SSMHealth

2022-2024

Community Health Needs Implementation Strategy

SSM Health DePaul Hospital

12303 DePaul Dr. | Bridgeton MO 63044

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Message to our community

SSM Health DePaul Hospital, a member of SSM Health, has delivered exceptional, compassionate care to North St. Louis County for 45 years. Inspired by our founding Franciscan Sisters of Mary and guided by our Mission – Through our exceptional health care services, we reveal the healing presence of God – we cherish the sacredness and dignity of each person as demonstrated through our Values of compassion, respect, excellence, stewardship and community.

Our sustained community commitment can be seen through our collaborative partnerships with residents and organizations. We rely on these relationships to help us identify and develop plans to address high-priority community health needs. We are grateful for the opportunity to partner with the following organizations: Operation Food Search, St. Louis Area Foodbank, IFM Community Medicine, Pattonville and Ritenour School Districts, North County Incorporated, just to name a few.

Throughout 2021, in collaboration with our hospital and community partners, we conducted our community health needs assessment by gathering health and social determinants of health data from a variety of sources, including directly from our communities, to identify greatest concerns as well as opportunities and ideas for addressing those concerns. In our 2022-2024 community health improvement plans, we will look to a variety of strategies to address these needs based on the level of importance to community members and the hospitals' ability to make meaningful impact.

The priorities we will address over the next three years:

Behavioral Health

Heart Health/Nutrition

Respiratory Diseases

During this time, SSM DePaul Hospital will further develop its community partnerships and deliver an exceptional experience through high-quality, accessible and affordable care to all residents. Please visit our website at https://www.ssmhealth.com/locations/depaul-hospital-st-louis to learn more about how we will continue to make a difference in our community.

I welcome your thoughts on how we can create a healthier North Saint Louis County. communitybenefits@ssmhealth.com

Sincerely,

Tina Garrison

President & CEO

SSM Health DePaul Hospital

Executive Summary – North St. Louis County

SSM Health DePaul Hospital

Background

Under the Patient Protection and Affordable Care Act (PPACA) enacted in 2010, nonprofit hospitals are required to conduct a Community Health Needs Assessment (CHNA) every 3 years. In the CHNA process, it is also imperative that hospitals pay specific attention to health care concerns that affect vulnerable and marginalized populations. For the 2021 Community Health Needs Assessment, SSM Health followed standard processes, consistent with IRS regulations and standards. As part of the CHNA, hospitals must also develop a Community Health Improvement Plan (CHIP) or implementation strategy. While CHIPs primarily focus on the priorities identified as highest need, they may also incorporate other community needs and priorities.

Identified Priorities

In collaboration with other local health systems (BJC, Mercy, St. Luke's and Shriner's Hospital for Children) and many other community partners, we conducted a community health needs assessment by gathering health and social determinants of health-related information directly from the communities we serve through a single, regional community survey, a single, regional stakeholder survey and focus groups. Due to the ongoing COVID-19 pandemic, all surveys and focus groups were conducted virtually. 2,915 total CHNA community survey responses, 454 were submitted from North St. Louis County zip codes. Additionally, a total of 14 Stakeholder CHNA surveys were submitted by organizations serving North St. Louis County. A limited number of focus groups were held to capture additional input from regions with the lowest response rates, primarily in St. Louis City. Additionally, hard copy surveys were provided to a local homeless center (St. Patrick Center) and community center (The Youth and Family Center), both located in under-resourced zip codes of St. Louis City.

Quantitative data from a variety of secondary data sources were also assessed, in addition to our own 2019 hospital emergency department utilization data, to further inform our 2022-2024 health priorities. Input received directly from our communities through surveys and focus group conversations have been incorporated to identify concerns about the health of our communities, the types of community-based programs, organizations and services that currently exist to address community needs, as well as to identify gaps and opportunities for the enhancement and advancement of services.

Each source of data: 1) Community Survey, 2) Stakeholder survey, 3) Secondary data and 4) Hospital ED utilization data, played an important role in helping to identify and prioritize health needs based on the level of importance to community members and the hospital's ability to contribute to measurable impact.

Strategies

At SSM Health, we know that healthy communities don't just happen. Improving community health requires long-range, strategic efforts that take into account the entire eco-system of health by also addressing social determinants of health including, social, economic, environmental as well as political factors. Through our community health improvement plans (CHIPs), will engage in a wide-range of activities to address and support meaningful improvements within each identified health priority within the hospitals' capacities. Key strategies will include: Leveraging community collaborations and partnerships; strategic funding and communications; as well as policy and advocacy.

What is a Community Health Improvement Plan (CHIP)?

Many factors influence health and well-being in a community, and many entities and individuals in the community have a role to play in responding to community health needs. The CHIP provides a framework for a comprehensive approach to maintaining and improving health. A community health improvement plan is a long-term, systematic effort to address public health challenges on the basis of the results of community health needs assessment (CHNA) activities and the implementation strategies chosen to address community needs. The purpose of the community health improvement plan is to describe how not only our hospitals, but a host of community partners will work together to improve the health of our region.

Key Components of a CHIP include:

- Engaging Partners
- Visioning
- Collecting and Analyzing Data
- Identifying and Prioritizing Strategic Issues
- Developing Goals Strategies and an Action Plan
- Taking and Sustaining Action

2022-24 North St. Louis County Priorities

Behavioral Health	Hearth Health/Nutrition	Respiratory Diseases
		

Over the next several years, SSM DePaul Hospital will continue to take strategic and collaborative actions within the hospital's capacity to respond to and address the above priorities, primarily through collective impact approaches, leveraging resources, education and collaboration. While we will focus on these four priorities, our hospitals are in constant motion, working to address a myriad of community health challenges and social determinants of health. Our logic model on page 11 displays our broader approach to health equity and social determinants of health and how we will stay engaged and accountable as our region works dismantle long-standing barrier and create healthier communities will all residents can thrive.

Behavioral Health

Behavioral Health (BH), inclusive of mental health and substance use disorders, was determined to be a priority health need in each hospital ministry community's CHNA process. The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability. Substance abuse disorders have a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. In 2019, 18.5% of residents in the Inner North region of St. Louis County reported experiencing 14 or more poor mental health days in the past month compared to the national average of 13.6%.

Resources

- Community Coalitions & partners
- Behavioral Health Data
- Direct & Collaborative Funding
- Behavioral Health Services
- Facilities and Infrastructure
- Staff Time, Expertise & Commitment
- Leadership

Strategies

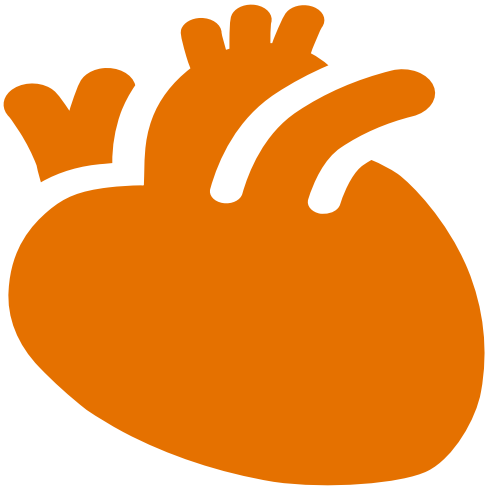
- Increase access to existing BH programs/services
- Support initiatives that build capacity of local partners addressing access to BH services and care
- Support/advocate for policies that improve access and services to BH
- Strengthen internal BH services and capacities
- Promotion of safe medication disposal
- Fund evidence based & innovative approaches
- Data Equity
- Public Health Education

Impact

Long-Term

- Increased policies supporting equitable behavioral health treatment & care
- Healthier communities with improved access to mental health/substance abuse care

Heart Health/ Nutrition



Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure, cigarette smoking, and high blood cholesterol are still major contributors to the national epidemic of cardiovascular disease. The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the U.S. population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use. Black/African American residents in St. Louis County are disproportionately affected by heart disease to a staggering degree, consistently having higher mortality and hospital visit rates compared to other racial/ethnic groups in the county.

Resources

- Community coalitions, partners
- Staff expertise, time & commitment
- Direct & collaborative funding
- Heart disease management services
- Nutrition insecurity data
- Leadership
- Facilities & infrastructure

Strategies

- Support initiatives that build capacity of local partners addressing nutrition/heart disease
- Increase access to heart disease management services
- Support/advocate for policies that improve access to nutritious foods
- Strengthen internal awareness/knowledge of heart disease disparities through education, skills development
- Direct and/or collaborative funding
- Data Equity
- Public Health Education

Impact

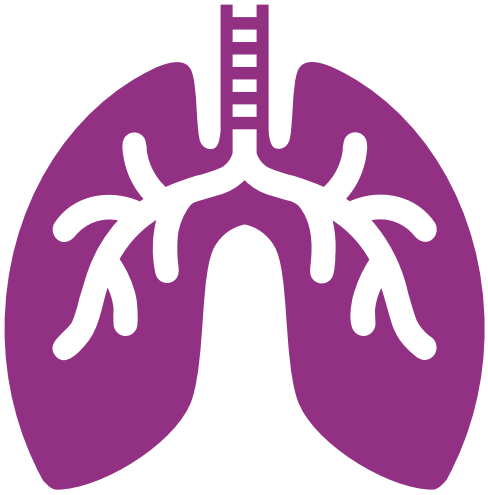
Short-Term

- Strategic SSM community partnerships focused on heart health and nutrition
- Increased internal and community awareness & knowledge of importance of heart health and nutrition

Long-Term

- Increased community consumption of nutrition foods
- Increased heart healthy activities
- Increased advocacy for change
- Increased policies supporting healthy living for all

Respiratory Diseases



Respiratory diseases affect millions of people in the United States. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. There are also several emerging respiratory health issues such as the impact of environmental change and increasing importance of indoor air quality. North St. Louis County has disproportionately higher rates of asthma compared to other areas in St. Louis County. High asthma hotspots are associated with characteristics of environment risk.

Resources

- Community coalitions & partners
- Staff time, expertise & commitment
- Respiratory health services
- Facilities & infrastructure
- Leadership
- Respiratory health data

Strategies

- Support initiatives that build capacity of local partners addressing respiratory health
- Increase access to respiratory health services and prescriptions
- Support/advocate for policies that improve air quality
- Strengthen internal respiratory health services, ensuring equity & cultural competency
- Direct and/or collaborative funding
- Ensure data equity
- Public health education

Impact

Short-Term

- Strategic & consistent SSM community partnerships focused on respiratory diseases
- Increased staff awareness, knowledge and abilities to carryout culturally competent care

Long-Term

- Increased community knowledge of importance respiratory disease management
- Increased policies that support healthy environments
- Increased advocacy for change
- Reduced disparities in respiratory diseases

Community Assets & Strategic Partners

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Community Health

Physical spaces & built environment
- Community gardens
- Playgrounds
- Parks & trails
- Transportation

Faith-based organizations
- Houses of worship
- Faith-based service groups

Schools & educational institutions
- Public, private, and parochial schools
- Universities & community colleges
- Technical & vocational education

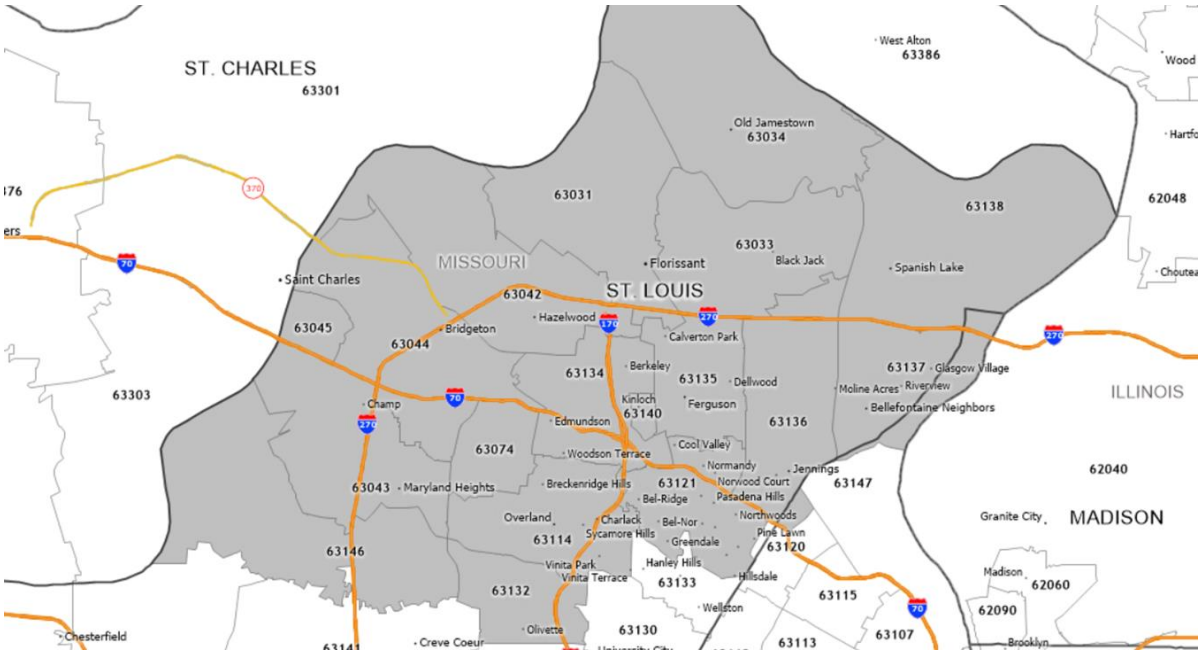
Hospitals & health care providers
- Nursing homes
- Behavioral & mental health
- Pharmacies
- Emergency medical services

Social service & health nonprofits
- Health service nonprofits
- Food service nonprofits
- Housing service nonprofits

Businesses, employers, & economic groups
- For-profit businesses
- Chamber of Commerce
- Business associations

Associations, boards, & commissions
- Neighborhood groups & associations
- Government-appointed boards
- Health coalitions & commissions

Government & public agencies
- Public health & health departments
- Human services
- Libraries
- Fire department & law enforcement



SSM Health DePaul Hospital's Service Area Map

Addressing Other Community Needs & Priorities Through the Lens of Health Equity and Social Determinants of Health

Health Equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life, rate of disease, disability and death; severity of disease and access to treatment. CDC

Addressing Social Determinants of Health and Health Equity

Inputs

- Needs assessment
- Collaborative strategy development
- Policy/advocacy
- Staff support & expertise
- Coalition participation & support
- Community engagement & partnerships
- Leverage direct community input/expertise
- Data/information sharing
- Philanthropy
- Consistent and strategic communications
- High quality facilities & services

Strategies

- Advance and implement evidence-based strategies to reduce poverty and adverse childhood events/trauma
- Staff education & training
- Increased access to care opportunities
- Collaborate with key partners & stakeholders
- Fund evidence-based and innovative strategies to address social determinants of health and health equity
- Adoption of evidence programs and practices
- Support and advocate for improvements to environment health
- Use quality, relevant data to inform decision
- Advocate for and support policies and strategies that reduce health and health disparities

Impact

Short/Long Term

- Consistent and active engagement in addressing health equity and social determinants of health that adversely affect health outcomes
- More diverse and culturally and linguistically competent staff
- Internal capacities to address health inequities and SDoH are strengthened
- Stronger, more connected and consistent community partnerships
- Improved care coordination and health care access for those most at risk for health inequities
- Increased policies that reduce health disparities and improve access
- Communities experience greater sense of control and improved social outcomes
- Healthier and Safer communities

Moving Social Determinants of Health Upstream!

SSMHealth

2022-2024

Appendices

Appendix A:
Local Health/Social Determinants of Health Data Sources

Local Data Sources	
2-1-1 Counts	Using 2-1-1 Counts, you'll find a snapshot of community-specific needs displayed by ZIP code, region or call center as recently as yesterday, enabling you to easily check trends, make comparisons and share information. 2-1-1 Counts works with your local 2-1-1 to share this information with community leaders and service agencies.
2019 Regional Scorecard	Released by a regional health improvement collaborative, the scorecard provides regional benchmarks and measures of the St. Louis region's progress towards becoming a national leader in the quality and value of its health care services.
Coordinated Entry Dashboard	Here, you can view the number of households entering and exiting the St. Louis Coordinated Entry System.
Equity Indicators	The Regional Equity Indicators Dashboard is an expansion of the work released by the City of St. Louis and a response to the Ferguson Commission's calls to action for a benchmarking process to quantify the state of racial equity in the St. Louis region and to measure progress over time
Explore MO Health	exploreMOhealth is designed to help stakeholders assess the health of their communities. This tool allows visitors to explore hyperlocal health data to better understand the factors that can influence health outcomes. Site can be used to compare county and zip code data.
Food Access Story Map	This map allows users to explore patterns of food access and its intersectionality with built environment, race, income and a multitude of other factors, in the St. Louis region.
Missouri Public Health Information Management Systems	Provides a common means for users to access public health related data to assist in defining the health status and needs of Missourians.
STL Response COVID-19 Resource Dashboard	A comprehensive collection of resources, data and news from across the St. Louis region, updated daily.
Think Health STL	Includes data on a wide-range of local issues including: health, economy, education, environment, government & politics, public safety, social environment & transportation and gun violence.
United Way 2020 Community Needs Assessment (Missouri)	United Way engaged four research partners, and together this team designed a collaborative approach to understand priority needs, map regional funding, and identify community partnerships.

Appendix A:
National Health/Social Determinants of Health Data Sources

National Data Sources	
2020 Census Response Rates	Provides up to date response rates for 2020 Census for communities across the nation.
County Health Rankings	The annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work, and play. They provide a starting point for change in communities
Arizona Self Sufficiency Matrix	An assessment tool to effectively manage client and program performance and demonstrates results to stakeholders. Provides the ability to report on a client or program's progress towards self-sufficiency.
Census Data	Data.census.gov is the new platform to access demographic and economic data from the U.S. Census Bureau. The vision for data.census.gov is to improve the customer experience by making data available from one centralized place so that data users spend less time searching for data and content, and more time using it.
City Data	By collecting and analyzing data from a variety of government and private sources, we're able to create detailed, informative profiles for every city in the United States. From crime rates to weather patterns, you'll find the data you're looking for on City-Data.com.
Community Commons	A community of change-makers working to create healthy, equitable, sustainable communities. Find curated tools, resources, and inspirational stories to drive your work forward.
Community Toolbox	Use to get help taking action, teaching, and training others in organizing for community development. Dive in to find help assessing community needs and resources, addressing social determinants of health, engaging stakeholders, action planning, building leadership, improving cultural competency, planning an evaluation, and sustaining your efforts over time.
COVID At Risk	Conduent Healthy Communities Institute (HCI) has launched this publicly available website to help locate and assist populations that may be at risk of not having basic needs met due to COVID-19 stay-at-home orders.
Eviction Lab	The Eviction Lab at Princeton University has built the first nationwide database of evictions. Find out how many evictions happen in your community. Create custom maps, charts, and reports. Share facts with your neighbors and elected officials.
Healthy People 2030	Healthy People 2030 sets data-driven national objectives to improve health and well-being over the next decade.
Hunger Vital Sign Food insecurity screening tool	The Hunger Vital Sign™ identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):
Race Forward: Racial Equity Impact Assessment	A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.