SSMHealth

2022-2024

Community Health Needs Implementation Strategy

SSM Health Academic Hospitals

SSM Health Saint Louis University Hospital| 1201 S. Grand Blvd. | St. Louis, MO 63104

SSM Health Cardinal Glennon Children's Hospital| 1465 S. Grand Blvd | St. Louis, MO 63104

SSM Health St. Mary's Hospital - St. Louis |6420 Clayton Rd.| St. Louis, MO, 63117

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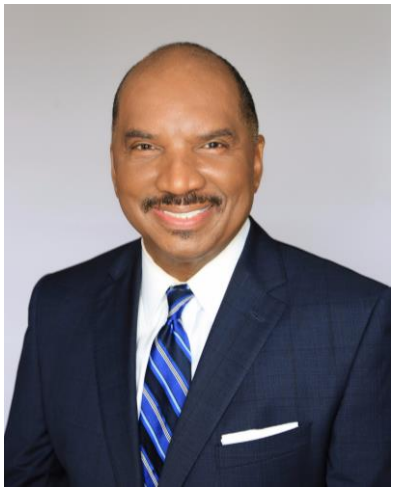
Message to our community

Saint Louis University Hospital, Cardinal Glennon Children's Hospital and St. Mary's Hospital are each members of SSM Health, and have delivered exceptional, compassionate care to the St. Louis Community for 150 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.



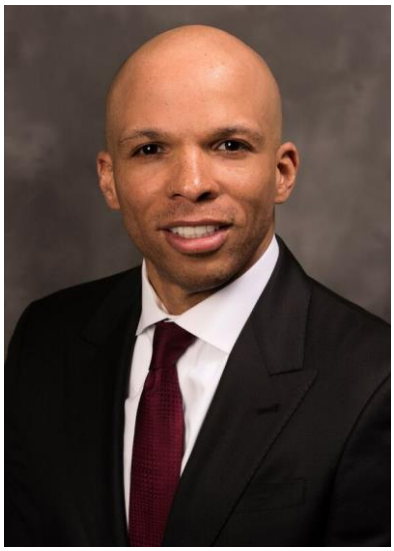
Our sustained community commitment can be seen through our collaborative partnerships with residents and organizations. We rely on these relationships to help us identify and develop plans to address high-priority community health needs. We are grateful for the opportunity to partner with numerous community partners, many of which are named in our CHIP.

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
- Obesity/Chronic Conditions
- Violence and Injury Prevention
- Women's Health/High Risk Pregnancy

During this time, Saint Louis University Hospital, Cardinal Glennon Children's Hospital and St. Mary's Hospital will further develop our community partnerships and deliver an exceptional experience through high-quality, accessible and affordable care to all residents. Please visit our website at www.ssmhealth.com to learn more about how we will continue to make a difference in our community.



We welcome your thoughts on how we can create healthier communities. Please email feedback to communitybenefits@ssmhealth.com

Sincerely,

Steven M. Scott	Steven Burghart	Travis Capers
President SSM Health Saint Louis University Hospital	President SSM Health Cardinal Glennon Children's Hospital	President SSM Health St. Mary's Hospital

Executive Summary - St. Louis City

SSM Health Saint Louis University, SSM Health Cardinal Glennon Children's Hospital and SSM Health St. Mary's Hospitals

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, 378 were submitted from St. Louis City zip codes. Additionally, a total of 26 Stakeholder CHNA surveys were submitted by organizations serving St. Charles 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.

Saint Louis University Hospital	Cardinal Glennon Hospital	St. Mary's Hospital
Behavioral Health	Behavioral Health	Behavioral Health
Obesity/Chronic Conditions	Obesity Chronic Conditions	Obesity/Chronic Conditions
Violence/Injury Prevention	Violence/Injury Prevention	High-Risk Pregnancy/Women's Health

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; helping to build capacities of strategic community partners, education and training, philanthropy, strategic 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

2022-2024 SSM St. Louis City Priorities

			
Behavioral Health	**Obesity/Chronic Disease**	**Violence & Injury Prevention**	**Women's Health/High Risk Pregnancy**

Over the next several years, SSM St. Clare 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 health equity framework on page 11 displays our broader approach to community which focuses on health equity and social determinants of health and how we will stay engaged and accountable as our region works dismantle long-standing barriers and create healthier communities where all residents can thrive.

Behavioral Health

Background

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 St. Louis City, residents experience an average of 5 poor mental health days per month, above the statewide average of 4.5. and sixteen percent of St. Louis City resident experience mental health distress.

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
- Strengthen internal BH services & capacities
- 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
- Promote efforts that empower local communities to drive change
- Fund evidence based & innovative approaches
- Ensure Data Equity
- Promote public health education & strategic communication

Impacts

- Consistent and strategic SSM community partnerships focused on behavioral health
- Increased internal and community knowledge & awareness of the importance and impact of BH access & care
- Increased policies supporting equitable behavioral health treatment & care
- Healthier communities with improved access to mental health/substance abuse care
- Increased advocacy for change

Obesity/Chronic Diseases

Background

Good nutrition, physical activity, and a healthy body weight are essential parts of a person's overall health and well-being. Most Americans, however, do not eat a healthful diet and are not physically active at levels needed to maintain proper health and weight. In St. Louis City, 35% of Adults are considered obese and about 30% report no leisure time physical activity.

Additionally, St. Louis City ranks below the state average when considering factors that contribute to healthy food environments. Chronic diseases, often strongly linked to obesity, are the leading cause of death and disability in the United States, causing 7 out of 10 deaths each year. Examples of chronic diseases include cardiovascular disease, arthritis, diabetes and cancer. Healthy Eating & Active Living (HEAL) is essential to managing obesity and chronic diseases.

Resources

- Community coalitions, partners
- Staff expertise, time & commitment
- Direct & collaborative funding
- Chronic disease management services
- Obesity/chronic disease data
- Leadership
- Facilities & infrastructure

Activities

- Support initiatives that build capacity of local partners addressing obesity/chronic disease
- Increase access to chronic disease management services
- Support/advocate for policies that improve access to healthy eating/active living (HEAL)
- Strengthen internal awareness/knowledge of obesity disparities through education, skills development
- Direct and/or collaborative funding
- Ensure data Equity & evaluation focused on measurable impacts
- Public Health Education & strategic communications

Impacts

Short Term → Long Term

- Strategic SSM community partnerships focused on food insecurity/healthy food access & physical activity
- Increased internal and community awareness & knowledge of importance of healthy eating & chronic disease management
- Increased community consumption of healthy foods
- Increased community physical activity
- Improved community environments, schools and worksites that support HEAL
- Increased advocacy for change
- Increased policies supporting healthy living for all

Violence and Injury Prevention

Background

Violence, as well as unintentional injuries are wide-spread in society. Both unintentional injuries and those caused by act of violence are among the top 15 killers for Americans of all ages. Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans. Unintentional injuries are a leading killer of children ages 1-17 in Missouri. Easier access to safety measures such gun safety locks, car seats and poison prevention strategies help to reduce such preventable injuries. Violence in St. Louis City has been a long-standing challenge for local residents, however, in 2021, homicides in St. Louis City dropped 25% - a testament to how collective action and region-wide collaboration can begin to make a positive difference when addressing complex community issues. To stay on this track, we must continue to invest in innovative programs, policies and leadership for sustained action.

Resources

- Community coalitions & partners
- Staff time, expertise & commitment
- Direct & collaborative funding
- Trauma care services
- Facilities & infrastructure
- Leadership
- Data

Strategies

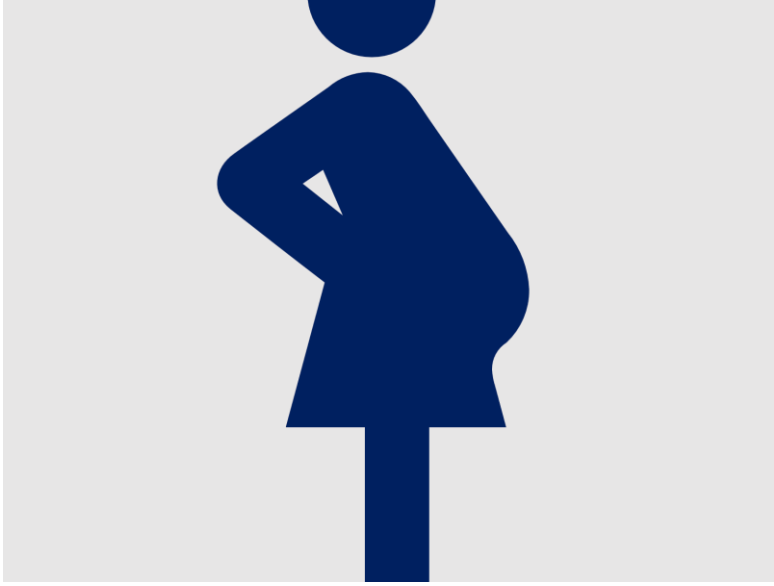
- Increase access to trauma and social needs services
- Support initiatives that build capacity of community partners addressing violence/injury prevention
- Support/advocate for policies that decrease violence & injury prevention
- Strengthen internal capacities to address violence/injury prevention through education, sills building
- Direct and/or collaborative funding
- Ensure data equity & evaluation focused on measurable impacts.
- Support public health education & strategic communication

Impacts

Short Term → Long Term

- Increased, more consistent SSM community partnerships focused on violence and injury prevention
- Increased internal and community awareness & knowledge of the affects of violence, trauma and unintentional injuries on vulnerable patients/communities
- Healthier, safer homes and community environments
- Increased policies supporting violence & injury prevention
- Increased advocacy for change

Women's Health/High Risk Pregnancy



Women's health before, during, and after pregnancy Can have a major impact on infants' health and well-being. Women who get recommended health care services before they get pregnant are more likely to be healthy during pregnancy and to have healthy babies. In St. Louis City, Black babies are three times as likely to die before their first birthday as white babies. Strategies to help pregnant women get medical care and avoidrisky behaviors like smoking or drinking alcohol can also improve health outcomes for infants. Additionally, providing care that is culturally appropriate, including effective communication, listening, and respect can help to reduces stress in the pregnancy cycle.

Resources

- Community coalitions & partners
- Staff time, expertise & commitment
- Direct & collaborative funding
- Women's health services
- Facilities & infrastructure
- Leadership
- Women's health data

Strategies

- Increase access to women's health/high risk pregnancy services
- Support initiatives that build capacity of local partners addressing women's health/high risk pregnancy/infant mortality
- Support/advocate for policies that improve access to women's health services
- Strengthen internal women's health services, ensuring equity & cultural competency
- Direct and/or collaborative funding
- Ensure data equity &evaluation focused on measurable impacts
- Public health education
- Monitor & evaluate progress

Impacts

Short Term → Long Term

- Strategic & consistent SSM community partnerships focused on women's health
- Increased staff awareness, knowledge and abilities to carryout culturally competent care
- Increased community knowledge of importance of self care during pregnancy & access to services
- Increased policies that support women's health/prevent high risk
- Increased advocacy for change
- Reduced disparities in infant/maternal health

Community Assets & Strategic Partners

SSMHealth.
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

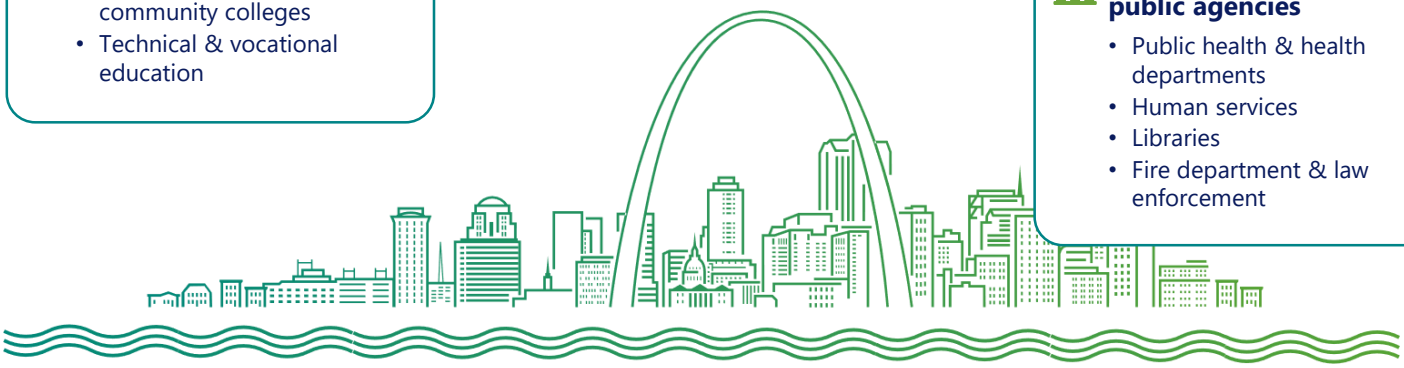
Hospitals & health care providers
- Nursing homes
- Behavioral & mental health
- Pharmacies
- Emergency medical services

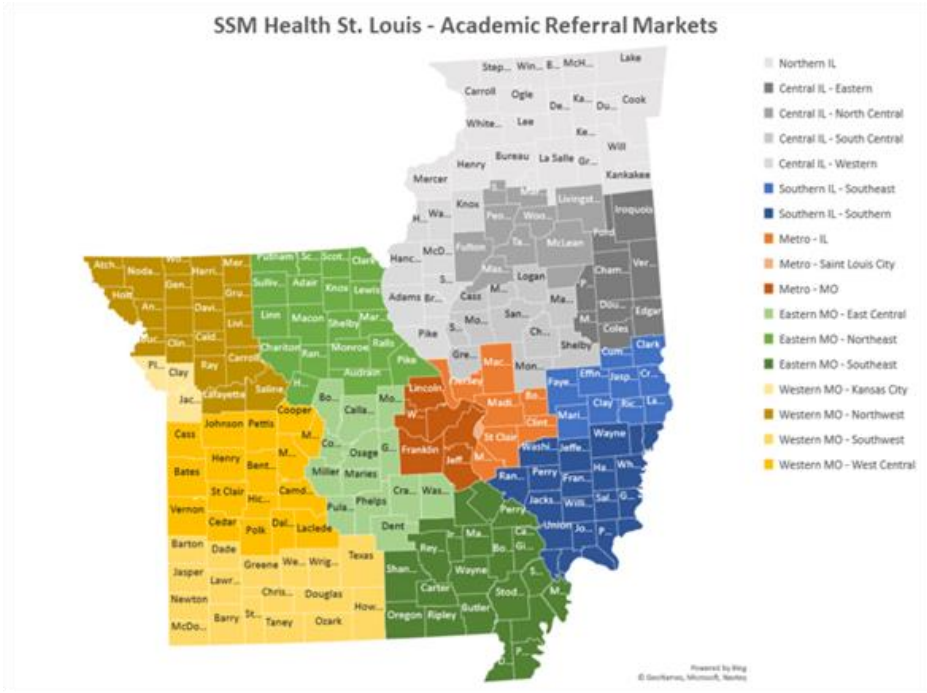
Social service & health nonprofits
- Health service nonprofits
- Food service nonprofits
- Housing service nonprofits

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





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

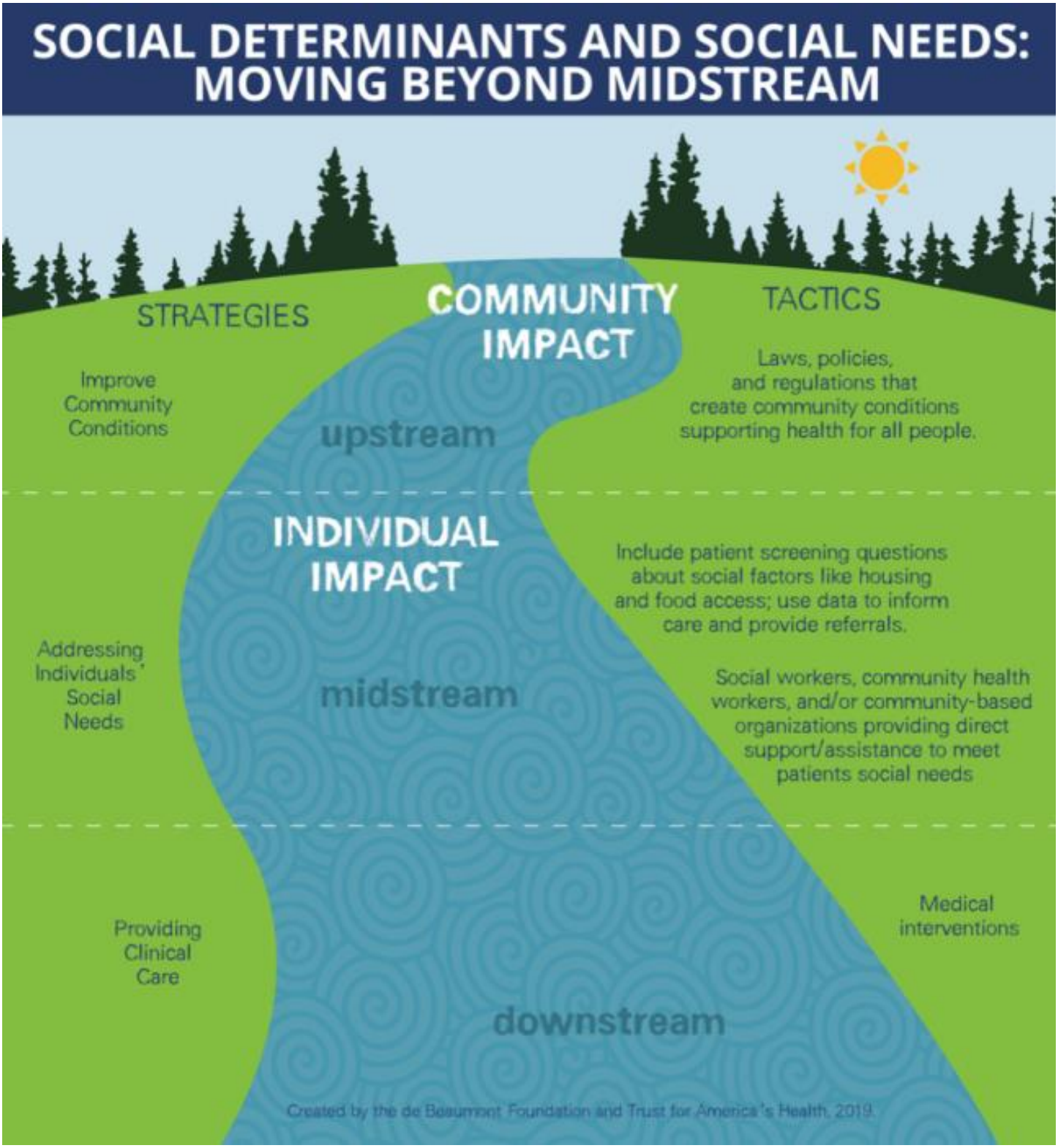
Health Equity

Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one 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, rates of disease, disability and death; severity of disease and access to treatment. CDC

Addressing Social Determinants of Health and Health Equity

Inputs	Strategies	Impacts Short Term | Long
Needs Assessment	Advance and implement evidence-based strategies to reduce poverty and adverse childhood events/trauma.	Communities experience greater sense of control and improved social standing
Collaborative Strategy Development	Staff Education & Training	Increased social support
Policy/Advocacy	Increased access to care opportunities	Healthier and Safer communities
Staff Support & Expertise	Collaborate with key partners and stakeholders	More diverse and culturally and linguistically competent staff
Coalition Participation & Support	Fund evidence-based and innovative strategies to address social determinants of health and health equity	Internal capacities to address health inequities and SDoH are strengthened
Community Engagement & Partnerships	Adoption of evidence programs and practices	Stronger, more connected and consistent community partnerships
Leverage Direct Community Input/Expertise	Support and advocate for improvements to environmental health	Improved care coordination and health care access for those most at risk for health inequities
Data/Information Sharing	Use quality, relevant data to inform decisions	SSM is consistently and actively engaged in addressing health equity and social determinants of health that adversely affect health outcomes
Philanthropy	Advocate for and support policies and strategies that reduce health and healthcare disparities	
Consistent and Strategic Communications		
High Quality Facilities & Services		

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.

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.