Louis	Missouri
63141	2	21463	Saint Louis	St. Louis	Missouri
63143	3.6	9318	Saint Louis	St. Louis	Missouri
63144	2.4	8903	Saint Louis	St. Louis	Missouri
63146	3	29384	Saint Louis	St. Louis	Missouri

Appendix II

Saint Louis Region
Community Health Assessment &
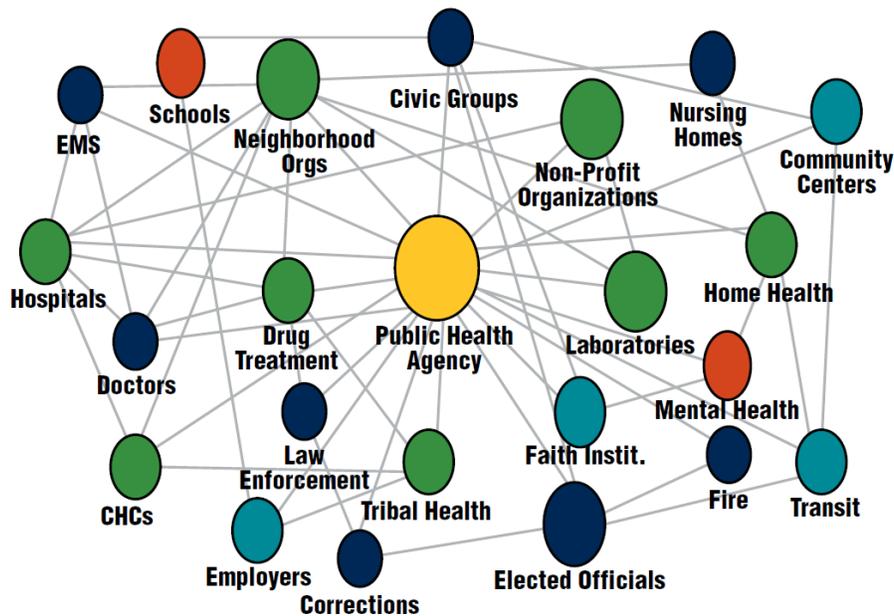# Community Health Improvement Plan

August 2018

Introduction

• St. Louis Partnership for a Healthy Community

St. Louis Partnership for a Healthy Community (STLPHC) is comprised of a broad range of stakeholders from within the public health system and individual advocates who subscribe to a comprehensive definition of health.[2] The public health system includes any organization, entity, or individual that contributes to or impacts the community's health (see Figure 1).[3]

Figure 1: Generalized Public Health System Diagram (Source: NACCHO)

The membership of STLPHC is intended to represent the wide range of entities that impact health- it includes both the City of St. Louis Department of Health and the St. Louis County Department of Public Health, area hospital systems, government agencies/departments, coordinated care organizations, community-based organizations, academic institutions, and business partners in the City of St. Louis and St. Louis County. See Appendix A for participating organizations.

The purpose of STLPHC is to align the efforts of the participants and the residents of the communities they serve to develop and implement a shared community health assessment (CHA) and Community Health Improvement Plan (CHIP) across the City of St. Louis and St. Louis County. STLPHC aims to eliminate duplicative efforts, prioritize needs, and enable collaborative

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[2] According to the World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Source: http://www.who.int/about/mission/en/
[3] Source: https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html

efforts to implement and track improvement activities across the region. This collaborative approach enables an effective and sustainable process; strengthens relationships between communities, organizations and government; creates meaningful community health needs assessments; and results in a platform for collaboration around regional health improvement plans and activities, leveraging collective resources to improve the health and wellbeing of our communities. See Figure 2 for a diagram of the STLPHC.

Figure 2: STLPHC Structure

- Community Health Advisory Team

In January 2017, STLPHC convened a Community Health Advisory Team (CHAT) comprised of local public health system community leaders, partners, and stakeholders to provide direction and decision-making throughout the Mobilizing for Action through Planning and Partnerships (MAPP) process. The CHAT met regularly throughout 2017 and 2018 to guide the CHA process and to shape the direction of the CHIP and will continue to convene on a semi-annual basis to provide feedback and guidance on the implementation of the CHIP.

- ## Regional Planning and Leadership Group

The Regional Planning and Leadership Group (RPLG) acts as the STLPHC steering committee and is comprised of leadership from both public health departments (City of St. Louis and St. Louis County), hospital systems, regional health organizations, and neutral facilitators. The RPLG is a continuation of the work started with the CHAT, to ensure that effort is sustained from the assessment phase into the into the action planning, implementation, and evaluation phases of the MAPP cycle. RPLG members work to align priorities across organizations, secure resources for implementation, and sustain STLPHC planning, community engagement, and reporting of the CHA/CHIP progress.

- ## Commitment to Addressing Health Disparities

STLPHC and member organizations are committed to a vision and process that can identify and address structural racism, health disparities, and inequities. The 2017-2018 CHA and 2019 CHIP include data on disparities in our region, driven by the vision of identifying and describing factors that impact the health of City of St. Louis and St. Louis County residents, workers, and visitors so that we can address and improve equity in achieving optimal health for all.

- ## CHA/CHIP Framework

STLPHC tailored the Mobilizing for Action through Planning and Partnerships (MAPP) model (see Figure 3) to conduct the CHA and CHIP. MAPP is a community-driven strategic planning process for improving community health. It is an interactive process that helps communities prioritize public health issues and identify resources to address them.

Figure 3: MAPP Model (NACCHO)

Beginning in early 2017, partners convened to determine the shared vision and guiding values for the process (see next page). Following the development of the shared vision and guiding principles, the four MAPP assessments were conducted over the course of 2017 and analyzed together to identify strategic issues and priorities. Action planning started in late 2017 and continued throughout 2018 with implementation scheduled to begin January 2019.

- ## Vision and Guiding Principles

The CHAT drafted the 2017-18 St. Louis CHA/CHIP vision and guiding principles in January 2017 and fine-tuned the statements at subsequent meetings to the final set depicted in Figure 4. The vision represents an inspirational and aspirational statement for a desired future based on collective action and achievement. The guiding principles represent fundamental values and beliefs that guide day-to-

day interactions with each other and the community through the MAPP process. Together, these statements play an important role in the CHA/CHIP process by providing a framework for engagement, decision-making, data collection, and implementation of strategies.

Figure 4: 2017-18 St. Louis CHA/CHIP Vision and Guiding Principles

Our Vision:
St. Louis, an equitable community achieving optimal health for all.

Equity: Racial equity is an essential component of health equity. We prioritize allocation of resources to remedy disparities and to achieve equity.

Respect: We respect everyone in the community, valuing all cultures and recognizing strengths, needs, and aspirations without judgment.

Integrity: We use the highest standards of ethics and professionalism to maintain integrity and build community trust through honesty and commitment.

Data + Results Driven: We are committed to a transparent, data-driven process, including community feedback, actionable data, and evolving priorities, that results in measurable improvements/outcomes.

Community Engagement + Inclusion: Through intentional inclusion, engagement, and empowerment, we foster a culture of equity that respects and values the contributions of every individual toward a healthy community.

Systems level change + regional shared plan: We achieve systemic change and policy solutions locally and within a regionally shared plan to improve population-level health.

Resources: We collaborate regionally, coordinate existing resources, and develop new resources to accomplish healthy outcomes for all.

2017-2018 Community Health Assessment (CHA)

The 2017-2018 St. Louis Community Health Assessment documents the health of City of St. Louis and St. Louis County residents and the strengths and opportunities of the local public health system. The CHA includes data from four different assessments: Community Health Status, Community Themes and Strengths, Forces of Change, and the Local Public Health System (see Figure 5). Together the assessments inform the identification of issues impacting the health of the St. Louis community and assist in the selection of health priorities and improvement strategies. Comprehensive reports for each assessment can be found on STLPHC's regional dashboard, ThinkHealthSTL.org, and in the appendices of this report.

Figure 5: The Four MAPP Assessments

Assessment	Question
Community Health Status Assessment (CHSA)	What does our data tell us about our health?
Community Themes & Strengths Assessment (CTSA)	What is important to community members and what assets do we have?
Forces of Change Assessment (FOCA)	What is occurring, or might occur, that will affect the community or public health system?
Local Public Health System Assessment (LPHSA)	How are the essential public health services being provided to our community?

- Community Health Status Assessment (CHSA)

The Community Health Status Assessment (CHSA) report documents the health status of City of St. Louis and St. Louis County residents. The broad goal of the health status assessment was to analyze community demographics and population health data as well as to identify important health issues affecting the community. A CHSA workgroup (see page 2 of the CHSA report), along with community input, prioritized health indicators using the following criteria:
- Existence of a disparity by race/ethnicity or sex;
- Comparison with the State of Missouri (ability to benchmark);
- Ability to analyze trends over time;
- Severity; and
- Magnitude.

Data came from a wide variety of secondary sources, which are listed in Figure 6.

Figure 6: CHSA Data Sources (Alphabetical Order)

- American Lung Association: State of the Air Report
- Assessor's Office, City of St. Louis
- Community Commons
- Community Sanitation Program, City of St. Louis Department of Health
- County Health Rankings & Roadmaps (CHRR)
- U.S. Environmental Protection Agency (EPA)
- Federal Deposit Insurance Corporation (FDIC): National Survey of Unbanked & Underbanked Households
- Feeding America: Map the Meal Gap
- Missouri Department of Elementary and Secondary Education
- MODHSS: Bureau of Health Care Analysis & Data Dissemination
- MODHSS: Bureau of Vital Statistics
- MODHSS: Missouri Information for Community Assessment (MICA)
- Missouri Department of Natural Resources Air Monitoring Stations
- Nielsen Site Reports
- Office of the Medical Examiner, City of St. Louis
- Prosperity Now: Assets & Opportunity Scorecard
- Robert Wood Johnson Foundation (RWJF)
- SAMHSA Buprenorphine Treatment Physician Locator
- St. Louis Metropolitan Police Department
- U.S. Census Bureau: American Community Survey (ACS) 5-Year Estimates
- U.S. Census Bureau: Population Division, Annual Estimates of the Resident Population
- U.S. Census Bureau: Survey of Income and Program Participation (SIPP)
- U.S. Department of Agriculture (USDA): FNS SNAP Retailer Locator
- U.S. Department of Agriculture (USDA): Food Environment Atlas
- U.S. Department of Housing and Urban Development (HUD)
- U.S. Department of Labor: Bureau of Labor Statistics
- University of Wisconsin Public Health Institute

- *Key Findings*

- *Social determinants of health and equity[4]*

STLPHC worked to understand why there were differences in health across the St. Louis region by looking at opportunities such as income, housing, and transportation. The percent of families living in poverty in St. Louis County was 7.9% and 21.7% in the City of St. Louis. St. Louis County poverty levels were highest in the Inner and Outer North sub-regions and most zip codes in the City of St. Louis had a medium, high, or very high percent of families living below the poverty line.

When looking at renter- or owner-occupied homes by race in the St. Louis region, 45% of Blacks/African Americans, 75% of Whites/Caucasians, 54% of Asians, and 44% of other races were

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[4] All data sources in this section are cited in the full CHSA report, which can be found in Appendix C.

homeowners. There is a disparity between races when it comes to homeownership. In the St. Louis region, a much higher percentage of homeowners and renters in the lowest income brackets were spending 30% or more of their yearly income on housing costs. Substandard housing is defined by having one or more severe conditions related to plumbing, kitchen facilities, overcrowding, and housing costs. The City of St. Louis had 41.5% and St. Louis County had 30% of homes with one or more substandard housing conditions.

The percentage of City of St. Louis and St. Louis County residents using public transportation as their primary means of commute to work was 9.43% and 2.48%, respectively. The northeastern St. Louis region had the highest percentage of residents using public transit.

- *Mortality[5]*

Measuring how many people die each year and why they died is one of the most important means for assessing the health of the community and the local public health system.

- The top two Leading Cause of Death (LCOD) for City of St. Louis, St. Louis County, and the United States (2010 to 2014 average) were heart disease and cancer. The third LCOD in the City of St. Louis was chronic lower respiratory disease (which includes asthma and chronic obstructed pulmonary disease), and stroke was the third LCOD for St. Louis County. Unintentional injury was the fourth LCOD for St. Louis County and the fifth LCOD for the City of St. Louis.
- The three leading causes of death among ages 1-19 years old were: Accidents (unintentional injury), suicides, and homicides. A racial disparity exists in both the city and county, as the rate of death among black children was significantly higher than the rate of death for white children.
- The leading cause of death among children ages 15-19 in the City of St. Louis was homicide and the leading cause of death of this group in St. Louis County was unintentional injuries.
- While much of the US has steadily decreased infant mortality rates for years, infant mortality rates in both the City of St. Louis and St. Louis County combined, continue to remain higher than the state average and national average.
- From 2010-2014 in the St. Louis region there was a 13% decrease in heart disease mortality in Whites/Caucasians compared to a 7.1% increase in Blacks/African Americans and a 20% decrease in diabetes mortality in Whites/Caucasians and a 4.6 % decrease in Blacks/African Americans.
- The population with "high" and "very high" poverty levels had the highest rates of heart disease, diabetes, and cancer mortality in St. Louis County on average (years 2010 and 2014) when compared across all poverty levels.
- The City of St. Louis' homicide rate was seven times higher than Missouri's rate and St. Louis County's homicide rate was almost double that of Missouri.

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[5] All data sources in this section are cited in the full CHSA report, which can be found in Appendix C.

- From 2010 to 2016 there was a 228.5% increase in opiate-related deaths in the City of St. Louis and a 22.9% increase in St. Louis County.

Additional data and information on social and economic conditions, the environment, clinical care, and health behaviors are discussed in depth in the full CHSA report. Data are organized around Demographics; Opportunity Measures; Access to and Linkage with Clinical Care; Environmental Health; Chronic Disease and Injury Prevention; Communicable Disease, and Maternal, Child and Family Health. Additional regional health status data can be found on STLPHC's data dashboard ThinkHealthSTL.org.

• Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) report documents the community's perspective on the characteristics of a healthy community; the barriers and issues impacting quality of life and health in the St. Louis region; strengths and assets to support health; and ideas to address some of the most important issues impacting the health and wellness of the community. The CHAT identified several groups of individuals as priorities for listening sessions due to their potential understanding and experiences related to health inequities. Organizers specifically sought out participants who identify with, or interact with, populations such as racial or ethnic minorities, limited English speakers, low-income communities, individuals with physical and intellectual disabilities, individuals with mental health or substance use disorders, and seniors. Further, in many listening sessions, participants were asked to identify population groups that were most vulnerable and experiencing the greatest inequities.

Fourteen listening sessions, two surveys, and twelve focus groups were conducted over a period of four months in 2017 with residents throughout the region. To better understand the barriers and needs of frequently overlooked populations, organizers used surveys and discussions with key stakeholders who frequently provide services to these populations in addition to listening to the populations themselves.

• *Key Findings*

Through the listening sessions, surveys and focus groups, residents identified key themes related to what a healthy community should look like, current St. Louis conditions that impact health as barriers or facilitators, and ideas for improving the health of the community. Key themes were identified across the responses and summarized on the following page and in the full CTSA report.

The most frequently cited descriptions of a **healthy community** included factors such as:

- Positive relationships with neighbors and fellow community members
- Welcoming, kind, and supportive community
- Feeling safe inside and outside of the home
- Lack of violent crime, guns, and drugs
- Clean, safe, and well-maintained neighborhoods
- Quality, safe, and affordable housing
- Access to open, green space for recreation and exercise
- Access to healthcare, including behavioral health services
- Residents engage in regular physical activity

Listening session participants discussed several issues impacting health, with the **biggest issues** facing the St. Louis region as:

- Lack of jobs and training opportunities
- Poverty and low income is a barrier to home ownership, services, resources
- Racism and residential segregation
- Inequitable distribution of resources and lack of resources
- High rates of violent crime, gun violence, and drug activity makes the community feel unsafe
- Lack of safe and affordable spaces for young people to learn, socialize, stay physically active
- Easy access to substances (alcohol, tobacco, prescriptions, illicit drugs), heavy substance use

When asked about the **strengths and assets** of the St. Louis region that support health, participants identified factors such as:

- Abundance of museums and cultural institutions
- Good schools (though quality varies across the region)
- Recreation and entertainment for children, adults, and families
- Strong neighborhood associations and other community-based organizations
- Region is diverse and multi-cultural
- Plentiful parks and green space (though safety is a concern)
- Relatively low cost of living compared to other urban areas

Additional data and information on community strengths and assets, barriers and gaps to healthy living, and strategies to improve health and wellbeing are discussed in depth in the full CTSA report and on the ThinkHealthSTL.org dashboard.

- Forces of Change Assessment (FOCA)

The Forces of Change Assessment (FOCA) identifies trends or factors that are influencing, or may influence, the health and quality of life of the community and the effectiveness of the local public health system. The FOCA was completed by CHAT members and focused on two key questions:
- What is occurring, or might occur, that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

- *Key Findings*

Threats and opportunities emerged across five key areas (see Figure 7). The participants recognized the uncertainty and instability associated with potential changes to federal policy. There was particular concern regarding the repeal and/or replacement of the Affordable Care Act (ACA) and the impact it will have on regulations, funding for public health, and access to care. Another theme was lack of funding for programs due to budget cuts at federal, state, and local levels. The group pointed to reduced tax revenue due to population loss, shifts in political priorities, macroeconomic trends, and inequitable allocation as the drivers behind loss of funding for critical programs and services. Violent crime was a common theme across categories, including gun violence and violence directed towards communities of color. Violence is not only a threat to residents' safety but also affects access to opportunity and investment. Social justice surfaced as a cross-cutting theme, in relation to economic inequity (e.g. the impact of tax abatements), citizen-law enforcement relations, and environmental inequity. Finally, population shifts and urban renewal influence tax revenue, economic development, and social cohesion. Additional data and information on trends, factors, and events identified during the assessment are discussed in depth in the full FOCA report and on the ThinkHealthSTL.org dashboard.

Figure 7: FOCA Key Findings

- Local Public Health System Assessment (LPHSA)

The Local Public Health System Assessment (LPHSA) report documents the strengths, weaknesses, and opportunities related to how essential public health services are being provided to our community. Hosted by STLPHC, 96 multi-sector partners participated on May 22, 2017 in a full-day of dialogue and discussion. Participants representing a broad spectrum of the local public health system used a standardized tool[6] to review the optimal level of performance for the 10 Essential Public Health Services (EPHSs) and scored how well the St. Louis local public health system collectively performs the services. Through the scoring and discussion, participants identified local strengths, gaps, and opportunities for quality improvement.

- *Key Findings*

Overall, participants described the St. Louis local public health system's performance as "moderate" on a scale from no activity to optimal. EPHS 2, *Diagnose and investigate health problems and health hazards in the community* was described as the highest performing essential public health service by participants. EPHS 4, *Mobilize community partnerships to identify and solve health problems* was described as the lowest performing essential public health service by participants. From the discussion, participants identified eight strategic areas that the local public health system should collectively address to improve the function and effectiveness of the system (Figure 8).

Figure 8: LPHSA Key Findings

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[6] The LPHSA uses the National Public Health Performance Standards (NPHPS) to assess capacity and performance of local public health systems and local public health governing bodies. This framework can help identify areas for system improvement, strengthen state and local partnerships, and ensure that a strong system is in place for providing the 10 essential public health services. Source: https://www.cdc.gov/stltpublichealth/nphps/index.html

Participants in the LPHSA identified the following strengths of the local public health system:

- <u>Assessment and Data Collection</u>: LPHS organizations conduct many assessments and collect a great deal of data for data-driven decision making.
- <u>Community Engagement and Communication</u>: LPHS partners engage community members and stakeholders, and regularly gather input from community members. Community partnerships between research and practice are strong. Risk communication and emergency preparedness communication is well coordinated at the organizational level.
- <u>Partnership and Collaboration</u>: LPHS organizations partner and collaborate in many ways, including data collection and sharing, health promotion and education, policy development, service provision, and research. The increased city and county collaboration is notable and there is momentum for increased collaboration across sectors outside of what is considered traditional public health.
- <u>System-wide Workforce Development</u>: The LPHS has knowledgeable public health staff, good leadership, and high potential for the existing talent in the region.
- <u>Policy</u>: The LPHS has demonstrated willingness to take on policy reforms and has had some recent successes.
- <u>Resources</u>: Academic institutions are an important source of funding, expertise, research, and training for the LPHS.

Additional data and information on the strengths, weaknesses, and opportunities associated with each EPHS area are discussed in depth in the full LPHSA report and on the ThinkHealthSTL.org dashboard.

• Community Health Assessment: Overall Key Findings

While each assessment touched on many themes and issues that affect health and quality of life in the St. Louis region, the CHAT extracted key findings from each assessment, as described in the prior sections. Key findings that surfaced across two or more assessments are plotted in Figure 9. Key findings that surfaced in three or more assessments are highlighted in green.

Figure 9: MAPP Assessment Key Findings

	CHSA	CTSA	LPHSA	FOCA
Access to Care/ Social Services			X	X
Behavioral Health	X	X	X	
Child/Adolescent Development	X	X		
Chronic Disease Prevalence	X			X
Employment/ Workforce Needs		X	X	
Funding/ Resource Distribution		X	X	X
Health Equity	X	X	X	X
Housing Quality/ Burden	X			X
Policy			X	X
Poverty/ Economic Mobility	X	X		X
Transportation	X		X	
Violence/ Community Safety	X	X		X

Topics that surfaced in three or more MAPP assessments are detailed below, with the data source in parentheses.

Health Equity

The rate of death among Black/African American children is significantly higher than the rate of death among White/Caucasian children. From 2010-2014, in the St. Louis region there was a 13% decrease in heart disease mortality in Whites/Caucasians compared to a 7.1% increase in diabetes mortality in Blacks/African Americans and a 20% decrease in diabetes mortality in Whites/Caucasians and a 4.6 % decrease in Blacks/African Americans (CHSA). Listening session participants observed racism and residential segregation (CTSA). The assessment data lack disaggregation beyond a few variables such as age and race, which can inhibit the ability to assess smaller populations that may experience health disparities. Inclusion of marginalized populations is often a one-time event rather than a systematic process. Lack of trust from marginalized groups is a barrier to engagement in many EPHSs including assessment, constituency development, policy development, service provision, evaluation, and research, among other areas (LPHSA). The legacy of structural racism produced patterns of segregation, disinvestment, and injustice that have proven difficult to reverse (FOCA).

Poverty/ Economic Mobility

The percent of families living in poverty in St. Louis County was 7.9% and 21.7% in the City of St. Louis. St. Louis County poverty levels were highest in the Inner and Outer North sub-regions and most zip codes in the City of St. Louis had a medium, high, or very high percent of families living below the poverty line (CHSA). Poverty and low income are barriers to home ownership, services, and resources (CTSA). Reduced access to higher education, higher interest rates for communities of color, and lack of tax abatements for low-income areas of the City may reduce economic mobility (FOCA).

Violence and Community Safety

Unintentional injury was the fourth leading cause of death (LCOD) for St. Louis County and the fifth LCOD for the City of St. Louis. The City of St. Louis homicide rate was seven times higher than Missouri's rate and St. Louis County's homicide rate was almost double that of Missouri (CHSA). High rates of violent crime, gun violence, and drug activity makes the community feel unsafe (CTSA). Violence disproportionately affects communities of color and is not only a threat to residents' safety but also affects access to opportunity and investment in the community. The participants also noted greater incidence of violence against the Muslim community and other immigrant groups (FOCA).

Behavioral Health

From 2010 and 2016 there was a 228.5% increase in opiate-related deaths in the City of St. Louis and a 22.9% increase in St. Louis County (CHSA). Listening session participants reported easy access to substances (alcohol, tobacco, prescriptions, illicit drugs), heavy substance use, and difficulty accessing available, integrated, and affordable care (CTSA). The LPHS has gaps in access to care due to lack of behavioral health services (LPHSA).

Funding and Resource Distribution

Listening session participants observed inequitable distribution of resources and lack of resources (CTSA). When there is a budget crisis, public health is often the first area to be cut. Dependence on grant funding rather than consistently being part of the normal budget process threatens the sustainability of the public health organizations. The assets and resources that do exist in the LPHS are not well documented or coordinated (LPHSA). Participants reported a lack of funding for critical programs and services due to budget cuts at federal, state, and local levels (FOCA).

- Community Assets and Resources

A community asset can be a person, physical structure or place, community service, or institution. The MAPP framework emphasizes the identification of assets and resources to give a more complete picture of the community, rather than simply focusing on deficits. This enables the community to act from a position of strength and leverage its own assets for solutions, especially when external resources (e.g. state or federal money) may not be available. [7] The STLPHC gathered information about community assets and resources from three sources: the CHAT, the LPHSA, and the CTSA. CHAT members identified regional assets and resources in three separate meetings, January 17, June 19, and December 11, 2017. A selection of their findings is provided in Figure 10 and Figure 11. Participants in the LPHSA identified the strengths of the local public health system (see page 34) and participants in the CTSA identified many strengths and assets that support health in the St. Louis region (see page 31).

Figure 10: Assets and Resources Identified by the CHAT (January 2017)

PARTNERSHIP & COLLABORATION	Connections with community partners
	Collaboration across St. Louis region
	Accountable care community network
	Neighborhood stabilization team
	Collaboration with universities
	Relationships with other local health departments and businesses
	Relationships with HIV/AIDS agencies
	Unified Health Command and emergency response planning coalition
	City and county government working together
CIVIC ENGAGEMENT	Growing number of young people committed to making a difference
	Involved community members, organizing and civic engagement
	People want to be involved and make community better
	Diversity of population
BUILT ENVIRONMENT	Public transit/infrastructure
	Parks and access to green space
	Place-making efforts
	Community gardening
	International housing standards that city adopted in code
HEALTH CARE	Public health clinics and pediatric clinics
	Free EKG program for adults at St. Louis University
	Health care institutions
	Community health workers
	Gateway to Better Health (safety net program)

[7] "Section 8: Identifying Community Assets and Resources." The Community Toolbox. https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

DATA	Ability to analyze data and make data-driven decisions Progress Toward Building a Healthier St. Louis: Access to Care Data Book 2017 BJC CHNA Report is available online For the Sake of All: A report on the health and well-being of African Americans in St. Louis and why it matters for everyone
OTHER SERVICES	Legal counsel team Citizen Service Bureau (City of St. Louis) Recreation centers (YMCA) STLcondoms.com Music therapy program Philanthropic resources and United Way
WORKFORCE	Health department employees and partners Passionate and culturally competent workforce High level of professionalism All the different city and county departments/employees Law enforcement reform with a focus on mental health issues
HEALTH EQUITY APPROACH	Public health approach Being outcome driven Coming together to address social determinants of health Inclusiveness Willing to put health as priority Recommendations from the Ferguson Commission Recognize need for human development

Figure 11: Existing Coalitions or Initiatives Working on Issues Identified in CHA (June 2017)

24:1 Initiative	HEAL/Healthy Living Coalition
Behavioral Health Network	Incarnate Word Foundation
Beyond Housing	Large hospitals
Clark-Fox Family Foundation	Missouri Foundation for Health
Community Action Agencies	Promise Zone
Community Development Administration	Regional Health Commission
Continuum of Care	School based health initiatives
Deaconess Foundation	St. Louis University
Emergency Planning	St. Louis Community Foundation
Food Policy Coalition	St. Louis Economic Development Partnership
Gateway Center for Giving	St. Louis Metro Police Department
Generate Health	United Way
Geographic collective impact groups	Violence Prevention Collaborative
Healthy Schools, Healthy Communities	

Opportunities for the Community to Review and Contribute to the CHA

During the assessment period, the CHAT, representing over 52 multi-sector organizations across the region, and the community at large were provided with preliminary assessment findings and opportunities to review and contribute to the assessment. CHAT members were provided assessment updates at monthly meetings from January 2017 through September 2017 and will continue to receive updates on the CHA/CHIP through semi-annual meetings beginning December 2017. CHAT members provided extensive feedback during the monthly meetings and through periodic surveys and worksheets between meetings. The ThinkHealthSTL.org website was launched in February 2017 and included a description of the MAPP process and updates on the CHSA. The CHSA indicators were hyperlinked to available data on other pages of the website. In addition, the ThinkHealthSTL.org website was linked on partners' websites and social media sites as a regional data dashboard and a place to receive updates on plans and progress. STLPHC receives and responds to emails directly from the ThinkHealthSTL.org website "Contact Us" form and a CHAandCHIP.dph@stlouisco.com email address. Interested residents and organizations have contacted STLPHC representatives to get involved in the CHA/CHIP and to comment on information they have read.

2019 Community Health Improvement Plan (CHIP)

The 2017-2018 CHA described the health of the population, identified areas for health improvement, named contributing factors that impact health outcomes, and documented community assets and resources that can be mobilized to improve population health in the St. Louis region. The CHA informed the identification of strategic issues impacting the health of the St. Louis community and assisted in the selection of health priorities and improvement strategies. STLPHC developed a regional Community Health Improvement Plan (CHIP) to frame a collaborative approach to addressing the priorities and goals of our community.

- Prioritization Process

Based on the CHA findings, STLPHC developed a set of regional priority health issues with input from the RPLG, CHAT, and the general community. At the August 2017 CHAT meeting, members reviewed the CHA assessment data, identified potential strategic issues that the region should work on collectively for the next three to five years, and then participated in a consensus building workshop to arrive at three to five priorities for the CHIP. The CHAT members considered the following prioritization criteria:
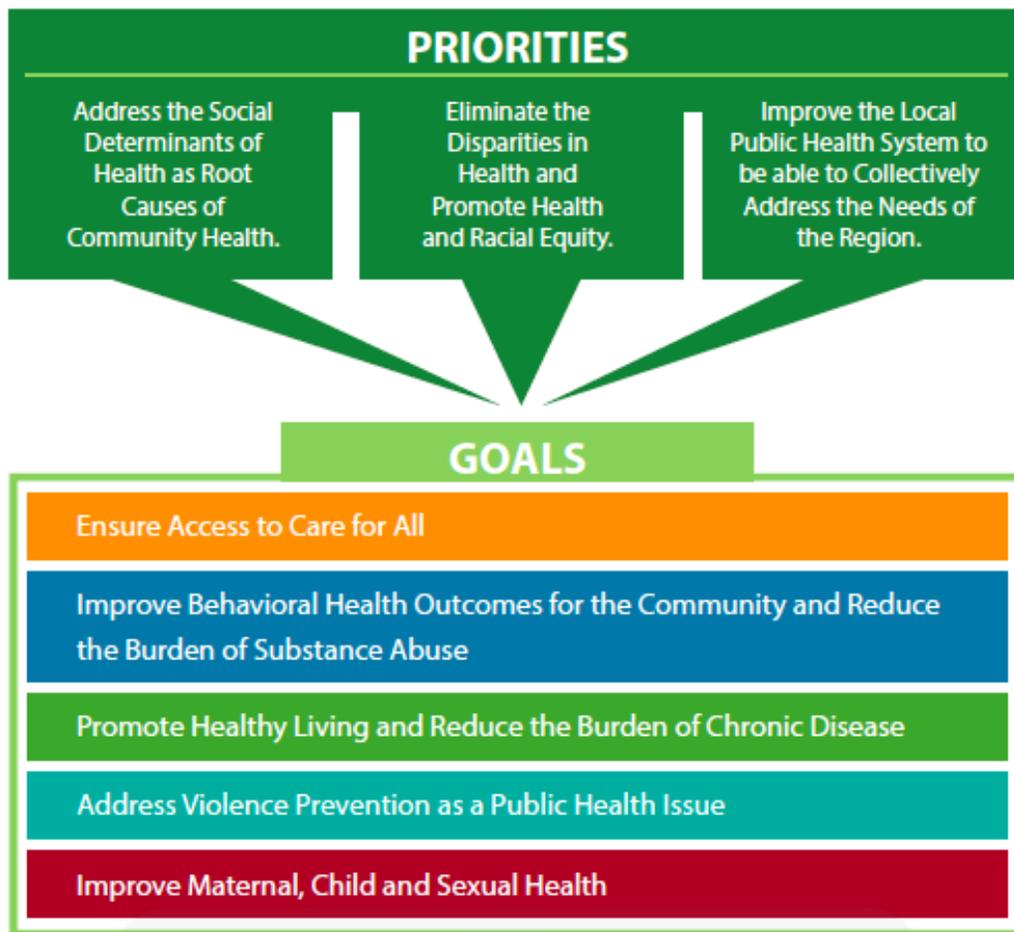
- A strategic issue will surface in at least **3 of the 4 assessments as a need**.
- Focusing on this issue will help achieve our **vision.**
- The **consequences** of not addressing this issue are severe.
- This issue requires a **multi-sector, multi-faceted** approach.
- This issue is a **root cause for multiple health/system issues.**
- We can **leverage opportunities, strengths and assets.**

The September 2017 CHAT meeting was used to narrow down the priorities and determine how to organize for the CHIP.

- CHIP Priorities and Goals

The final CHIP structure is depicted in Figure 12, with three priorities and five goals. The goals represent the strategic issues that the CHIP will address over the next five years. The three priorities underpin all of the CHIP work, explicitly recognizing the need to address the social determinants of health, promote health and racial equity, and support regional infrastructure in all of the CHIP goals. The priorities were identified as a commitment and intentional approach to improve public health outcomes while also recognizing limited infrastructure and the need to strengthen multi-sector (i.e., community development, transportation) collaboration in the local public health system to address social and structural determinants of health.

Figure 12: 2019 CHIP Priorities and Goals

STLPHC identified community coalitions to lead Action Teams for each of the five goals (see Figure 13) and invited additional community organizations to join the teams. The Action Teams will have designated members that will report to the CHAT and RPLG on implementation progress and can seek assistance from both advisory bodies for CHIP planning and implementation needs.

ACTION TEAMS

Regional Planning and Leadership Group

Access to Care and Social Services Action Team
Regional Planning and Leadership Group

Behavioral Health Action Team
Behavioral Health Network

Chronic Disease Prevention and Management Team
Healthy Living Coalition/HEAL

Violence Prevention Action Team
Violence Prevention Commission

Maternal, Child, Family, and Sexual Health Team
Generate Health

Community Health Advisory Team

- ## CHIP Action Planning

At the December 2017 CHAT meeting, members began preliminary planning by discussing how member organizations are currently addressing the issue, gaps in the region, potential strategies and member organization roles to address gaps. It was important for the CHAT to identify the existing initiatives and coalitions working in each goal area in order to reduce duplicative work and to leverage existing assets and resources in the community for greater sustainability. CHAT members also explored how working on each goal may advance the local public health system's development in data, policy and community engagement. Finally, members explored the role of the business community and other potential new public health partners in addressing the goals. More detail can be found in Appendix F "Chip Priority Planning Launch."

Action Teams convened in January 2018 to adopt the CHIP Action Team Charter, solidify the action planning process with consideration of current coalition plans, adapt planning templates/tools, and adopt a timeline for completion of draft action plans by August 2018. Over the course of five months, each Action Team developed an Action Plan with measurable objectives, improvement strategies, and activities with time-framed targets. The plans indicate which individuals and organizations have accepted responsibility for implementing the strategies and outline policy changes that are needed to accomplish health objectives. Where possible, teams considered both national and state health improvement priorities to maximize alignment across jurisdictions. Action Teams presented posters

with high level overviews of the action plans at the May 2018 CHAT Open House. The final Action Plans are located in Appendix G.

- Community Participation in CHIP

The CHIP planning process included participation by a wide range of community partners representing various sectors of the community. Community partners and community members involved in the CHA process were invited to continue participating in CHIP planning and implementation. Each Action Team is co-chaired by community coalition leaders and team membership is comprised of RPLG and CHAT representatives as well as a variety of community organization representatives. See Appendix A for participating organizations. CHIP updates will be available via the ThinkHealthSTL.org website and community members can continue to share feedback through the "Contact Us" form and a CHAandCHIP.dph@stlouisco.com email address.

The May 2018 CHAT meeting was hosted as an open house for CHAT members, RPLG members, and organizers and participants from community listening sessions to learn about the CHA/CHIP and provide feedback on assessment findings, CHIP priorities, and preliminary action plans. The CHAT met regularly throughout 2017 and 2018 to guide the CHA process and to shape the direction of the CHIP and will continue to convene on a semi-annual basis to provide feedback and guidance on the implementation of the CHIP. The full assessment report can be found at http://www.thinkhealthstl.org/.

Appendix III

**PERCEPTIONS OF THE HEALTH NEEDS
OF ST. LOUIS COUNTY RESIDENTS
FROM THE PERSPECTIVES OF COMMUNITY LEADERS**

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BJC HealthCare

NOVEMBER 5, 2018

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BACKGROUND

In the Patient Protection and Affordable Care Act (PPACA) passed in March 2010, non-profit hospitals were mandated to conduct a community-based health needs assessment (CHNA) every three years. As a part of that process, each hospital is required to solicit input from those who represent the broad interests of the community served by the hospital as well as those who have special knowledge and expertise in the area of public health and underserved populations.

Several St. Louis County hospitals have chosen to work together on this part of the assessment process, even though they are on different time lines for completing their CHNAs. They include Barnes-Jewish West County Hospital, Missouri Baptist Medical Center, Mercy Hospital St. Louis, Mercy Hospital South (formerly St. Anthony's Medical Center) and St. Luke's Hospital. For the first time this year, St. Luke's Des Peres was also included in the process. Many of these hospitals have been working together since the initial stakeholder assessment, conducted in 2012, followed by a second in 2015.

The hospitals continue to be on different timelines with this iteration of the needs assessment. The assessments of Mercy Hospital South, Mercy St. Louis, St. Luke's Hospital and St. Luke's Des Peres are due at the end of June 2019. Those of Barnes-Jewish West County and Missouri Baptist Medical Center are due at the end of December 2019. However, all hospitals continue to cooperate on soliciting the community feedback to be incorporated into each individual assessment.

RESEARCH OBJECTIVES

The main objective of this research is to solicit feedback on the health needs of the community from experts and those with special interest in the health of the community served by the hospitals of St. Louis County.

Specifically, the discussion focused around the following ideas:

1) Determine whether the needs identified in the 2016 hospital CHNAs are still the right areas on which to focus

2) Explore whether there are there any needs on the list that should no longer be a priority

3) Determine where there are the gaps in the plans to address the prioritized needs

4) Identify other organizations with whom these hospitals should consider collaborating

5) Discuss what has changed since 2016 when these needs were prioritized, and whether there are new issues to be considered

6) Understand what other organizations are doing to impact the health of the community and how those activities might complement the hospitals' initiatives

7) Evaluate what issues the stakeholders anticipate becoming a greater concern in the future that we need to consider now

METHODOLOGY

To fulfill the PPACA requirements, the sponsoring hospitals conducted a single focus group with public health experts and those with a special interest in the health needs of St. Louis County residents, especially of those who reside in the west and south regions of the county. It was held on August 28, 2018, at the BJC Learning Institute in Brentwood, MO. The group was facilitated by Angela Ferris Chambers of BJC HealthCare. The discussion lasted about ninety minutes.

19 individuals representing various St. Louis County organizations participated in the discussion. (See Appendix)

Trish Lollo, President, Barnes-Jewish West County Hospital, welcomed participants at the beginning of the meeting. Those who were observing on behalf of the sponsoring hospitals were also introduced.

During the group, the moderator reminded the community leaders why they were invited - that their input on the health priorities of the community is needed to help the hospitals move forward in this next phase of the needs assessment process.

The moderator shared the demographic and socioeconomic profile of St. Louis County. This included specific breakouts on the north, south and west-central sectors, when data was available. Information on the needs prioritized by each of the hospitals in their most recent assessments, and the highlights of each hospital's implementation plan, were sent in advance of the presentation and were reviewed during the discussion. The moderator also reviewed the steps that the hospital collaborative has taken to commonly address the health need of diabetes, an issue they have chosen to tackle together within the last year.

Because these hospitals occasionally referred to the same needs differently, some changes were made in the nomenclature to ensure that the same health need was being referenced. This was based on work that BJC HealthCare conducted in 2015 and 2016 to develop a common nomenclature to use among all of its hospitals.

The following health needs (based on the revised nomenclature) were identified in the 2016 hospital CHNAs and implementation plans.

Needs Being Addressed	BJWCH	MBMC	Mercy Hospital South	St. Luke's	Mercy St. Louis
Access to Care: Coverage					X
Access to Care: Services			X		X
Cancer: Breast				X	X
Cancer: Colon				X	
Cancer: Head and Neck	X				
Cancer: Lung				X	
Chronic Conditions: Diabetes		X	X		X
Chronic Conditions: Heart & Vascular		X		X*	
Maternal/Child Health					X
Mental Health			X		X
Obesity			X		
Substance Abuse	X		X		X

*Addressing diabetes as part of this

Other health needs were identified in the 2016 hospital plans, but not addressed, due to factors such as lack of expertise and limitations in resources. These included:

Needs Not Being Addressed[8]
Cancer: Skin
Cultural Competence/Health Literacy
Senior Health
Sexually Transmitted Infections
Smoking/Tobacco use and Education
Violence

The moderator also shared several pieces of information to help further identify the health needs of St. Louis County. They included:

- the best performing health indicators
- the best performing social determinants of health
- the worst performing health indicators
- the worst performing social determinants of health

Other health indicators were also shared that described access to health insurance, access to healthcare providers, and infectious disease rates (including STDs).

At the end of the presentation, the community stakeholders rated the identified needs based on their perceived level of concern in the community, and the ability to collaborate to address them.

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[8] Although some of these needs may not have been individually identified to be addressed, they may have been taken into consideration within the tactics described in the implementation plans of those needs that were addressed.

KEY FINDINGS

FEEDBACK ON THE NEEDS BEING ADDRESSED:

The details on the needs being addressed by each hospital was sent to the group for review one week prior to the meeting. During the meeting, the moderator shared a summary slide to remind them about the needs that each hospital has chosen to address.

One stakeholder was particularly interested in how the hospitals are addressing the specific needs of **immigrant communities** with respect to cultural competence and language barriers. He was especially concerned about addressing **diabetes in Hispanic communities**. Another was wondering whether the hospitals have addressed the willingness of **Muslims who are diabetic** to take insulin during Ramadan or Eid.

Another stakeholder wanted clarification on Mercy St. Louis' objective to decrease disparities in the **incidence of diabetes in North St. Louis County**, and which specific ZIP codes were being targeted in these efforts. The Mercy representative addressed the question, and referenced the Mercy Clinics that are located around Interstate 270 and Lindbergh Boulevard as well as in Hazelwood.

There was another suggestion that the hospitals **look at race and ethnicity data separately**. There have been some cases in which Hispanics and Caucasians are counted together, resulting in totals of more than 100% in the demographic distributions. He suggested that ethnicity, as defined as the percent of Hispanics in a population, should be tracked separately from race.

Another stakeholder questioned **why Christian and DePaul Hospitals were not included** in this meeting. The moderator explained that there had been a separate discussion on the specific needs of north St. Louis County in which those hospitals were collaborators. Both hospitals have also been invited to participate in the Diabetes Collaborative.

The school nurse representative commented on the fact that **asthma was missing** from the list of identified needs. Her data suggests that number of asthma cases among school-age children has soared in the last several years, while diabetes has not increased at as dramatic a rate.

There were also questions around the **emergency department (ED) utilization** data that were shared, and the moderator clarified that the number of visits is based on where the patient lived as opposed to where the hospital was located. The high ED utilization in North County may be considered a reflection of lack of access to primary care providers in that market.

NEEDS THAT SHOULD BE REMOVED FROM THE LIST:

Stakeholders agreed that the needs being addressed should remain and nothing should be removed from the list.

OTHER NEEDS THAT SHOULD BE ADDRESSED:

The representative from the Kirkwood Fire Department was surprised that **Senior Health** is not one of the needs being addressed through the implementation plans. He mentioned that the majority of the calls to which his paramedics respond are related to heart and respiratory conditions in the elderly, including CHF and COPD. He also said that many of the needs he sees among Seniors are related to a lack of social support – they are living alone and unable to care for themselves, with no family support available close by.

Another questioned why **cultural competency** and **health literacy** were not being addressed, as they would impact every need that was identified on the left hand side of the table.

Another stakeholder observed that, although **violence** was identified as a need, there was no mention of **trauma**. They should be considered as two separate issues. She also suggested that cultural competence, health literacy and trauma should be evaluated for every health need that is identified.

Housing availability was mentioned as an additional need that may impact the health of the community.

SPECIAL POPULATIONS FOR CONSIDERATION:

One stakeholder cautioned the hospitals about how they examine their data. Being able to **disaggregate the data** to hone in on all types of disparities should be an essential component of the process. Although a disparity may seem small percentage-wise, it can represent tens of thousands of people. It may appear not be a significant issue when it really is. She encouraged the group to take this step and examine the data by race, age, ethnicity and gender so as not to miss health issues that are more serious in specific segments. Otherwise, the data points get whitewashed when they are examined in aggregate.

Similarly, every health issue that is identified should be examined through the lens of **cultural competence** and **health literacy**.

The Jewish Federation representative mentioned that her organization is currently going through a planning process to prioritize the issues on which they should focus. **Senior health** is one that rose to the top of their list of prioritizations. Many of the older adults in their community are living alone and do not have social support. They are concerned about their social isolation and the impact that has on their access to health services.

Another stakeholder from the National Council of Alcohol and Drug Abuse suggested that the **LGBTQIA** (Lesbian, Gay, Bisexual, Transgender/Transsexual, Queer/Questioning, Intersex, Asexual/Allies) were not mentioned in any of the identified needs. He suggested that there are issues of cultural competence that should be considered, especially when they show up in the emergency department and need to reveal their romantic status/gender identity to the doctor.

Another stakeholder identified those who are **victims of human trafficking** as a special population with unique health needs.

The specific needs of **immigrant communities** were identified by the representative of the Laborer's Union as an area not to be forgotten. In working with the data, he cautioned hospital representatives not to under count the number of Hispanic individuals by mixing them with racial groups, as the two measures are different and distinct, although they may overlap.

- He also cautioned the hospital community to recognize that there are **cultural differences** that impact the need for health care. One example is how the Latino community treats their oldest family members, preferring to care for them at home and not to send them to long-term care facilities. This creates mental health issues for the care givers that may not be recognized.
- The issue of **health insurance coverage** impacts this community, and the number of individuals who are un- and underinsured should be evaluated through this lens,
- **Substance abuse** and **opioid addiction** is not often recognized as impacting immigrant communities. The stakeholder was concerned that is often viewed only as a black and white issue and that the needs of immigrant communities are often forgotten when opioid solutions are identified.

GAPS BETWEEN DEFINED NEEDS AND OUR ABILITY TO ADDRESS THEM:

One stakeholder suggested that we need to look at these individual needs in a holistic way based on the entire person. The hospitals' assessment needs to involve more than just the patient's physical health.

Another mentioned **access to medication**, especially among diabetics who have no health insurance or regular source of income.

When it comes to **mental health**, several stakeholders mentioned that there is a lack of available services. When services are available, it is often challenging for those who need them to get access.

- Another stakeholder suggested that within each of the needs each hospital identifies, they should consider the impact of **mental health issues**. For example, how do mental health issues contribute to an individual's obesity, or how does depression impact diabetes?

When it comes to addressing **substance abuse**, one stakeholder recalled that there was no mention of access to Narcan as a part of any of the hospitals' plans. That led into a discussion about the EPICC program (Engaging Patients in Care Coordination) in which several St. Louis area hospitals are participating. Access to Narcan is available through this program.

- This program represents a cultural shift in how opioid addiction is treated. It involves administration of a medication (buprenorphine) in the ED to stop short-term cravings. In addition, former addicts provide counselling in the ED and act as recovery coaches, also helping patients to secure resources and get into outpatient treatment. Only select hospital ED physicians are authorized to prescribe buprenorphine at this time.

- Another stakeholder discussed the importance of having an electronic medical record (EMR) that can track clinical encounter information between different hospital and outpatient settings. This would be especially important in identifying patients who suffer from addiction and may seek drugs at several different locations. Having an EMR that is shared among different health systems and facilities would help ensure continuity of care and services for these individuals and others.

- There is also an issue of limited grants and funding to address the opioid crisis and the entire continuum of care, including mental health, physical health and residential care. Having more collaboration among all of the area's hospitals and health care organizations would be a way to move forward in addressing these issues.

Several stakeholders expressed concern that this discussion was not deliberately addressing the **health needs of north St. Louis County**. The hospitals included in this discussion were counselled not overlook that area, even though DePaul and Christian are specifically focusing on it. Those hospitals should not be left alone to address the health of north County. The degree of health needs in that community, especially when disparities are considered, may be more than those two hospitals alone can address.

OTHER ORGANIZATIONS WITH WHOM TO COLLABORATE:

The representative from the **American Cancer Society** mentioned that they are exploring barriers to clinical specialty services among the underserved and uninsured. She cited the example of a patient who tests positive for a fecal occult blood test (FOBT) and needs a colonoscopy. They are exploring how to address this need for those diagnostic services that catch cancer early before it becomes more advanced and requires a higher level of care.

Casa de Salud is another organization that should be considered for future inclusion in discussing the needs of immigrant communities.

The **St. Louis Effort for AIDS** could also be an effective partner when considering how to address sexually transmitted disease.

Missouri Access for All is an important organization when considering partners to support and advocate for Medicaid expansion.

Organizations that address the need for housing may also be important collaborators, including the **St. Patrick's Center** and **Places for People**. For many organizations, access to housing is a requirement to paying for health services and will help establish stability for those in need.

The issue of transportation can also affect the ability to access health services. Including **Metro** and **Gateway** may help the group better understand these issues and what resources are available to address them.

CURRENT COLLABORATIONS THAT WERE HIGHLIGHTED:

One stakeholder reminded participants about the **Gateway to Better Health** program, which is under the Regional Health Commission. It covers outpatient healthcare services for qualified city and county residents. Normally, those who apply for Medicaid but who are deemed ineligible can be considered for this program.

CHANGES SINCE THE 2016 CHNA:

The representative from the **St. Louis County Department of Public Health** mentioned that they are in collaboration with the St. Louis City Health Department to prepare their most recent Community Health Improvement Plan (CHIP), as a part of the St. Louis Partnership for a Healthy Community. This partnership includes not only the health departments, but a coalition of a broad range of stakeholders, community organizations, and advocates, including our collaborating hospitals, who share a common vision for achieving a more equitable St. Louis community, with optimal health for all. During the CHIP process, the health departments were challenged by their community partners to rethink the way they defined their health needs, moving from disease conditions and health outcomes, to addressing how social determinants of health impact health outcomes. As a result, they committed to changing how they classified their needs and analyze at their data, incorporating **social determinants of health** and racial disparities as part of their needs to be addressed.

The representative from the Health Department reported that **violence** is also worse than it was in 2016 along with **sexually transmitted infections**.
- With regard to violence, the specific issues of domestic violence, interpersonal violence, and suicide have impacted the overall rates of firearms mortality, which has been rising every year.
- The rise in violence also creates a need for recognizing that trauma-informed care must be included as part of the solution, especially for those individuals whose first encounter is at the emergency department.

There was also agreement that the **opioid crisis** is worse than it was three years ago. Specifically, fentanyl was not around in 2014 and 2015. In 2017, 85% of overdose deaths were due to fentanyl in St. Louis City and County.

The representative of the American Heart Association noted that **heart disease** continues to be the number one cause of death in the St. Louis region. They are exploring the root causes of this major health issue. They suggest that changes need to be explored at the larger health system level to have the greatest impact, rather than continuing to focus on the individual. The required policy and organizational changes need to be organized and coordinated if the area is going to see any substantive improvement in this area.
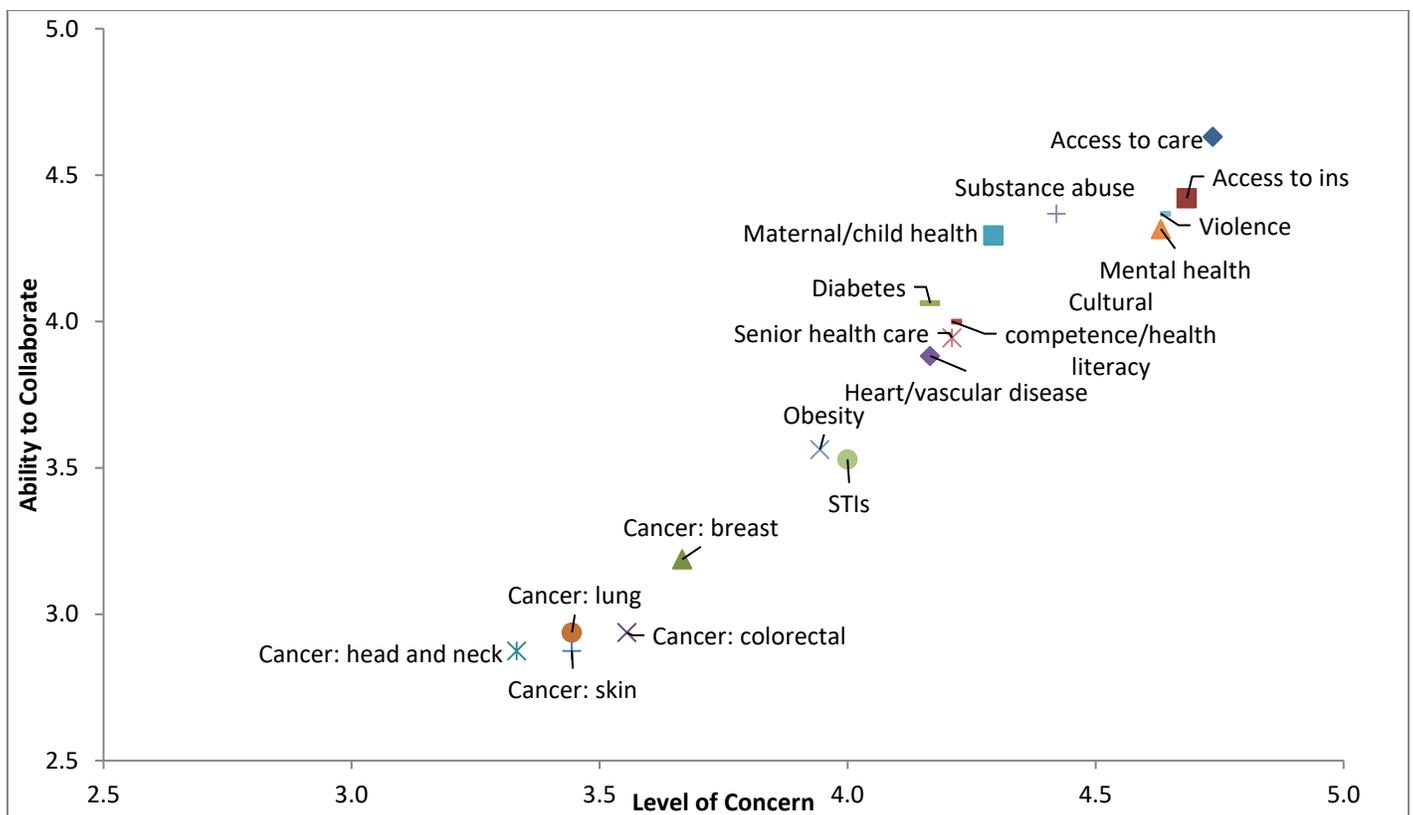
HEALTH CONCERNS FOR THE FUTURE:

Access to health insurance, especially Medicaid in Missouri, continues to be a concern for many. A few expressed a belief that health indicators were less negative when the Missouri Medicaid program was not as restrictive as it currently is. Many believe that there needs to be a continued effort to support the expansion of Medicaid in Missouri.

There also needs to be vigilance in monitoring **alcohol use** as well as **methamphetamine and cocaine use**. Abuse of those two stimulants is on the rise, and there is an increase in overdose deaths resulting from them.

RATING OF NEEDS

Participants rerated the needs identified in the 2016 assessment on a scale of 1 (low) to 5 (high), based on their **perceived level of community concern** and the **ability of community organizations to collaborate around them**.

The issues of **access to care** and **access to insurance** were rated the highest in terms of level of concern and ability to collaborate, followed by **violence** and **mental health**. **Substance abuse** and **maternal/child health** were not far behind.

The table on the next page shows the actual ratings for each need that was evaluated.

Average Scores

Health Need	Level of Concern	Ability to Collaborate
Access to care	4.7	4.6
Access to insurance	4.7	4.4
Violence	4.6	4.4
Mental health	4.6	4.3
Substance abuse	4.4	4.4
Maternal/child health	4.3	4.3
Cultural competence/health literacy	4.2	4.0
Senior health care	4.2	3.9
Diabetes	4.2	4.1
Heart/vascular disease	4.2	3.9
STIs	4.0	3.5
Obesity	3.9	3.6
Cancer: breast	3.7	3.2
Cancer: colorectal	3.6	2.9
Cancer: lung	3.4	2.9
Cancer: skin	3.4	2.9
Cancer: head and neck	3.3	2.9

NEXT STEPS

Using the input received from community stakeholders, the St. Louis County hospitals will consult with their internal workgroups to evaluate this feedback. They will consider other secondary data, and determine whether/how their priorities should change.

The needs assessments and associated implementation plans must be completed by June 30, 2019 for Mercy St. Louis, Mercy Hospital South, St. Luke's Hospital and St. Luke's Des Peres; and by December 31, 2019 for Barnes-Jewish West County, Missouri Baptist Medical Center,.

APPENDIX A

PARTICIPANT ROSTER

NAME	ORGANIZATION	ATTENDANCE
Bartnick, Rachelle	American Heart Association	X
Bradshaw, Karen	Integrated Health Network	X
Burgess, P. Ariel	International Institute of St. Louis	X
Costerison, Brandon	NCADA	X
Ditto, Nicole	Gateway Region YMCA	X
Duggan, Debbie	St. Louis Counseling	X
Franklin, Wil	People's Health Center/Hopewell Community Mental Health Center	X
Harbison, Ryan	American Diabetes Association	X
Leonardis, Deborah	American Cancer Society	X
Marek, Michael	American Diabetes Association	X
Menefee, Maggie	ALIVE	X
Neumann, Linda	St. Louis Suburban School Nurses Assoc	X
Orson, Wendy	Behavioral Health Network	
Schmidt, Spring	St. Louis County Public Health Dept	X
Smith, David	Kirkwood Fire Dept	X
Underwood, Brooke	American Diabetes Assoc	X
Valdez, Sal	LiUNA	X
Waldman, Missy	City of Olivette	X
Weinstein, Nikki	Jewish Federation of St. Louis	X
Wessels, Robert	United Way 211	X

OBERVERS ROSTER

NAME	ORGANIZATION	ATTENDANCE
Arney, Stacy	BJWCH	X
Bub, Laura	Mercy Hospital South	X
Carroll, Megan	St. Luke's Hospital	X
Carter, Traci	Mercy St. Louis	X
Donato, Cyndy	MBMC	X
Egan, Cara	MBMC	X
Finetti, Yoany	BJWCH	X
Hoefer, Bill	Mercy Hospital South	X
Hudson, Gregory	St. Luke's	X
King, Karley	BJC HealthCare	X
Lollo, Trish	BJWCH	X
Loving, David	St. Luke's Hospital	X
Ray, Diane	St. Luke's	X
Weinstein, Cindy	BJWCH	X

Appendix IV

Community Health Council
Mercy Hospital St. Louis

Leadership

<u>CHAIR</u>
MHSL Administration: Steve Mackin

<u>MEMBERS</u>
Community Health: Traci Carter, Sharon Neumeister
Mission: Mike Doyle, Mary Beth Bulte
Women's Services: Trish Geldbach
Community Relations: Katie Burkhalter
Medical Affairs: Paul Hintze
Business Development & Planning: Don Kalicak
Board Member: John Kelly
Foundation: Tanya Lieber
Behavioral Health; Patty Morrow
Mercy Clinic: Tesh Jewell, MaryAnne Gross
Emergency Department: Kim Shelton
Finance: Denise Scoffic
Talent Selection: Paul Kinsey
Inpatient Care Management: Julie Brooks
Integrated Health Network: Stephanie Ganachaud

The local Community Health Council is accountable for ensuring Community Benefit meets mission, compliance and IRS guidelines. Mercy Hospital St. Louis, in partnership with the St. Louis County Department of Public Health and other community organizations, continues to participate in the Mobilizing for Action through Planning and Partnerships (MAPP) model for assessment and planning.

Responsibilities:

1. Completes:
   a. Community health needs assessment every three years
   b. Annual written implementation plan
   c. Annual community impact plan
2. Develops & manages a Community Benefit budget
   a. Annual Community Benefit amount falls between 5-8%
3. Assures Community Benefit activities:
   a. Meet a prioritized community health need
   b. Make a measurable impact on a community health indicator
   c. Involve collaboration/partnership with key community stakeholders and advocacy with key legislators
   d. Connect programs to service line and community master planning strategies
   e. Develop innovative programs/medical management of charity & Medicaid populations
4. Reports:
   a. Community Benefit activities accurately and thoroughly
   b. Information for 990H/990, especially narrative questions
   c. Community Benefit activities quarterly to local boards and ministry oversight group

To comply with new IRS guidelines, the following timeline will guide Community Benefit program development and reporting. beginning
1. Community Health Needs Assessments (CHNA) are completed (including posting) – **6/30/2019**
2. Community Health Improvement Plans (CHIP) are written and approved by local boards – **11/15/2019**

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314.579.6100

Mercy

Your life is our life's work.