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# CITY OF ST. LOUIS

# COMMUNITY HEALTH IMPROVEMENT PLAN

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St. Louis City is the kind of great city that attracts residents and businesses from throughout the region. The Slay Administration and its public and private partners have received national and international recognition for a St. Louis renaissance over the past eight years.

It's also a place where residents, organizations, businesses and governmental entities work tirelessly to make St. Louis City a healthy St. Louis community every day, all of the time. And although we have work to do we are headed in the right direction.

There has been significant improvement in major health indicators such as overall mortality, heart disease, cancer, stroke, diabetes, infant mortality, lead poisoning, gonorrhea and asthma in the City of St. Louis over the past 10 years:

- Overall mortality rates have decreased 14%
- Heart disease mortality decreased 26%
- Incidence of the top four types of cancer has decreased by an average of almost 10%
- Deaths due to stroke have decreased 36%
- Diabetes deaths have decreased 11%
- Infant mortality is down 7%
- Childhood lead poisoning prevalence has fallen by 80%
- Incidence of gonorrhea is down 41%
- 6% fewer children with asthma on Medicaid are requiring acute care in a hospital setting

Mayor Slay has dedicated $5.5 million annually to urgent and specialty care as part of a federal match guaranteeing $25 million for these services. Between 2001 and 2010, St. Louis City and County safety net institutions provided over 3.6 million primary and 1.1 million specialty care visits and they have grown by 25% and 30% respectively, during this time.

Access to care has significantly improved in St. Louis over the past ten years:

- Between 2001 and 2010, more than 6 million outpatient visits were made by low-income residents to regional health care safety net institutions. In 2010 alone, more than 750,000 outpatient visits were made by the uninsured and Medicaid population to health care safety net sites in St. Louis. The funding provided through the Regional Health Commission (RHC) over this time represented 20-25% of all funding to community health centers.
- Safety net sites saw more than 175,000 more visits by uninsured and Medicaid patients in 2010 than in 2001, a 25% increase in volume, without a large increase in funding over this time.
- Use of emergency department services for non-emergencies decreased 12% (-20,000 visits) between 2001 and 2010. Notably, use of emergency department services for non-emergencies decreased 26% among the uninsured, in part due to the increase in access at community health centers over this time.

However, there is still much work to do. For example, despite overall improvement in health status over the past ten years in both the African American and Caucasian populations in St. Louis City, race- and gender-based disparities persist. And in some ZIP Codes where there are few cases the rates in comparison to federal and state rates are unacceptable.

The Community Health Assessment and Community Health Improvement Plan was ordered by me to help us better understand community needs and health disparities. It has been funded in part by the Missouri Foundation for Health. It was a dynamic and informative process led by REESSI. Ninety residents attended seven focus groups to help identify community priorities. Twenty-four representatives actively participated in analysis and planning from a diverse set of organizations including educational institutions, regional coalitions, service providers, government agencies, and businesses. Two City Aldermen were part of the group. And twenty-two individuals participated on a residents group representing a diverse set of neighborhoods and communities in the City of St. Louis.

This was a data-driven process utilizing the City DOH Understanding Our Needs City Health Assessment data, which is compiled from State data sources such as birth and death certificates and hospital discharge data.

Clear goals have been established through the CHA and the CHIP development process pertaining to mortality, violence, education, self destructive behavior and poverty.

Experience-On-Demand led the St. Louis City Board of Health and DOH managers through an in depth review of programs, essential services and core business.

Clear strategic initiatives have been established for the Department through the Strategic Plan development process pertaining to increasing regional collaboration and partnerships; actively engaging the community; improving accountability, quality and performance; improving communications; utilizing technology; increasing grant funding; and improving talent management.

The CHIP and the DOH Strategic Plan will be implemented and updated over the next 18 to 24 months.

The Understanding Our Needs City Health Assessment, Community Health Assessment, Community Health Improvement Plan and the City Department of Health Strategic Plan all reflect the commitment and the concern that residents, organizations, businesses and governmental agencies have to assure that St. Louis City is a viable city that is safe, clean and healthy.

Signed by

Pamela Rice Walker, MPA, CPHA,
Interim Health Director for the City of St. Louis

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# I. INTRODUCTION

## I.A. CITY OF ST. LOUIS DEPARTMENT OF HEALTH

St. Louis, a charter city in the state of Missouri, is bordered by the Mississippi River on the east and St. Louis County on the north, south and west. The City of St. Louis is located in a metropolitan region of six counties with a population of 2.7 million and is a completely separate entity from St. Louis County. An area map of the city with Wards and ZIP codes is attached in **Appendix A**. The City is divided into 79 distinct neighborhoods. While these neighborhoods have no legal jurisdiction, the social and political influence of neighborhood identity is powerful in St. Louis.

The Institute of Medicine (2002) defines public health as what society does collectively to assure conditions for people to be healthy.[1] More specifically it is one of many efforts organized by a society to protect, promote and restore the people's health (Last, 1988).[2] Health is not merely the absence of disease but a complete state of physical, mental and social well-being (WHO, 1948).[3] The public health infrastructure, primarily consisting of federal, state and local government agencies, carries out the majority of public health activities in partnership with non-government agencies, coalitions and individuals. The City of St. Louis Department of Health is the local public health agency serving the City through its vision, mission and values. The Department of Health's vision is for the City of Saint Louis to be a *healthy environment where citizens realize their desire for longer, healthier and happier lives at home, at work and in their neighborhoods*. The organizational mission is *to assure a healthy community through continuous protection, prevention and promotion of the public's health.* Caring, qualified, culturally competent employees who are responsive and proactive to community needs support the achievement of this mission. The department was established in 1867 and has delivered outreach and prevention services to the City for 145 years–currently serving a population of 319,294. The City of St. Louis Department of Health is fully accredited at the comprehensive level, which is the highest granted by the state accrediting board–Missouri Institute of Community Health.

## I.B CONTEXT FOR THE COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

After more than six years of exploration and investigation, the Centers for Disease Control and Prevention (CDC), in collaboration with the Robert Wood Johnson Foundation, is supporting a national voluntary accreditation program for public health agencies. The newly created non-profit Public Health Accreditation Board (PHAB) oversees the accreditation process. PHAB is working to promote and protect the health of the public by advancing the quality and performance of all public health departments in the U.S. through national public health department accreditation. PHAB's vision is a high-performing governmental public health system that leads to a healthier nation. For a public health department to be accredited, it must meet stringent requirements for the 10 essential services of the core public health functions and demonstrate a commitment to constant improvement. The functions exclude Medicaid, mental health, substance abuse, primary care and human service programs. Thirty health departments have already tested the process of national accreditation and local officials were pleased with and support the outcomes. In July 2009 the PHAB Board approved a set 30 proposed standards and 102 proposed measures for local health departments.

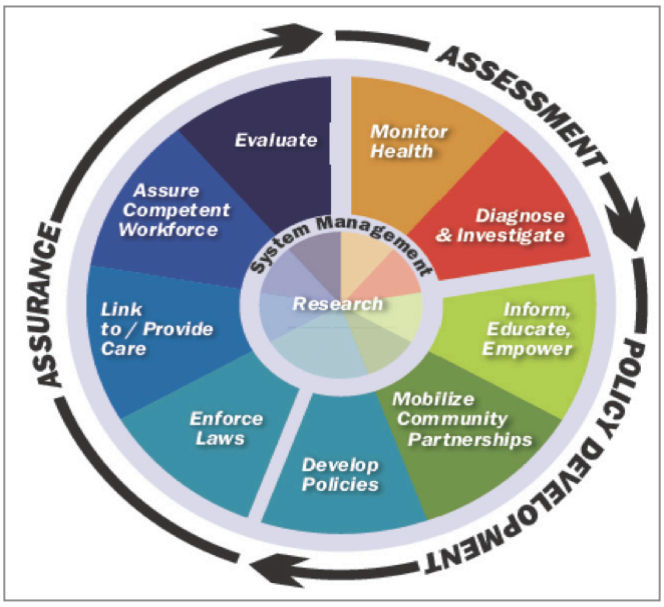



**Figure 1–Core Public Health Functions/Essential Services**

Each measure can be classified as either capacity (something that is in place), process (something that must be done), or outcome (a change or lack of change resulting from an action or intervention). Two subtypes of outcomes are used: process outcome, in which the results of a process are tracked and health outcome, where the results may include health status information. In September 2011, the national accreditation process was launched and 97 health departments are at various stages in the accreditation system. The process involves 12 domains and the first ten domains address the ten Essential Public Health Services as shown in **Figure 1**. The services are part of the three core functions of public health–1) Assessment, 2) Assurance and 3) Policy Development.

Domain 11 addresses management and administration and Domain 12 addresses governance. Four out of the twelve domains lend themselves to the engagement of external organizations and the community: Domain 1–Conduct and disseminate assessments focused on population health status and public health issues facing the community; Domain 3–Inform and educate about public health issues and functions; Domain 4–Engage with the community to identify and address health problems; and Domain 5–Develop public health policies and plans. The City of St. Louis Department of Health plans to seek national accreditation and initiated a joint effort involving a community health assessment (separate report, October 2012) and a process to develop a Community Health Improvement Plan (CHIP) in November 2011 that included receiving input and feedback from a cross section of residents in the City. From March–July 2012, the health department convened a select group of partners and citywide residents to construct a citywide health improvement plan as an agency responsibility under the ***Policy Development*** core public health function. The department engaged a research and evaluation consulting firm (REESSI) to facilitate the development of the plan.

# II. OVERVIEW OF THE PROCESS

## II.A. THEORETICAL FRAMEWORKS

The REESSI team employed elements of three theoretical models to guide the planning process–1) Precede-Proceed[1], 2) Community Health Assessment and Group Evaluation (CHANGE)[2] and 3) Mobilizing Action Through Planning and Partnership (MAPP)[3].

**Precede-Proceed Model**

- It is founded on the disciplines of epidemiology; the social, behavioral and educational sciences; and health administration.
- The goals are to explain health-related behaviors and environments and to design and evaluate the interventions needed to influence both the behaviors and the living conditions that influence them and their consequences.
- It has been applied, tested, studied, extended and verified in over 960 published studies and thousands of unpublished projects in community, school, clinical and workplace settings over the last decade.
- REESSI used this model to develop the North St. Louis Strategic Health Plan.

[1] This model was developed by Lawrence Green and Marshall Kreuter (2005, 1999, 1991)
[2] This model was developed by the Centers for Disease Control and Prevention (CDC).
[3] The National Association of County and City Health Officials (NACCHO) developed this model.

**Community Health Assessment and Group Evaluation (CHANGE)**
Community Health Assessment aNd Group Evaluation (CHANGE) is a data-collection tool and planning resource for community members who want to make their community a healthier one.

- The CDC's Healthy Communities Program designed the CHANGE tool for all communities interested in creating social and built environments that support healthy living.
- The purpose of CHANGE is to gather and organize data on community assets and potential areas for improvement prior to deciding on the critical issues to be addressed in a Community Action Plan.

**Mobilizing for Action Through Planning and Partnerships (MAPP)**

- A strategic approach to community health improvement, this tool helps communities improve health and quality of life through community-wide and community-driven strategic planning.
- Through MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking into account their unique circumstances and needs and forming effective partnerships for strategic action.
- MAPP focuses on strengthening the whole system rather than separate pieces, thus bringing together diverse interests to collaboratively determine the most effective way to conduct public health activities.
- This model was used in the St. Louis Department of Health STRYVE process. An illustration of the framework is presented in **Figure 2.**

**Figure 2–MAPP FRAMEWORK**

The MAPP framework was used as a *primary tool*, integrated with appropriate components of the other two models, to develop the City of St. Louis CHIP plan. For example, the partners chose to use the *Windshield Survey* assessment from the CHANGE model. Various elements such as the behavioral, environmental, education and ecological assessments were used from the Precede-Proceed model to guide the earlier planning meetings. The information in **Table 1** shows the elements of each model, how they are similar and how they are different.

**Table 1–Side-by-Side Comparison of Theoretical Models**

| Phase/Step | PRECEDE-PROCEED | CHANGE | MAPP |
|---|---|---|---|
| Phase/Step 1 | Social Diagnosis | Commitment | Organize for Success/Partnership Development |
| Phase/Step 2 | Epidemiological, Behavioral, & Environmental Assessment | Assessment | Visioning |
| Phase/Step 3 | Educational & Ecological Assessment | Planning | 1. Community Themes & Strengths<br>2. Local Public Health System<br>3. Community Health Assessment<br>4. Forces of Change |
| Phase/Step 4 | Administrative & Policy Diagnosis | | Identify Strategic Issues |
| Phase/Step 5 | Implementation | Implementation | Formulate Goals & Strategies |
| Phase/Step 6 | Process Evaluation | Evaluation | The Action Cycle |
| Phase/Step 7 | Impact Evaluation | | Evaluation |
| Phase/Step 8 | Outcome Evaluation | | |

## II.B GOALS, STRUCTUREAND PARTICIPANTS

The overarching goal of the CHIP planning process was *to engage both partners and residents in an intensive and efficacious set of activities that led to learning, the identification of key health issues in the City of St. Louis and the construction of strategies for positive change.* The planning structure involved a group of health department partners who met twice a month and a cohort of citywide residents who met once a month to respond to and approve the work of the partners. According to the partners and residents, the process was innovative and dynamic. Partners were always conscious of how the residents would receive their work and outcomes and the residents consistently expressed appreciation that they were being heard and that their opinions mattered. The REESSI staff planned and facilitated the meetings.

The partners' CHIP work group consisted of 24 representatives from a diverse set of organizations that included educational institutions, regional coalitions, service providers, government agencies and businesses. Two City Aldermen were part of the group. Each representative submitted a Memorandum of Agreement, making commitments to attend at least eight hours of planning meetings per month from April–July, 2012. A list of the members of the CHIP

work group is attached in **Appendix B.** During the orientation meeting for the work group, REESSI conducted an audience response assessment to determine the demographics, talents and interests of the group. The full results and profile of the CHIP work group are attached in **Appendix C**, however a snapshot of the results from the 20 respondents reveals the following:

- 90% of the organizations are based in the City of St. Louis.
- 50% of the organizations have been in existence for 50 years or more.
- 70% of the organizations serve more than 1000 City residents per year.
- 68% of the organizations have engaged in prior work with the health department.
- 70% of the organizations expressed a willingness to engage in the CHIP process.

The residents' group consisted of 22 individuals from a diverse set of neighborhoods and communities in the City of St. Louis. They all were participants in the focus groups (Total N=89) for the Community Health Assessment and agreed to be part of the health department's *Residents Advisory Group*. A list of members of the Residents Advisory Group is attached in **Appendix D.**

## II.C. PLANNING ACTIVITIES

The planning activities consisted of seven four-hour meetings with the partners and four two-hour meetings with the residents. A meeting schedule with the dates, locations and content of the meetings was provided to both groups in advance. A schedule of the meeting and process is attached in **Appendix E.**

### *II.C.1. Partners Meetings*

The information in **Table 2** shows the meetings for the partners, the content of the meeting and the outcomes of each meeting. During the first meeting in April, the REESSI team divided the CHIP work group members into four small groups (known as Microgroups) and each selected a facilitator. Two meetings were held monthly from April-June 2012. One final meeting was held in July 2012 to accommodate summer vacation plans and schedules. At the onset of each meeting, the REESSI Project Director presented background information and contextual frameworks. Most of the time in each meeting was dedicated to small group work involving structured activities using customized worksheets. The health department staff is in possession of the electronic and hard copies of more than 11 worksheets that were used to guide the CHIP process with the partners.

**Table 2–Partners CHIP Meetings and Outcomes**

| Dates | Topics | Purpose | Outcomes |
|---|---|---|---|
| Orientation Meeting 3/27/2012 | Partner Orientation | To introduce the CHIP process and secure support. | 24 individuals from multiple sectors and organizations agreed to be part of the CHIP process |
| Meeting 1 4/12/2012 | Partner Skill-Building and Visioning | To offer background knowledge and establish expectations. | ➢ Small groups assigned<br>➢ Ideas about vision |
| Meeting 2 4/17/2012 | Vision and Values | To draft a vision statement and an initial list of values. | Vision statement adopted |
| Meeting 3 5/10/2012 | Final Values and Community Themes and Strengths | To complete values and assess the community themes and strengths. | ➢ Values statements adopted<br>➢ Community Themes Developed |
| Meeting 4 5/15/2012 | Windshield Survey Tour of St. Louis City | To tour the City and assess both threats and assets. | Greater understanding of the City, its people, the threats and the assets |
| Meeting 5 6/14/2012 | Community Assets; Forces of Change; and Priority Issues | To use prior data, information and discussions to identify priority issues. | Priority Issues were identified in the context of assets and forces of change. |
| Meeting 6 6/19/2012 | Establish Goals and Objectives | To use the Precede-Proceed elements to establish goals and objectives that are linked to the issues. | Goals and objectives were established for each issue. |
| Meeting 7 7/12/2012 | Strategies linked to the Goals and Objectives | To use the background information and link strategies to the approved goals and objectives. | Strategies were linked to each issue and its respective goals and objectives. |

The goals, objectives and agenda for each the meetings, along with primary outcomes documents are presented in **Appendix F.**

*II.C.2. Residents Meetings*

The information in **Table 3** shows the meetings for the residents, the content of the meetings and the outcomes of each meeting. One meeting was held monthly from March–July 2012 with the Residents Advisory Group. The primary tasks of the group were to review, approve, or disapprove the products and outcomes of the Partners CHIP work group. This group was highly committed and at each meeting seriously and diligently approached their assignments. At the request of the residents, guest speakers on health topics were added to the latter meetings. The health department staff is in possession of the electronic and hard copies of more than four worksheets that were used to guide the CHIP process with the residents.

**Table 3–Residents CHIP Meetings and Outcomes**

| Dates | Topics | Purpose | Outcomes |
|---|---|---|---|
| Orientation Meeting 3/27/2012 | Residents Orientation | To introduce the CHIP process, secure support and share the results of the focus groups. | 22 individuals from across the City agreed to be part of the CHIP process. |
| Meeting 1 4/18/2012 | Visioning | To offer background knowledge on Visioning and to get feedback on the Visioning outcomes. | The residents approved the Vision statement |
| Meeting 2 4/16/2012 | Values and Issue Themes | To offer background knowledge on Values and to get feedback on the Values outcomes. To get residents' input on the priority issues. | The residents adapted and approved the Values outcomes. The residents presented a list of priority issues based on the data and focus groups outcomes. |
| Meeting 3 6/20/2012 | Health Issues, Goals and Objectives | To offer background knowledge on Health Issues, Goal sand Objectives and to get feedback on Partners' issues and goals. | The residents rejected the list of priority issues |
| Meeting 4 7/16/2012 | Final Health Issues, Goals, Objectives and Strategies | To present the final set of Issues, Goals, Objectives and Strategies for approval. | The residents commended the Partners and approved the final set of Goals, Objectives and Strategies. |

The goals, objectives and agenda for each the meetings are presented in **Appendix G.**

# III. KEY OUTCOMES

## III. A. THE VISIONING STATEMENT FOR STAKEHOLDERS

The partners and residents developed and approved a final vision statement, mission and values for citywide implementation actions. They hope for an organized set of efforts that involve advocates and champions from multiple sectors who work to assure that St. Louis becomes healthier, with improved health, social and economic indicators.

**A final vision statement was approved on April 18, 2012:**
*St. Louis, the city where healthy living matters.*

**On April 18, 2012, both groups approved the name for a citywide campaign to educate and engage all stakeholders in the pursuit of the vision;**
*"St. Lou, Healthy U"*

**On May 10, 2012, a final mission statement for the activities was approved:**
*To assure that all residents have physical, mental, social and financial well-being.*

**On May 10, 2012 the final set of value statements to guide implementation of strategies and activities was approved:**
*Stakeholders include City leaders; the health department and its partners; service providers and City residents. As stakeholders, we believe and are committed to:*

- **Leadership**
  Stakeholders demonstrate commitment through identification, initiation and guidance of activities that effectively respond to health issues and disparities.

- **Communication**
  Stakeholders value and demonstrate open and diverse communication paths.

- **Inclusion and Diversity**
  Stakeholders value the involvement of diverse groups of residents, providers and other advocates to achieve the vision and mission.

- **Collaborative Activities**
  Stakeholders recognize that collaboration is essential to bring positive changes and encourage united efforts, but we also support organizational freedom, individuality and respect.

- **Accountability and Integrity**
  Stakeholders believe that all organizations and consumers are mutually committed to each other with demonstrated integrity and honesty.

- **Excellence and Quality**
  Stakeholders are committed to the proactive delivery of quality services and support to residents. The delivery will focus on respect, customer service and continuous improvement.

- **Recognition and Respect**
  Stakeholders understand that the success of activities to improve the health of St. Louis' residents and communities requires the commitment of many individuals and organizations. We respect and recognize both service providers and consumers.

- **Safe and Secure**
  Stakeholders will support responsible and nondiscriminatory actions that lead to a safe and secure environment.

- **Efficient and Effective Education System**
  Stakeholders support a quality school system that responds to the present and anticipates the future needs of residents.

- **Economic and Job Creation**
  Stakeholders value the economic viability of St. Louis and are committed to the creation of job opportunities.

- **Accessible and Affordable Health Services**
  Stakeholders recognize the challenges many residents face and will continuously seek new strategies to make health services equally accessible and affordable for all.

## III.B RESPONSE AND STRATEGY FOR MORTALITY IN THE CITY

### *III.B.1. Issue Overview*

The work group and residents identified four types of mortality (M4) to address– (Cardiovascular Disease, Cancer, Diabetes and Murder). It is most interesting and innovative that the work group, with concurrence of residents, classified *murder* as a chronic disease. In a similar manner, Sims et al., 1989 presented evidence that urban trauma, which is often defined as an acute episodic event, may actually be a chronic disease related to lifestyle, environment and other factors of the victim.[4] Chronic disease is defined as illness that is prolonged in duration, does not often resolve spontaneously and is rarely cured, completely.[5]

Over the years, the risk factors for the traditional chronic diseases are well defined by evidence. A diminutive set of common risk factors is responsible for most of the main chronic diseases. The modifiable risk factors, which are the same for men and women and across racial and ethnic groups, include unhealthy diet; physical inactivity; and tobacco use (CDC, 2011). These causes are manifested through the intermediate risk factors of raised blood pressure, raised glucose levels, abnormal blood lipids, overweight and obesity. The major modifiable risk factors, in conjunction with the non-modifiable risk factors of age and heredity, explain the majority of new events of heart disease, stroke, chronic respiratory diseases and some important cancers (WHO, 2011). Chronic diseases and poverty are interconnected in a vicious circle. The poor are more vulnerable for several reasons, including greater exposure to risks and decreased access to health services. Psychosocial stress also plays a role, especially across the lifespan.

Murder is defined as the willful killing of one human being by another and excludes deaths caused by negligence, suicide, or accident as well as justifiable homicides.[6] The risk factors for murder are gang activity, gun accessibility, drug trade, substance use and abuse and unemployment (Drucker, 2011).[7]

During the planning process, the CHIP work group developed four objectives and related strategies to respond to this issue area.

*III.B.2. Objectives and Strategies*

**Table 4–Mortality Objectives 1-2 and Related Strategies**

| **Issue** | M4–Mortality from Diabetes, Cardiovascular Disease, Cancer and Murder | | | | |
|---|---|---|---|---|---|
| **Program Goal** | Provide a supportive environment and structured activities for St. Louis residents to decrease the morbidity and mortality burden of leading chronic health diseases, including murder. | | | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** | **Strategy 2** | **Strategy 2 Barriers & Facilitators** |
| **Objective 1** | Reduce the incidence of Type II Diabetes to meet the Healthy People 2020 goals. (Identify targets) | Include nutrition component in Nurses for Newborns and Parents as Teachers home visits. | **Barriers and Threats**<br>Perceived Costs<br>Mistrust-Relationships<br>**Facilitators and Assets**<br>Community Gardens<br>Healthy Corner Stores<br>Parents as Teachers /Nurses for Newborns<br>Presence | Adopt a park to promote healthy active family opportunities. Check out bikes to ride. | **Barriers and Threats**<br>Getting Bikes<br>Secure return of bikes<br>Fear of violence<br>**Facilitators and Assets**<br>Trail Net<br>Bikes Donation Group |
| **Objective 2** | Reduce the rate of hypertension to meet the Healthy People 2020 goals. (Identify targets) | Create a "Know Your Numbers Campaign" for blood pressure (BP). | **Barriers and Threats**<br>Capturing numbers from BP machines<br>**Facilitators and Assets**<br>Pharmacies<br>State Health Department<br>Getting a discount on heart healthy items when you report your numbers | Put Blood Pressure Cuffs in Beauty and Barber Shops. Conduct drawings. | **Barriers and Threats**<br>Cost of equipment<br>**Facilitators and Assets**<br>Donors of incentive items |

**Table 5–Mortality Objectives 3-4 and Related Strategies**

| **Issue** | **M4–Mortality from Diabetes, Cardiovascular Disease, Cancer and Murder** | | |
|---|---|---|---|
| **Program Goal** | Provide a supportive environment and structured activities for St. Louis residents to decrease the morbidity and mortality burden of leading chronic health diseases, including murder. | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** |
| **Objective 3** | Increase screenings for colorectal, breast and prostate cancer to meet Healthy People 2020 goals. | Make screening vans available for walk-ins and appointments | **Barriers and Threats**<br>Costs of vans and personnel. |
| | | | **Facilitators and Assets**<br>Hospital Systems<br>American Cancer Society |
| **Objective 4** | Reduce murder rate in the City of St. Louis by 5% (1.6/100,000 per year) by 2020. | Initiate a broad mental health approach and change the level of acceptance for homicide. Use the grieving period of families of victims as reachable and teachable moments. | **Barriers and Threats**<br>Pervasive attitudes at multiple ecological levels |
| | | | **Facilitators and Assets**<br>Schools<br>Churches<br>Community Based Organizations<br>Public Safety<br>Police |

## III.C. RESPONSE AND STRATEGY FOR THE EDUCATION SYSTEM AND PIPELINE TO SUCCESS

### *III.C.1. Issue Overview*

The positive association between education and health is well established. Persons who are well-educated report higher levels of health and physical functions, while individuals with lower educational attainment experience higher rates of infectious diseases, self-reported poor health and shorter life expectancy (Cutler and Lieras-Muney, 2007 & Ross and Wu, 1995).[8] [9]

Early American education was primarily private or religious and brought mass schooling and literacy to the nation well before the public school system was legislated. Most learning occurred at home with parents and private tutors teaching children (Myer et al., 1979).[10] The Puritans were the first in this country to point out the need for some kind of public education (McClellan, 1992).[11] Public schools are operated at the state level through departments of education and locally by school districts and publicly elected or appointed school boards. Public education of all children is compulsory and many school districts, while meeting educational objectives, must also confront problems such as high dropout rates, overcrowding, violence, inadequate resources and teacher performance. Approximately 15,000 different school districts operate in the United States and most are run by county governments. Students generally go to the public school in the district in which they live; however, with the growth of charter and magnet schools, students are now being offered more options. According to the U.S. Department of Education, *almost 50 million students headed off to approximately 99,000 public elementary and secondary schools for the fall 2012 term and before the school year is out, an estimated $571 billion will be spent related to their education.*[12]

In the State of Missouri, for the past decade, the Annual Performance Report for school districts has been part of the Missouri School Improvement Program (MSIP), which began 20 years ago and is the foundation of the state's accreditation process for schools. It provides a practical tool for boards of education, school administrators and staff to identify strengths and needs in their school districts and to focus their efforts on improving instruction. To be fully accredited, a K-12 school district must meet at least nine of the 14 accreditation standards for academic performance. To be provisionally accredited, schools must meet at least six of which at least one must be a standard measured by the Missouri Assessment Program. A district that meets five or fewer standards may be classified as unaccredited by the State Board of Education when the district comes up for review. A K-8 school district must meet at least five of seven standards to be fully accredited.

The Missouri State Board of Education in March 2007 took over the City schools, which had lost accreditation (New York Times)[13]. In 2006, there was a 55 percent graduation rate; 19 percent of students dropped out; and cumulative debt had reached $25 million (Missouri State Board of Education).[14] A transitional school board was appointed to run the District for at least six years and since 2003, the District has had seven superintendents.

During the citywide focus groups in February 2012, residents stated that the operations and status of the education system in the City of St. Louis undermine the City in multiple ways–people with children are moving out and others will not come to the area; the high drop out rates decrease available funding from the state; and children and youth in the City cannot be successful:

> *...We can't attract anyone with, with kids because of the school system. And even the parochial system is getting tighter because more people are moving out for that reason and we're just losing people.*
> **City of St. Louis Resident, February 20, 2012 Focus Group**

> *And unfortunately that drop out rate is what's keeping St. Louis, one of the things that's keeping St. Louis Public Schools from becoming accredited, which means we get more tax money, which means we can hire more teachers, which means we can work with more students at risk.*
> **City of St. Louis Resident, February 16, 2012 Focus Group**

> *Education is the key to me. But the solution to that is not only education. [It is]…for us to, to be all we can be, we stay in school and be all we can be.*
> **City of St. Louis Resident, February 20, 2012 Focus Group**

The St. Louis City School district went from meeting three out of the required 14 performance standards in 2009 to six in 2011 and seven in 2012. One of the performance standards the district met was tied to test scores. To achieve provisional accreditation, the district needs to meet at least six performance standards over a three-year period. (CBS St. Louis, August 2012).[15]

During the planning process, the CHIP work group developed four objectives and related strategies to respond to this issue area.

### *III.C.2. Objectives and Strategies*

**Table 6–Education Objectives 1-2 and Related Strategies**

| **Issue** | **Education System/Pipeline** | | |
|---|---|---|---|
| **Program Goal** | Through the creation and activation of a coalition of parents/guardians and other advocates that demand excellence–every child in St. Louis has access to high quality education and a pipeline to success. | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** |
| **Objective 1** | By January 2014, create and convene a structured citywide coalition representing parents/guardians and other advocates of public, private, parochial and charter schools. | Identify existing groups of parents/guardians and advocates for all educational options to invite to the coalition. | **Barriers and Threats**<br>Time and resources to identify groups<br><br>**Facilitators and Assets**<br>There are existing groups that are committed to this issue |
| **Objective 2** | By July 2014, the coalition will create a document that describes its vision of high quality education and identifies measures for tracking progress towards achievement of the vision. | Identify a facilitator and convene members in regular planning meetings. | **Barriers and Threats**<br>Members are focused on their own specific agendas; educational systems are diverse; challenge of broad issue and problems<br><br>**Facilitators and Assets**<br>-Strong need for quality education in city, should have high commitment; perspective of greater community good<br>-What do we want available as options for <u>all</u> city residents? |

**Table 7–Education Objectives 3-4 and Related Strategies**

| Issue | Education System/Pipeline | | |
|---|---|---|---|
| **Program Goal** | Through the creation and activation of a coalition of parents/guardians and other advocates that demand excellence–every child in St. Louis has access to high quality education and a pipeline to success. | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** |
| **Objective 3** | By January 2015, the coalition and administrators of educational systems will document short and long-term strategies that work toward the achievement of the vision. | Conduct a similar process to visioning, but coalition representatives meet with each educational system. | **Barriers and Threats**<br>Resources available to each educational institution (affects feasibility); challenge of ensuring everyone working at same end goal; current policies in place; impact of recommendations can be profound and has greater effects than curriculum/education |
| | | | **Facilitators and Assets**<br>Large number of organizations that focus on youth and education; high number of donors that are committed to youth and education issues |
| **Objective 4** | By July 2015, transparency of the coalition will be promoted through creation of a website that ensures the vision and implementation plans are publicly available and progress on goals is annually updated. | Development of an Internet site and identify data sources for progress tracking and updates. | **Barriers and Threats**<br>None reported. |
| | | | **Facilitators and Assets**<br>None reported. |

## III.D. RESPONSE AND STRATEGY FOR VIOLENCE IN THE CITY

### *III.D.1. Issue Overview*

Defined as *intense, turbulent, or furious and often destructive action or force*, violence saturates the lives of most people around the world and it is one of the greatest health threats in the United States.[16] Multilevel acts of violence (personal, family, community, national, global) place the safety and overall well-being of the general public at risk. In the U.S., violence is a leading cause of injury, disability and premature death, disproportionately impacting youth of color. Further, it is a public health issue because of the effects it has on other health outcomes. Unity[4] (2009) offers the following facts about violence at the national level[17]:

***Violence is a leading cause of injury, disability and premature death***

- I5.5% of high school students feel too unsafe to go to school, 18% report carrying a weapon, 35.5% were in a physical fight per year, 12% report having been forced to have sex and 14.5% report having seriously considered attempting suicide.
- Homicide is the second leading cause of death among youth between the ages of 10 and 246 and for each such homicide there are approximately 1,000 nonfatal violent assaults.

***Violence is a significant disparity, disproportionately affecting young people and people of color***

- There are disproportionately high rates of community/street violence in low-income communities and communities of color and disparity contributes heavily to overall health inequities.
- Violence is among the most serious health threats in the nation today, jeopardizing the public's health and safety.
- Among African Americans between the ages of 10 and 24, homicide is the leading cause of death. In the same age range, homicide is the second leading cause of death for Hispanics and the third leading cause of death for American Indians, Alaska Natives and Asian/Pacific Islanders.

***Violence increases the risk of other poor health outcomes***

- Violence is a factor in the development of chronic diseases, which account for a majority of pre-mature US deaths, lost productivity and the majority and fastest growing percentage of our healthcare spending.
- Violence and safety concerns in some neighborhoods affect other determinants of health, such as whether or not parents will allow their children to be physically active outside or walk to school.

[4] Unity is Urban Networks to Increase Thriving Youth Through Violence Prevention.

Domestic violence and emotional abuse are behaviors used by one person in a relationship to control the other. Partners may be married or not married; heterosexual, gay, or lesbian; living together, separated or dating.[18] Domestic violence is increasingly one the most pressing public health issues facing families, women and girls. Nearly one in every four women will experience some form of domestic violence in her lifetime (Frieze, 2005)[19]. The cycle of violence is passed from generation to generation as children witness and experience acts of violence in their homes. Major warning signs are:

- *Exhibiting fear of the partner and/or anxious to please the partner*
- *Going along with everything the partner says or does*
- *Must check in often with the partner to report what they are doing and where they are*
- *Receiving frequent and harassing phone calls from the partner*
- *Patterns of untreated injuries to the face, neck, throat and breasts*
- *Reluctance to seek medical attention*
- *Stress related illnesses such as headache and chronic pain, sleep disorders and eating disorders*
- *Heart palpitations and panic attacks*
- *Sad, depressed affect and talk of suicide*
- *Isolation and withdrawal from families and friends*

From Faith Advocates for Healthy Relationships Curriculum © REESSI (2011)

Violence can be criminal and includes physical assault (hitting, pushing, shoving, etc.), sexual abuse (unwanted or forced sexual activity) and stalking. Although emotional, psychological and financial types of abuse are not criminal behaviors, they are forms of abuse and can lead to criminal violence.

During the planning process, the CHIP work group developed four objectives and related strategies to respond to this issue area.

*III. D. 2. Objectives and Strategies*

**Table 8–Violence Objectives 1-2 and Related Strategies**

| **Issue** | **Violence** | | | | |
|---|---|---|---|---|---|
| **Program Goal** | To prevent and deter violence through creating a community environment of "homeness", a sense of belonging and constructive outlets that allow residents to release passion; dream dreams; and live out promises. | | | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** | **Strategy 2** | **Strategy 2 Barriers & Facilitators** |
| **Objective 1** | 1-Seek and attain increased funding (20%) for innovative after school interventions for youth by 2014. (Need to identify current level-baseline of funding for youth programs in the City). | Determine existing after school interventions and programs by ZIP code and their respective funding levels. Place this information in a compendium. | **Barriers and Threats**<br>None reported.<br>**Facilitators and Assets**<br>None reported. | Establish a development plan to support existing programs and fill the funding gaps where programs are deficient. | **Barriers and Threats**<br>Lack of coordinated reporting<br>Unwillingness to share<br>**Facilitators and Assets**<br>St. Louis for Kids has a listing of programs |
| **Objective 2** | Establish functional youth opportunities centers in each ZIP code by 2014 that support 15-21 year olds and their families. | Develop a compendium of current safe and conducive locations and determine where the deficiencies are. | **Barriers and Threats**<br>Funds<br>Space<br>Safety Concerns<br>**Facilitators and Assets**<br>Existing locations<br>Police<br>Firefighters<br>Clergy<br>Community Leaders | Strategically identify and recruit 15-21 year olds and their families to participate in structured program opportunities. | **Barriers and Threats**<br>Transportation<br>Communications<br>Generation Gap<br>**Facilitators and Assets**<br>-Having exciting and appealing activities<br>-Peer-to-Peer Outreach<br>-Hunger for the need to belong |

**Table 9–Violence Objectives 3-4 and Related Strategies**

| Issue | Violence | | | | |
|---|---|---|---|---|---|
| **Program Goal** | To prevent and deter violence through creating a community environment of "homeness", a sense of belonging and constructive outlets that allow residents to release passion; dream dreams; and live out promises. | | | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** | **Strategy 2** | **Strategy 2 Barriers & Facilitators** |
| **Objective 3** | Establish summer jobs for youth ages 15-21 in each ZIP code of the city. | Develop jointly with participants a curriculum and opportunities in areas of career and life readiness using a theme of peaceful change (Gandhi and Martin Luther King). | **Barriers and Threats**<br>Time intensive<br>Funding qualified and committed organizations, who get it right.<br>**Facilitators and Assets**<br>Proven models exist<br>Police<br>Firefighters<br>Clergy<br>Community Leaders | Fund and hire committed and passionate employees for the centers. Recruit volunteers. | **Barriers and Threats**<br>Finding qualified people and organizations that are willing to keep the fees affordable<br>**Facilitators and Assets**<br>St. Louis has educated and qualified people who are willing |
| **Objective 4** | Decrease reports of domestic and relationship violence by 5% by 2015. (Look at crime statistics for St. Louis) | 1. a. Conduct a media advocacy campaign on healthy relationships.<br><br>1.b. Develop more referral resources. | **Barriers and Threats**<br>Hard to reach populations<br>Difficult behaviors to change<br>Costs<br>**Facilitators and Assets**<br>Recognized Need<br>Existing Efforts | Educate law enforcement about the importance of accurate reporting. | **Barriers and Threats**<br>-Quasi-military values<br>-Belief that their primary purpose is for murders, burglaries and robberies<br>**Facilitators and Assets**<br>New officers who are committed to total safety. |

## III.E. RESPONSE AND STRATEGY FOR SELF-DESTRUCTIVE BEHAVIORS IN THE CITY

### *III.E.1. Issue Overview*

Wellness means overall well-being and incorporates the mental, emotional, physical, financial, occupational, intellectual, environmental and spiritual aspects of a person's life (SAMHSA, 2012).[20] Most self-destructive behaviors are linked to behavioral health issues (substance abuse, poor emotional health and mental disorders) and risky sexual behaviors (Waitzkin and Britt, 1993).[21] These personal behaviors, when left unaddressed, place an enormous burden on families and communities–contributing to premature losses of lives and great expenditures of personal and public dollars.

**Drugs**

Drugs have been a major part of the U.S. culture since the middle of the 1900's. In the United States, results from the 2007 National Survey on Drug Use and Health showed that 19.9 million Americans (or 8% of the population aged 12 or older) used illegal drugs in the month prior to the survey.[22] The most commonly used and abused drug in the U.S. is alcohol. Alcohol-related motor accidents are the second leading cause of teen death in the United States. The most commonly used illegal drug is marijuana. Young people today are exposed earlier than ever to drugs. Based on a survey by the CDC in 2011, 71% of high school students nationwide had had at least one drink of alcohol on at least 1 day during their life (i.e., ever drank alcohol) and nationwide, 40% of students had used marijuana one or more times during their life (i.e., ever used marijuana).[23]

**Sex, HIV/AIDS and Sexually Transmitted Diseases**

The HIV/AIDS epidemic is not evenly distributed across states and regions in the United States.[24] Generally, HIV and AIDS are concentrated in urban areas, leading states with higher concentrations of urban areas to report higher rates of persons living with a diagnosis of HIV infection or AIDS. At the end of 2009, the rate of persons living with an AIDS diagnosis was highest in the Northeast, followed by the South, the West and the Midwest. In 2010, blacks accounted for the largest proportion of AIDS diagnoses in all regions except the West, where whites accounted for the highest proportion of diagnoses. STDs are one of the most critical health challenges facing the nation today. CDC estimates that there are 19 million new infections every year in the United States that cost the U.S. health care system $17 billion every year—and the costs to individuals are even

greater when lifelong outcomes are considered. Young people (aged 13–29) represent 25 percent of the sexually experienced population in the United States, but account for nearly 50 percent of new STDs, which affect people of all races, ages and sexual orientations.[25] When individual risk behaviors are combined with environmental barriers, health literacy, information access and inadequate STD prevention services, the risk of infection increases. For example, African Americans and Latinos sometimes face barriers that contribute to increased rates of STDs and are more affected by these diseases than whites.[26]

**Infant Mortality**

According to the CDC, infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors such as maternal health, quality and access to medical care, socioeconomic conditions and public health practices. During the 20th century, the infant mortality rate in the United States slowly declined, but the rates from 2000–2005 have caused concern among researchers and policy makers. The United States' international ranking fell from 12th in 1960 to 23rd in 1990and to 29th in 2004 (National Center for Health and Health Statistics, 2007).[27] The most recent statistics from 2007 show that the U.S. rate of almost seven deaths per 1,000 live births ranked the U.S. behind most of the other developed countries. Although the overall rates have been slowly declining since 2000, an enormous gap between whites and blacks persists. American women who are most likely to lose their babies are non-Hispanic black women, with a rate that is almost 2.4 times than that for non-Hispanic white women (McDorman and Matthews, 2008).[28] Many of the racial and ethnic differences in infant mortality are without explanation (CDC, 2008).[29]

During the planning process, the CHIP work group developed three objectives and related strategies to respond to this issue area.

*III.E. 2. Objectives and Strategies*

**Table 10–Self-Destructive Objectives 1-2 and Related Strategies**

| **Issue** | **Self-Destructive Behaviors** | | | | |
|---|---|---|---|---|---|
| **Program Goal** | Decrease self-destructive behaviors by encouraging positive life choices. | | | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** | **Strategy 2** | **Strategy 2 Barriers & Facilitators** |
| **Objective 1** | Decrease substance abuse/addiction by 50% (5% per year for 10 years). Measure by decrease of court ordered rehab, addicted births and overdoses seen in ER. | Convene all substance abuse agencies for a summit on "best practices" and determine final community-wide intervention approaches. | **Barriers and Threats**<br>Time<br>Openness<br>Budgets<br>**Facilitators and Assets**<br>Health Department | Develop Dreamboard education programs and integrate substance abuse risk reduction activities in high schools. | **Barriers and Threats**<br>High School dropouts<br>**Facilitators and Assets**<br>Schools |
| **Objective 2** | Decrease rate of STD/HIV by 50% (5% per year for 10 years). Measure by health department STD rates. | The development of innovative risk reduction interventions–1) Faith-based curriculum, 2) Consumer-based media messages and creating strong girls with the power to make the best choices. | **Barriers and Threats**<br>Openness<br>Duplication and redundancy<br>**Facilitators and Assets**<br>YWCA<br>Girl Scouts<br>Churches<br>Women's Groups | **None** | Barriers and Threats<br>N/A<br>Facilitators and Assets<br>N/A |

**Table 11–Self-Destructive Objective 3 and Related Strategies**

| **Issue** | **Self-Destructive Behaviors** | | | | |
|---|---|---|---|---|---|
| **Program Goal** | Decrease self-destructive behaviors by encouraging positive life choices. | | | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** | **Strategy 2** | **Strategy 2 Barriers & Facilitators** |
| **Objective 3** | Increase the number of healthy babies born through exceptional pre-conception and pre-natal care. Measure by birth rate mortality, addiction of infants at birth and pre-term birth rates. | To identify phone/internet applications that use pre-conception and pre-natal planning and promote their use. | **Barriers and Threats**<br>Access to Smart Phones<br><br>**Facilitators and Assets**<br>Maternal and Child Health Coalition<br>Health Department | Expand BabyCare Rewards programs such as the Thrive Pregnancy Resources Center | **Barriers and Threats**<br>Funding and resources<br><br>**Facilitators and Assets**<br>Existing model |

## III.F. RESPONSE AND STRATEGY FOR POVERTY IN THE CITY

### *III.F.1. Issue Overview*

Social determinants are the "*causes of the causes"* and include the economic and social conditions that determine the health of individuals, groups and communities as a whole (Navarro, 2002 & Lantz et al., 1998).[30] [31] The inequitable distribution of income, resources and power locally, nationally and globally is directly linked to unfairness in the well-being and immediate outcomes of the lives of people. These social factors impact "*their access to health care, schools and education, their conditions of work and leisure, their homes, communities, towns, or cities–and their chances of leading a flourishing life"* (WHO, 2008).[32] A person's health is shaped by behaviors, which in turn are associated with his or her socioeconomic level (i.e., income, education, opportunities) and the corresponding environmental setting (i.e., poverty levels, availability of jobs, health care access).[33]

The Institute of Medicine (IOM) report, *For the Public's Health: The Role of Measurement in Action and Accountability,* confirmed and emphasizes how imperative it is to address underlying factors that contribute to poor health, not just disease outcome data.[34] The Institute of Medicine (IOM) recommended changes in the structure, measures and strategies employed to collect data about social and environmental determinants, including a standardized core set of health outcome indicators and indicators of community health. Also, the goals and objectives of *Healthy People 2020* have identified social determinants as one of its 42 topic areas for the first time.[35] The HealthyPeople.gov site offers the following examples of *social determinants*:

| | | |
|---|---|---|
| • Availability of resources to meet daily needs (e.g., safe housing and local food markets)<br>• Access to educational, economic and job opportunities<br>• Access to health care services<br>• Quality of education and job training<br>• Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities | • Transportation options<br>• Public safety<br>• Social support<br>• Social norms and attitudes (e.g., discrimination, racism and distrust of government)<br>• Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community) | • Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)<br>• Residential segregation<br>• Language/Literacy<br>• Access to mass media and emerging technologies (e.g., cell phones, the Internet and social media)<br>• Culture |

During the planning process, the CHIP work group developed five objectives and related strategies to respond to this issue area.

*III.F.2. Objectives and Strategies*

**Table 12–Poverty Objectives 1-2 and Related Strategies**

| **Issue** | **Poverty Project** | | |
|---|---|---|---|
| **Program Goal** | In St. Louis, foster a more equitable distribution of wealth through increasing avenues of economic/financial autonomy. | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** |
| **Objective 1** | Increase access to grants and funding for entrepreneurial activities. To be measured by the annual income of businesses in five years and the number of businesses in five years. (Look at the Bloomberg model in New York for African American gang members). | Establish a coalition of bank presidents, credit unions, micro-loan organizations and chamber of commerce groups to strategize on how to make funds available. | **Barriers and Threats**<br>Lack of interest in helping the disadvantaged<br>Breaking down competition Barriers and Threats<br><br>**Facilitators and Assets**<br>Community leaders<br>Local government agencies |
| **Objective 2** | Increase access to scholarships for post high school education and access to specialized grants for extracurricular learning activities. To be measured by the number of scholarships, the number of college graduates and the number who receive funds. | Create a coalition of local college presidents and chancellors with the purpose of designing a portal where parents, students, veterans and other can access scholarship offerings. | **Barriers and Threats**<br>These leaders are quite busy<br>No deadlines<br>Accountability<br><br>**Facilitators and Assets**<br>Community stakeholders<br>Youth interactions<br>IT Departments of universities |

**Table 13–Poverty Objectives 3-4 and Related Strategies**

| Issue | Poverty Project | | |
|---|---|---|---|
| Program Goal | In St. Louis, foster a more equitable distribution of wealth through increasing avenues of economic/financial autonomy. | | |
| Program Objectives | | Strategy 1 | Strategy 1 Barriers & Facilitators |
| Objective 3 | Subsidize tuition to transitional vocational job training with an emphasis on training veterans and minority groups. To be measured by the number of subsidies given to veterans and minorities and the number of persons completing the training. | Create a coalition of presidents of vocational schools to come together to agree to allocate money for subsidies. | **Barriers and Threats**<br>These leaders are quite busy<br>No deadlines<br>Accountability<br>**Facilitators and Assets**<br>Community Leaders<br>Community Stakeholders |
| Objective 4 | Create an apparatus to assist the uninsured and underinsured residents who have experienced unforeseen traumatic events. To be measured by the amount of funds acquired for the program, the number of beneficiaries and the number of beneficiaries who reenter the workforce. | Establish a non-profit organization to solicit and receive funds to support the initiative. | **Barriers and Threats**<br>Austerity and decreased government funding<br>**Facilitators and Assets**<br>Community stakeholders<br>Entrepreneurs<br>The model of Joplin Rebuilding |

**Table 14–Poverty Objective 5**

| **Issue** | Poverty Project | | | | |
|---|---|---|---|---|---|
| **Program Goal** | In St. Louis, foster a more equitable distribution of wealth through increasing avenues of economic/financial autonomy. | | | | |
| Program Objectives | | **Strategy 1** | **Strategy 1 Barriers & Facilitators** | **Strategy 2** | **Strategy 2 Barriers & Facilitators** |
| **Objective 5** | Decrease the number of unbanked households by encouraging banks and credit unions to come into underserved communities and establish income management skills that promote financial maturity in families. | [The Residents at their last meeting added this objective. Strategies must be developed in the next phase.] | Barriers and Threats<br>Facilitators and Assets | [The Residents at their last meeting added this objective. Strategies must be developed in the next phase.] | Barriers and Threats<br>Facilitators and Assets |

# IV. PROPOSED NEXT STEPS

Implementation is a key phase or cycle for all three planning models that REESSI used to develop the Community Health Improvement Plan. The information in **Table 15** shows the descriptions of the action and implementation phase from each framework.

**Table 15–The Planning Theories on Taking Action**

| Framework | Action-Implementation Descriptions |
|---|---|
| **MAPP** | The *Action Cycle* links three key activities — Planning, Implementation and Evaluation. Each of these activities builds upon the others in a continuous and interactive manner. The first step in this phase is organizing for action. A subcommittee should be designated to oversee the implementation and evaluation activities. This subcommittee prepares for the subsequent steps and plans for how they will be implemented. |
| **PRECEDE-PROCEED** | Phases 4-5 involve pre-implementation and implementation of strategies. Phase four includes assessment of resources, development and allocation of a budget, looking at organizational barriers and threats and coordination of the program with all other departments, including external organizations and the community. This phase is followed by evaluation activities. |
| **CHANGE** | After completing the Community Action Plan, track your progress, note key successes and document obstacles to completing the plan. This is the time to connect with partner organizations, reach out to stakeholders and rally support for your work. As the Community Action Plan progresses, share the data and your accomplishments with the individuals and organizations that contributed their time and expertise. |

During the next twelve months, the start-up of the implementation and action cycle of the St. Louis City Community Health Improvement Plan (CHIP) is imperative to minimize the loss of community momentum and political will. The plan is innovative and challenging in that it involves a crosscutting set of issues and strategies that are broader than the essential services of public health. The engagement of multiple City agencies and departments and a **coalition** of residents, committed service providers, academics and business leaders is important to the progress and success of the plan.

Based on feedback, discussions and outcomes of the planning meetings with both service providers and residents, REESSI proposes that the City of St. Louis through the Department of Health focus on four categories of initial activities over a 12–month period.

1) **Develop and finalize the implementation strategy (Months 1-3)**

   - Conduct a two-day weekend retreat with a *select* group of partners and residents to develop a strategic implementation plan linked to the CHIP strategies. Retreat participants will include service providers with experience in the strategy areas and the 22 members of the Residents Advisory Group.
   - Conduct a 4-hour follow-up meeting to finalize the detailed implementation plan.

2) **Provide technical assistance and development support to select partners in identifying resources and funds to carry out the selected strategies and activities. (Months 4-12).**

   - Conduct one four-hour informational session to receive information on existing services that are linked to the CHIP program goals.
   - Establish a social media and blog site that focuses on funding and development for all City partners and service providers.
   - Conduct a two-day funding and development training institute for the service providers.
   - Establish a compendium of funding and resources for the select partners and offer them technical support and reviews for funding applications.
   - Conduct implementation oversight meetings once a month.
   - Assure that each partner in the select group submits at least two funding applications related to the CHIP strategies over the eight-month period.

3) **Convene an integrated group of residents and partners to plan and implement the *St. Lou, Healthy U* campaign (Months 1-12)**

   - Investigate and collect information on similar campaigns across the country. Pilot select elements of a proposed campaign in 4 ZIP codes.
   - Conduct meetings with an integrated group of residents and partners to plan the elements of the citywide

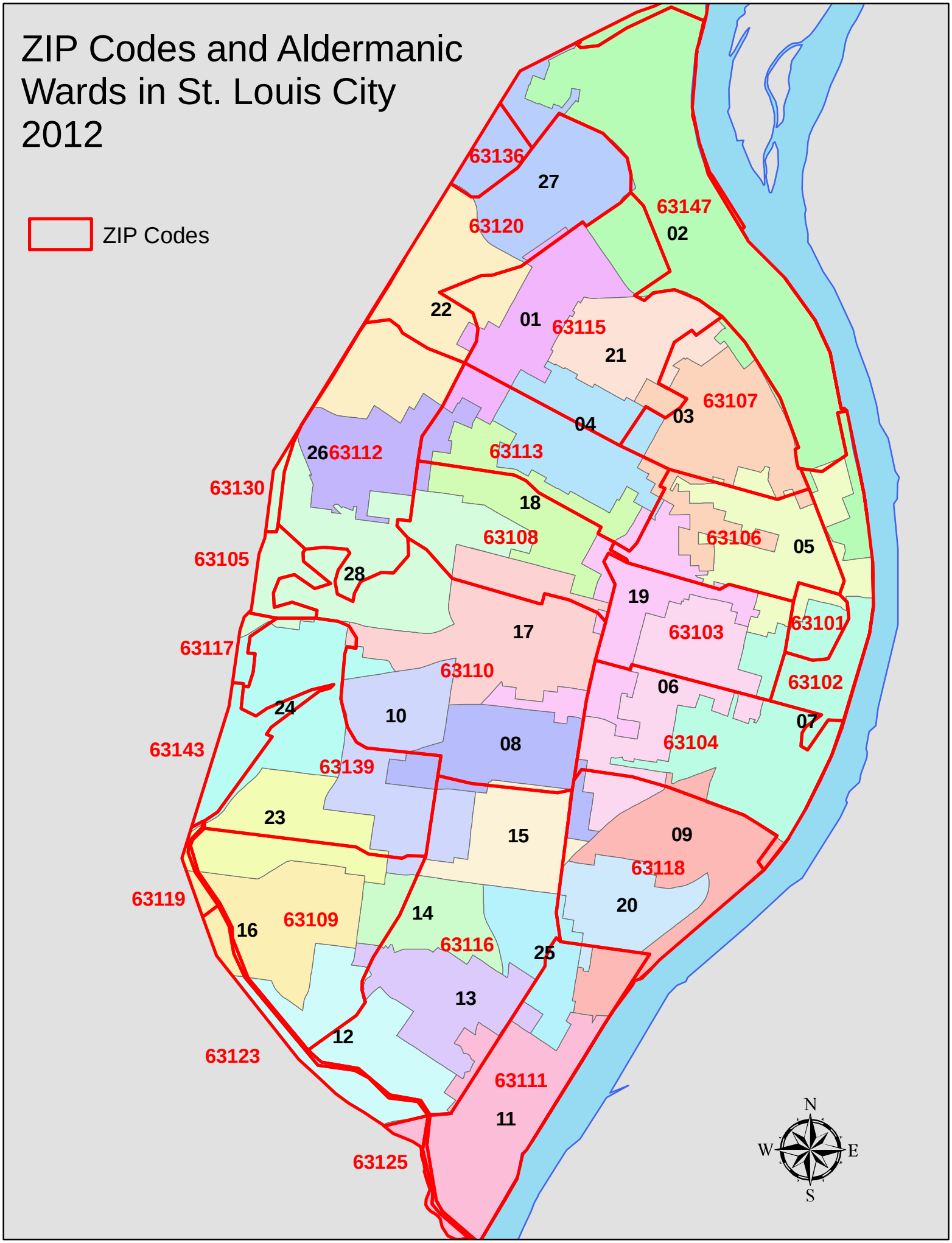
- Prepare a campaign plan with appropriate outreach and communication components and outcomes.
- Brand the campaign and prepare promotional materials.
- Establish the campaign social media and blog sites.
- Launch and manage the St. Lou Healthy U campaign.

**4) Conduct process and impact evaluations of activities during the project period. (Months 2-12)**

- Prepare an evaluation plan for the activities in items 1-3
- Conduct a process evaluation of all activities.
- Conduct an impact evaluation of items 2-3.

# APPENDIX A
# ZIP Codes and Ward Map

# ZIP Codes and Aldermanic Wards in St. Louis City 2012



# APPENDIX B
# Partners CHIP Work Group

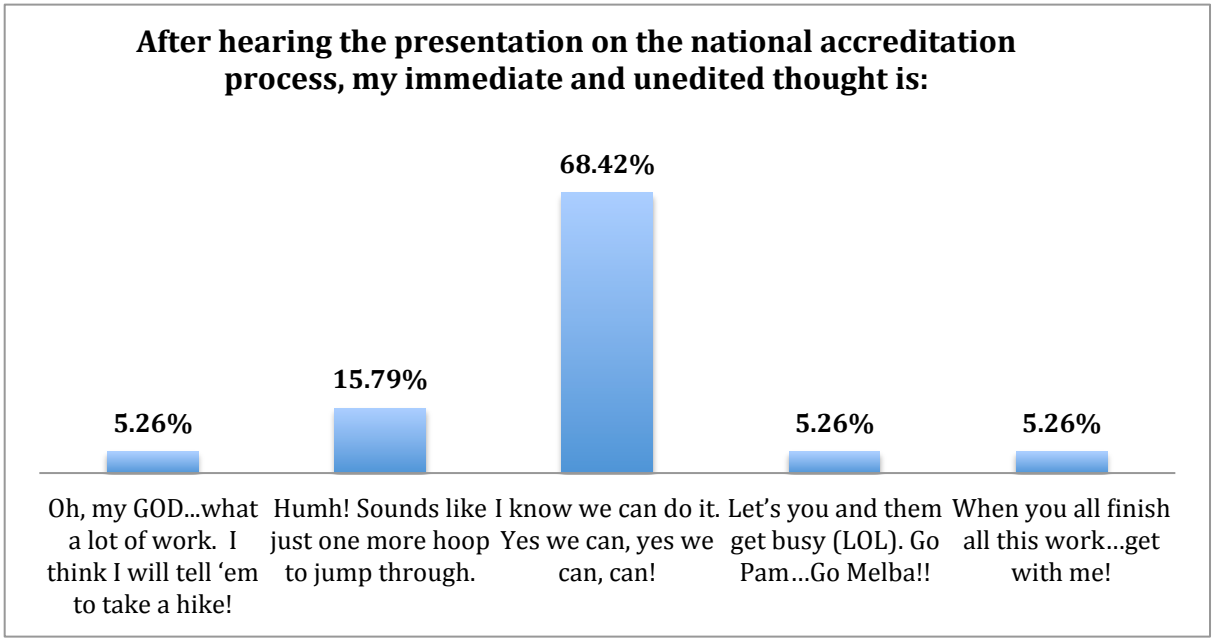
**St. Louis CHA/CHIP WORK GROUP**

| Name | Organization | Address | Phone | Email |
|---|---|---|---|---|
| Aziz, Kareema | Legal Services of Eastern Missouri | 4232 Forest Park Ave., St. Louis, MO 63103 | 314-534-4200, X1276 | kaaziz@lsem.org |
| Bolden, Koran | Street Dreamz | 5555 St. Louis Mills Blvd. # 285 | 314-266-9181 | mrkbolden@gmail.com |
| Bolden, LaPortcia | Street Dreamz | 5555 St. Louis Mills Blvd. # 285 | 314-556-9830 | mrssrightt@gmail.com |
| Bouman, Mary | Missouri Probation and Parole | 220 S. Jefferson, St. Louis, MO 63103 | 314-982-8208 | mary.bouman@doc.mo.gov |
| Bruhl, Penny, RN | Allways Care RCF | 5076 Waterman, St. Louis, MO 63101 | 314-367-9516 | pbruhl61@gmail.com |
| Butler, Cindy | Missouri Department of Health and Senior Services | 220 S. Jefferson, St. Louis, MO 63103 | 314-877-2857 | cindy.butler@health.mo.gov |
| Clark, Richelle | St. Louis Public Schools | 801 N. 11th Street, St. Louis, MO | 314-345-4401 | Richelle.clark@slps.org |
| Cohen, Betsy | Nestle Purina | One Checkboard Square, St. Louis, MO | 314-982-3809 | betsy-cohen@purina.nestle.com |
| Copanas, Kendra/ Michael, Jerri | Maternal, Child, and Family Health Coalition | 539 N. Grand, St. Louis, MO 63103 | 314-289-5680 | kcopanas@stl-mcfhc.org |
| Cross, Donald, Ph.D | Area Association of Psychological Services | # 7 Veverky Place, St. Louis, MO 63112 | 314-302-2077 | dnldcross@sbcglobal.net |
| Desai-Ramirez, Bijal | Herbert Hoovers Boys and Girls Club | 2901 N. Grand Ave., St. Louis, MO 63107 | 314-335-8011 | bijal@hhbgc.org |
| Gaertner, Paula | St. Louis Community Empowerment Foundation (Vashon/JeffVanderLou Initiative) | 3030 Locust Street, St. Louis, MO 63103 | 314-371-8585 | paulagaertner@sbcglobal.net |
| Herbers, Stephanie | Center for Community Health & Partnerships, Institute of Public Health, Washington University | 600 S. Euclid, Campus Box 8217, St. Louis, MO 63110 | 314-747-9234 | sherbers@wustl.edu |
| Hogan, Melissa, MPH | St. Louis Area Business Health Coalition | 8888 Ladue Rd., Suite 250, St. Louis, MO 63124 | 314-721-7800 | mhogan@stlbhc.org |
| McCain, Kenneth | St. Louis City Department of Corrections | | | kenneth.mccain@corizonhealth.com |
| Montgomery-Edwards, Gail & Keaton, Rosetta | St. Louis Connectcare | 5535 Delmar Blvd., St. Louis MO 63112 | 314-879-6308 | gxe5182@stlconnectcare.org |
| Opsal, Jamie | St. Louis County Department of Health | 111 S. Meramec | 314-615-1658 | jopsal@stlouisco.com |
| Porter, Deputy Chief Valerie | St. Louis Fire Department | 1421 N. Jefferson, St. Louis, MO | 314-533-3406 | porterV@stlouiscity.com |
| Schmid, Craig | Alderman, 20th Ward | City Hall 1200 Market St., Room 230, St. Louis, MO 63103 | 314-771-5576 | schmidc@stlouiscity.com |
| Staley, Holly, MSW | SSM Health Care | 477 Lindbergh Blvd., St. Louis, MO 63141 | 314-994-7694; 314-402-5925 (cell) | Holly_Staley@ssmhc.com |
| Sterling, Ryan, MPH | St. Louis Regional Health Commission | 1113 Mississippi, Suite 113, St. Louis, MO 63104 | 314-446-645 X 1102 | rsterling@stlrhc.org |
| Troupe, Charles Q. | Alderman, 1st Ward | City Hall 1200 Market St., Room 230, St. Louis, MO 63103 | 314-713-4632 | cqtroupe@hotmail.com |

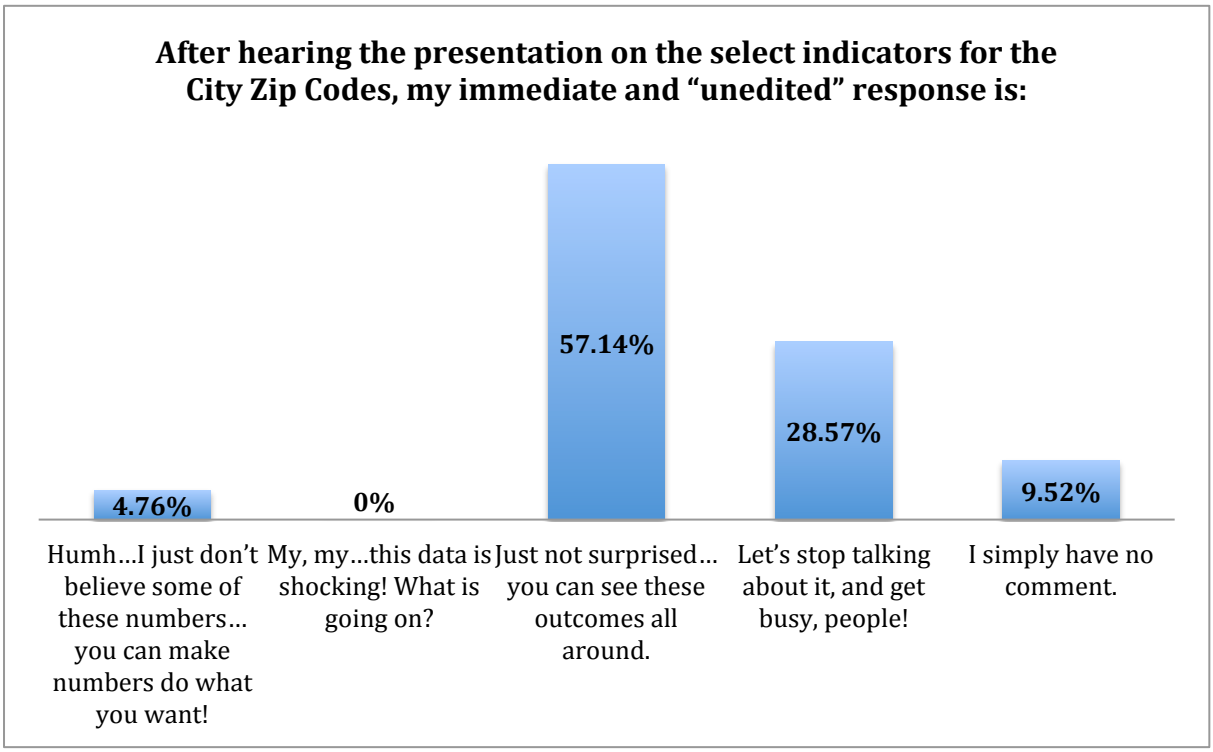
Updated 9/18/12

# APPENDIX C
# Partners Profile

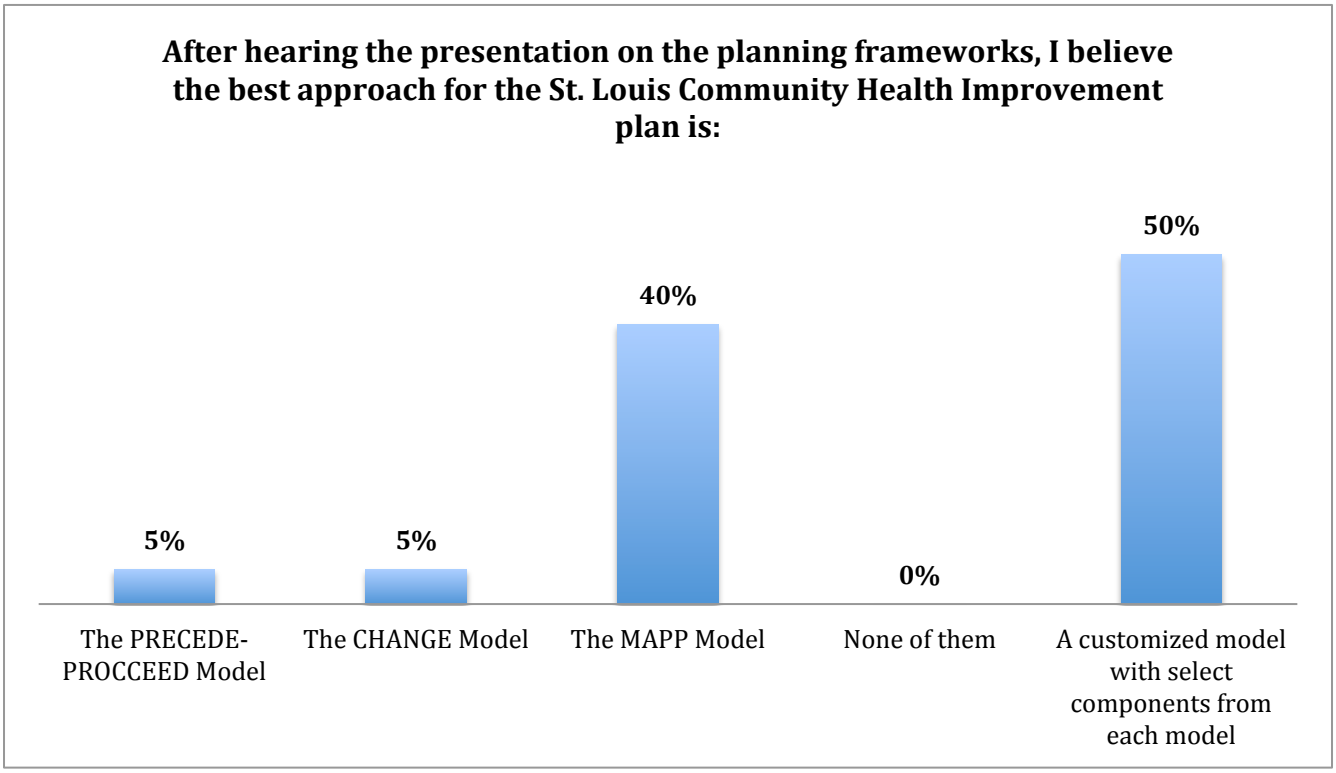
## Thoughts about the Community Health Improvement Plan process and health data




*Number Responding: 19*

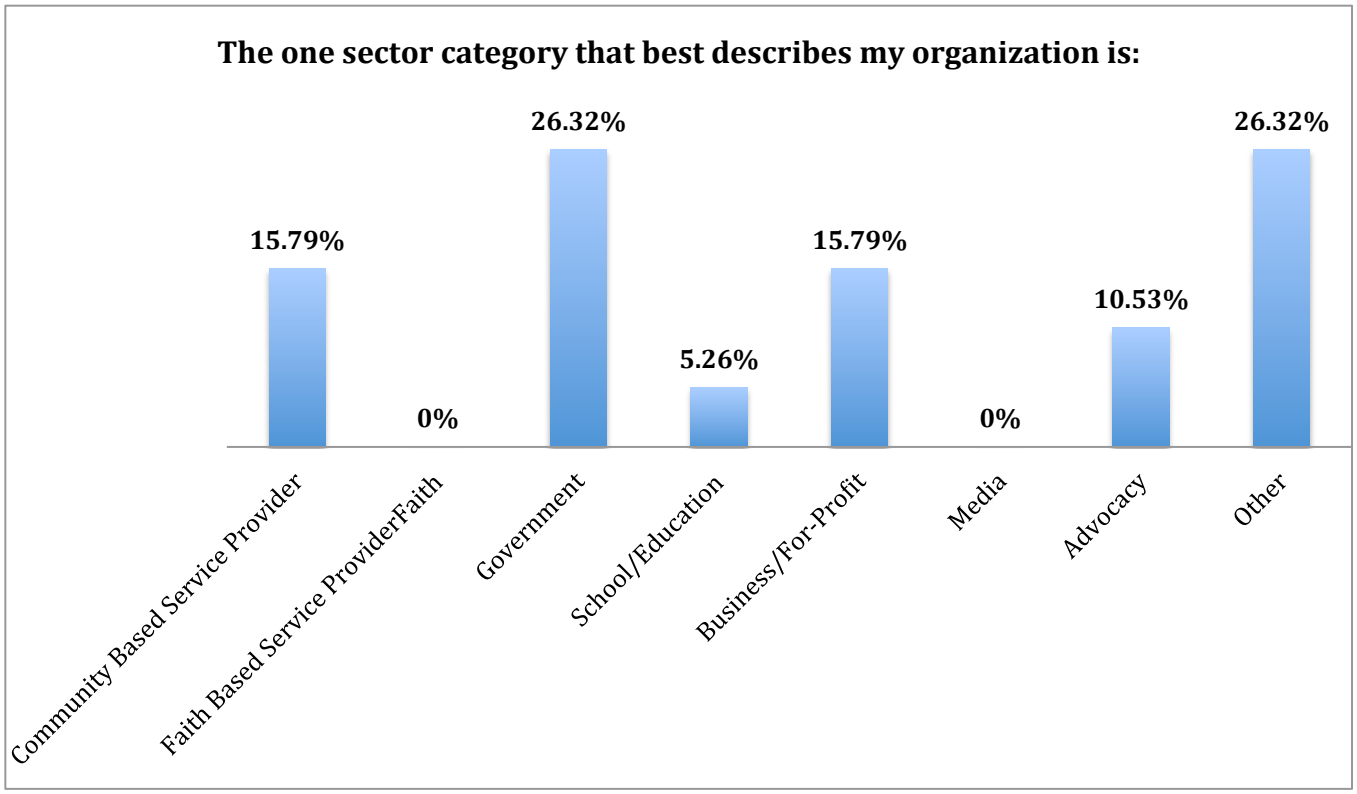



*Number Responding: 21*



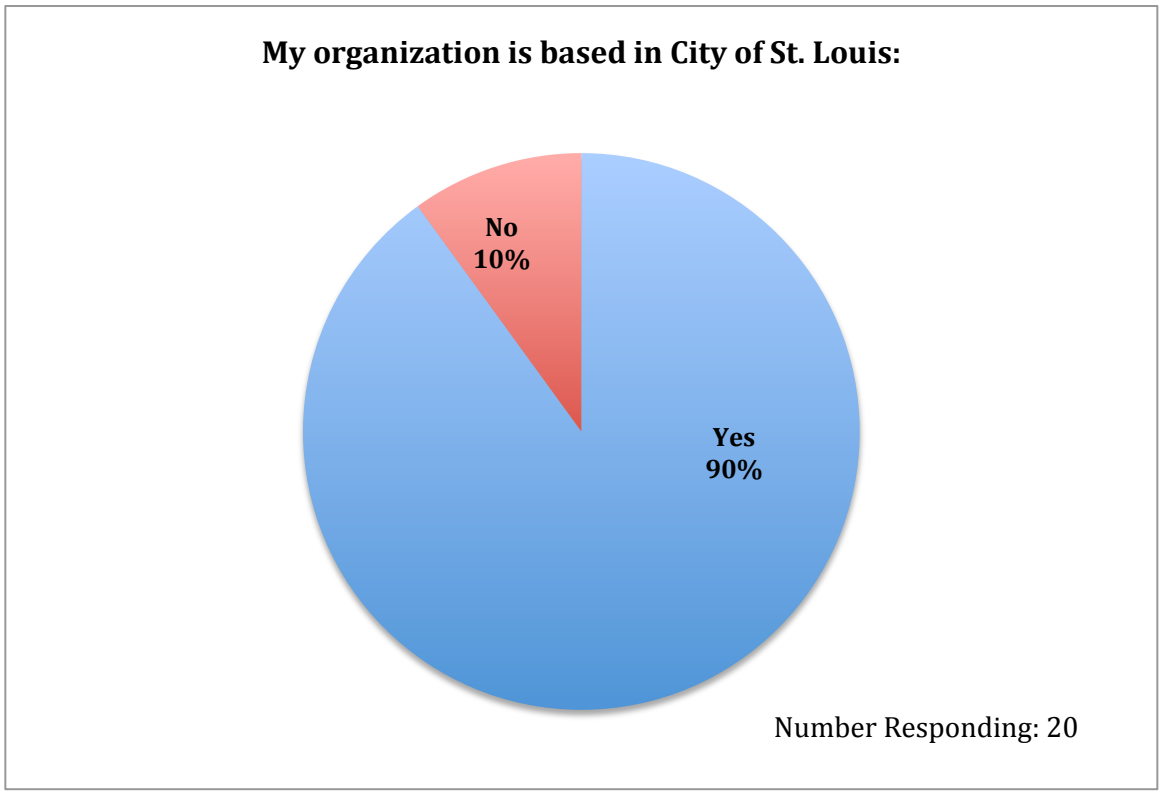

*Number Responding: 20*

## Participant Demographic Information

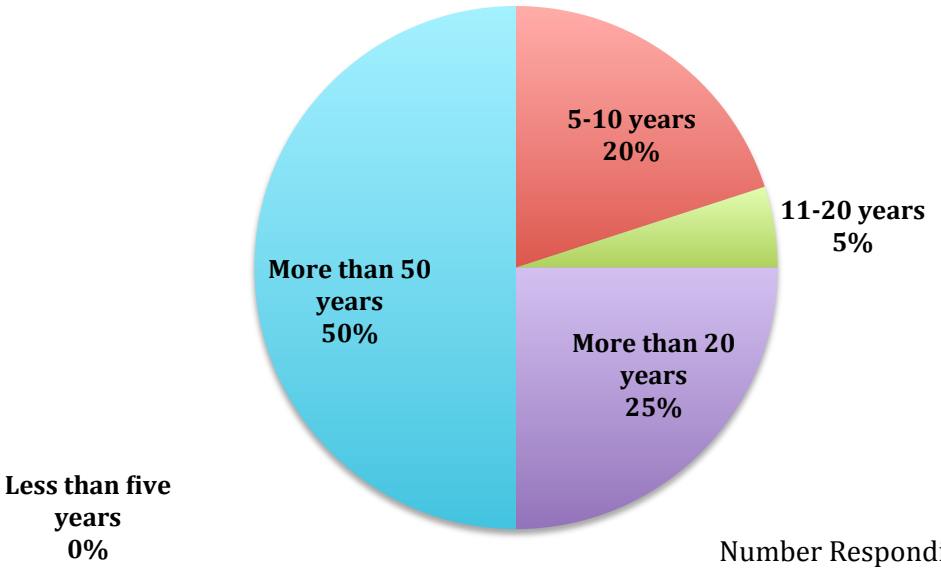



*Number Responding: 19*

*"Other" includes those who work for educational institutions, but are not involved in teaching and non-profit consulting type organizations.*

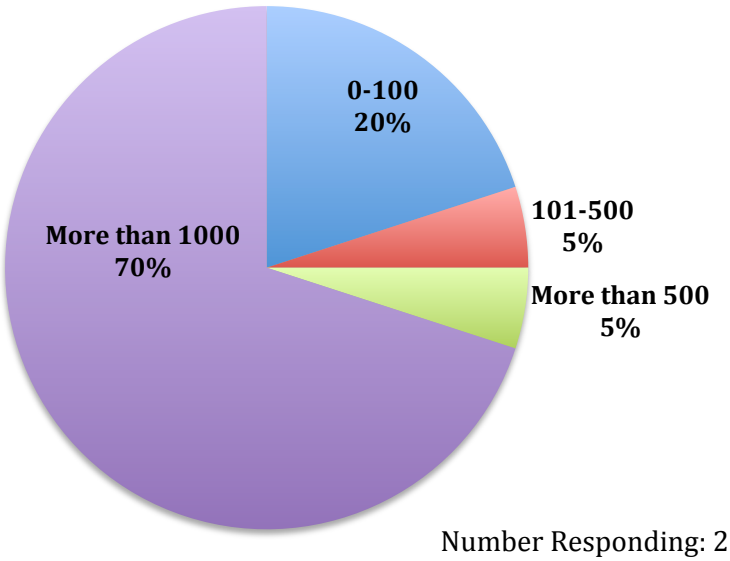


**My organization has been in existence and had a presence in the St. Louis region for:**




Number Responding: 20

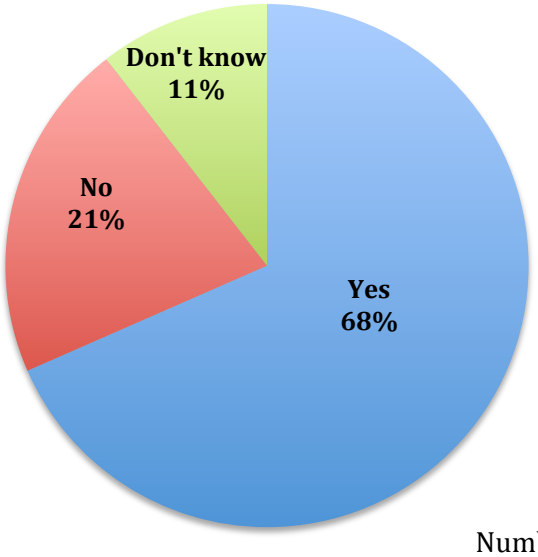
**The approximate number of city residents served by my organization is:**




Number Responding: 20

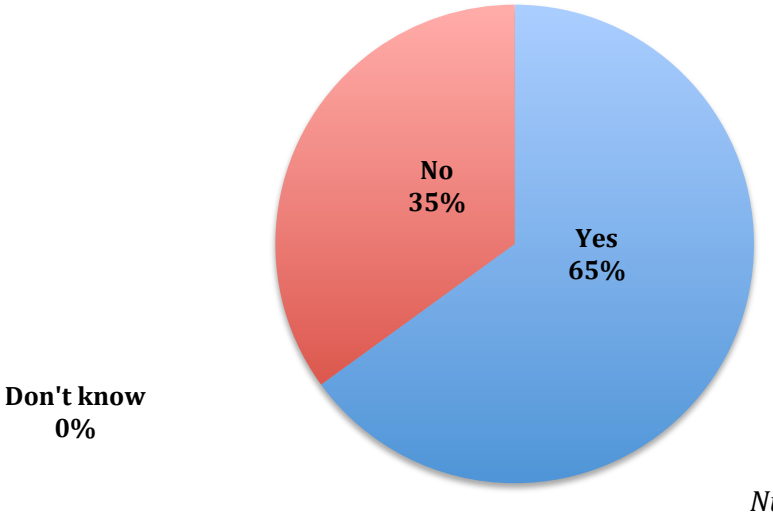
**Organizational experience with collaborations, community health improvement planning and outcome based strategy development**

**My organization has engaged in prior collaborations with the City of St. Louis Department of Health.**



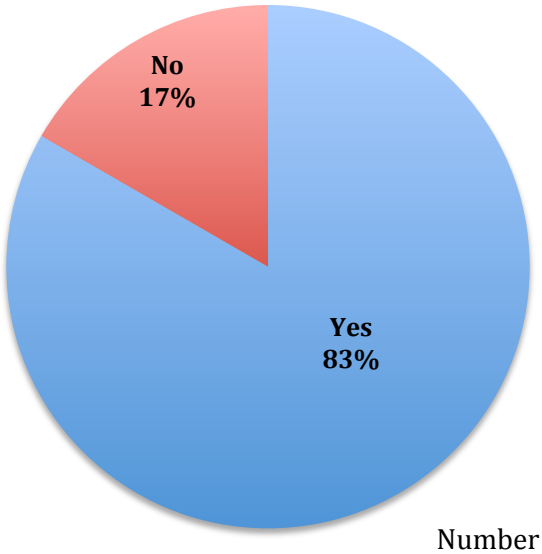

Number Responding: 19

**My organization has engaged in a process that created a community health improvement plan similar to what is being undertaken by the City of St. Louis Department of Health.**



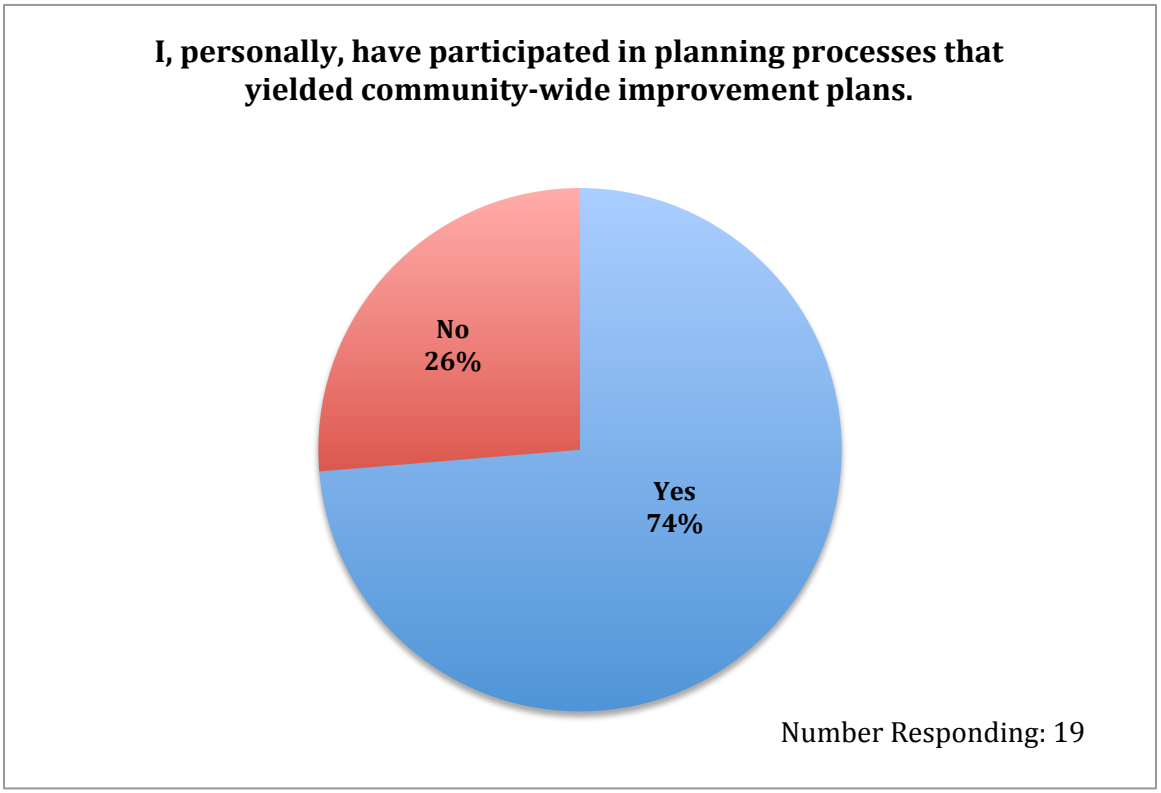

*Number Responding: 20*

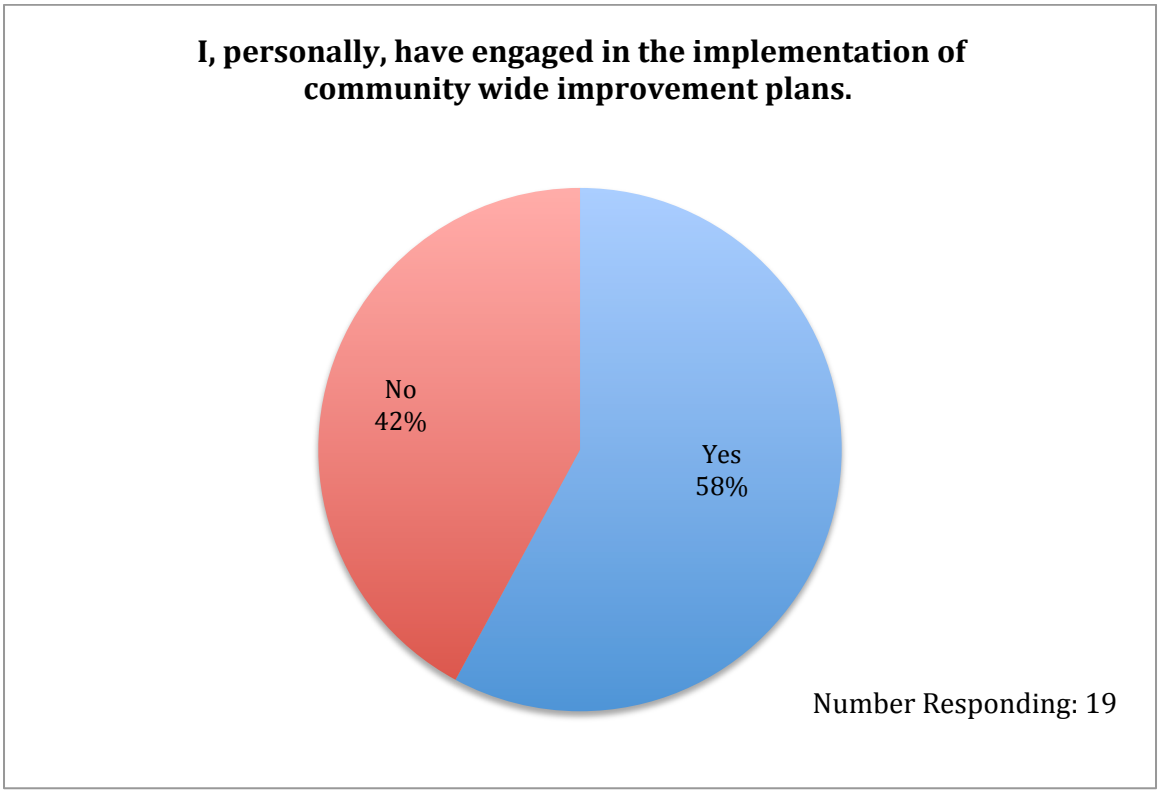
**My organization employs outcomes based strategies to serve our constituents.**

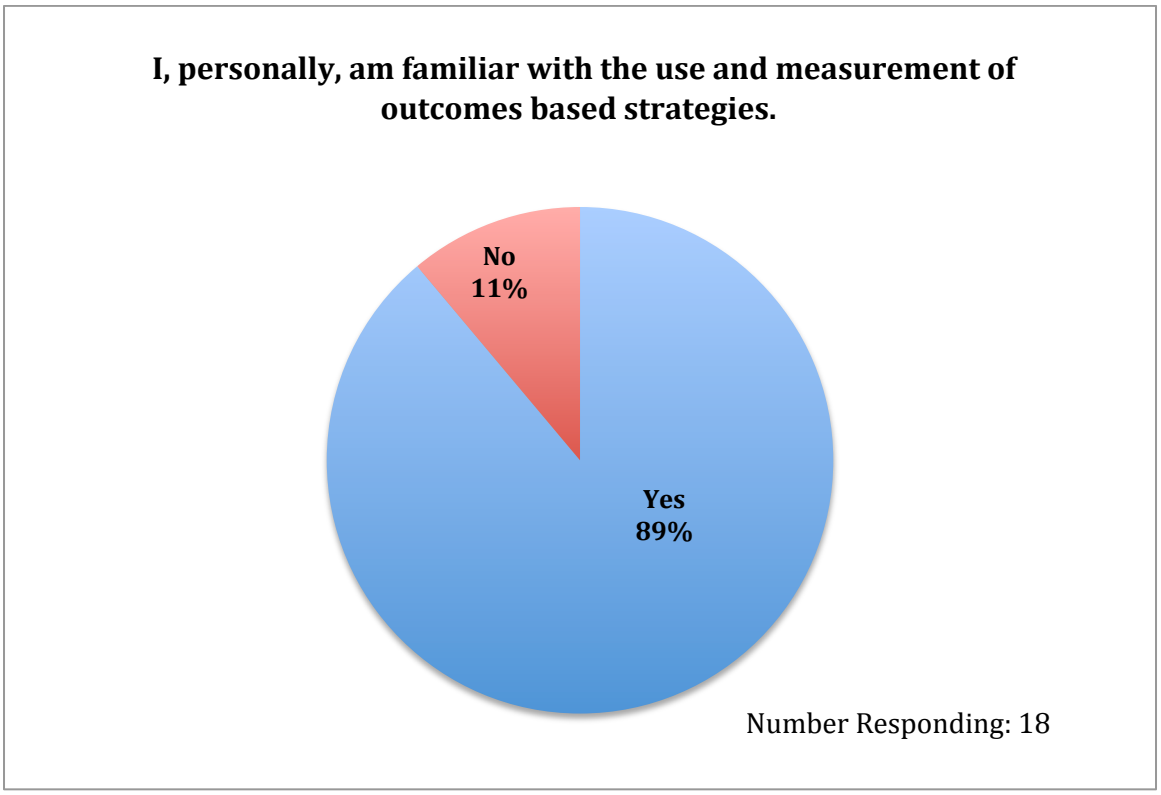



Number Responding: 19

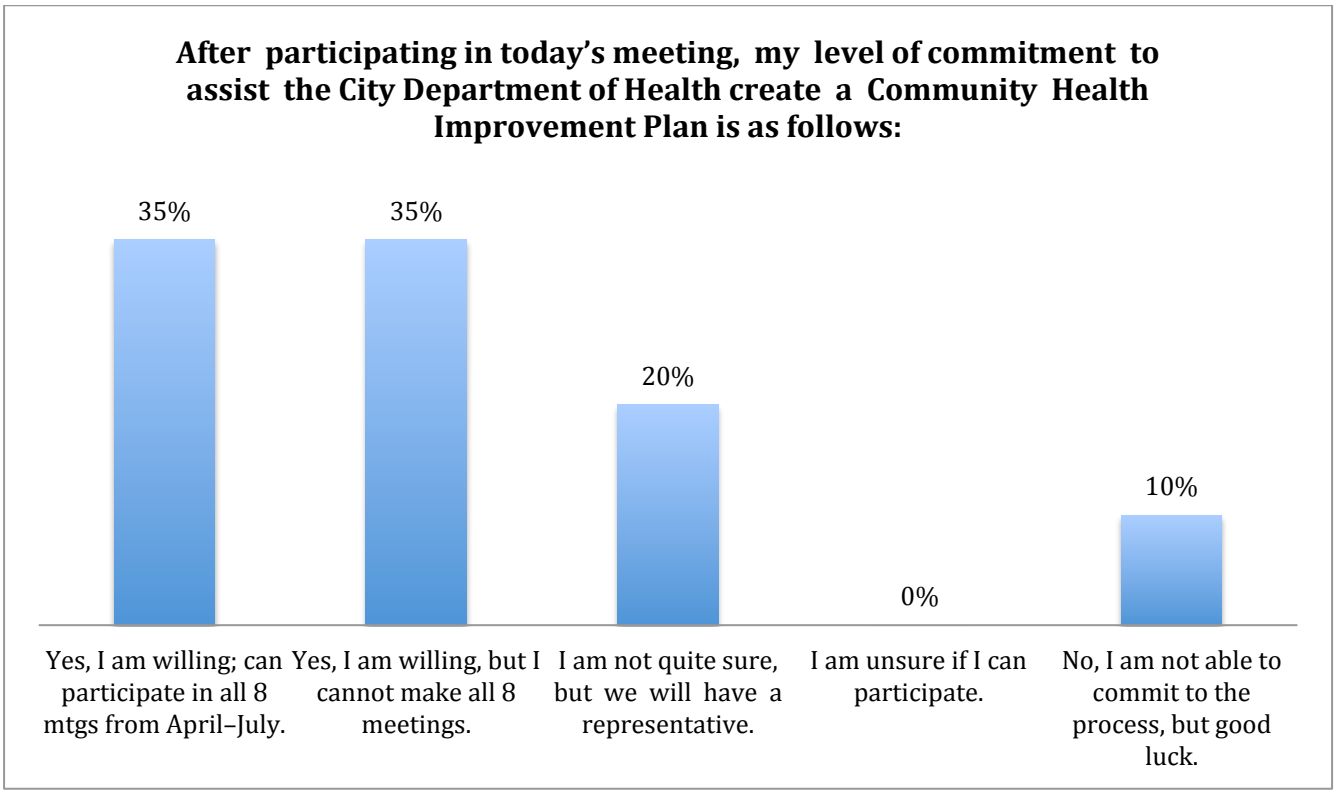
**Personal experience with community health improvement planning and outcome based strategy development**



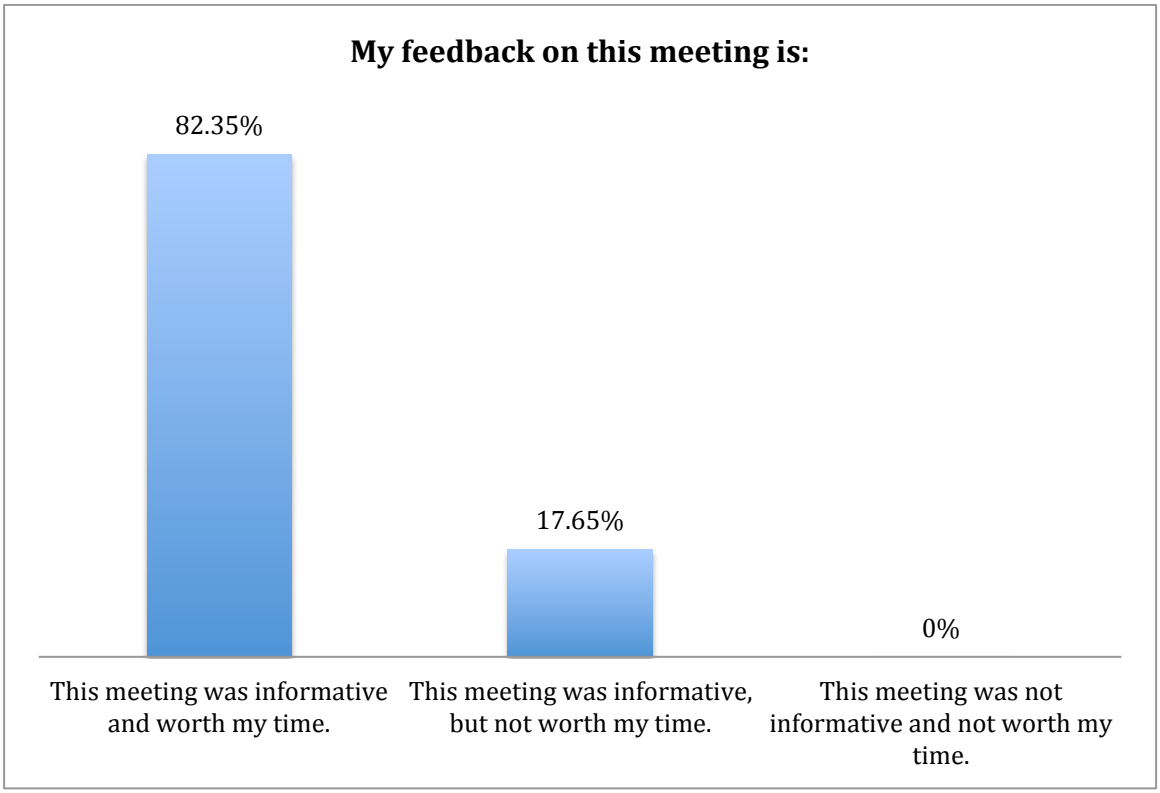



**Participation in planning process**




*Number Responding: 20*

## Meeting feedback




*Number Responding: 17*

# APPENDIX D
# Residents Advisory Group

# St. Louis City Residents Advisory Group

| Last | First | Zip |
|---|---|---|
| Bennett | Crystal | 63111 |
| Crow | George | 63136 |
| Culberson | Rachel | 63120 |
| Finch | Ramon | 63137 |
| Gentry | Wilma | 63118 |
| Hall | Alonzo | 63120 |
| Hardin | Tina | 63106 |
| Hardin | Isiah | 63106 |
| Hebron | Theresa | 63104 |
| Hilton | Paulette | 63107 |
| Jones | Marissa | 63103 |
| Jordan | Dorothy | 63103 |
| Louis | Roberta | 63113 |
| Modesto | Suzanne | 63139 |
| Rodriguez | Lupe | 63116 |
| Saavetra | Kimberly | 63116 |
| Schermann | Martha | 63111 |
| Squalls | Clarence | 63147 |
| Stalling | Olivia | 63104 |
| Street | Lessie | 63147 |
| Tate | JoAnn | 63106 |
| Weaver | Brenda | 63112 |

# APPENDIX E
# CHIP Meetings Schedule

RESEARCH & EVALUATION SOLUTIONS, INC.
There Can Be No Health With No Wealth

# St. Louis Community Health Improvement Plan
## Process and Meetings

| Month | Partner Work Group Activities | Dates | Time | Location |
|---|---|---|---|---|
| | | | | |
| **April-12** | | | | |
| Partner Meeting 1 | Visioning & Partner Skill Building:Health Promotion Basics (MAPP Model) | 12-Apr-12 | Done | Harris Stowe, Childhood Education Center, Room EC 204 |
| Partner Meeting 2 | Vision and Values (MAPP Model) | 17-Apr-12 | Done | Health Department, 1520 Market, Community Meeting Room |
| Citywide Residents' Meeting 1 | Review of partner meetings outcomes from 4/12-4/17 | 18-Apr-12 | Done | Harris Stowe, 3026 Laclede, AT&T Library and Technology Research Building, Telecommunity Room |
| **May-12** | | | | |
| Partner Meeting 3 | Final Values & Community Themes and Strengths | 10-May-12 | Done | Employment Connections, 2838 Market Street St. Louis, MO 63103 |
| Partner Meeting 4 | Windshield Survey Tour of City of St. Louis (CHANGE Model)-Threats and Assets | 15-May-12 | Done | Health Department, 1520 Market, Community Meeting Room |
| Citywide Residents' Meeting 2 | Review of partner meetings outcomes for 5/10 & 5/15 | 16-May-12 | Done | Casa de Salud (House of Health), 3200 Chouteau Avenue, St. Louis, MO 63103 |
| **June-12** | | | | |
| Partner Meeting 5 | Community Assets & Forces of Change (MAPP) and Policy and Administrative Barriers Precede-Proceed). Set Priority Issues | 14-Jun-12 | Done | Employment Connections, 2838 Market Street St. Louis, MO 63103 |
| Partner Meeting 6 | Establish Goals and Objectives focusing on Behavioral and Social Assessments (Precede-Proceed) | 19-Jun-12 | Done | Health Department, 1520 Market, Community Meeting Room |
| Citywide Residents' Meeting 3 | Review of partner meetings outcomes from 6/ 14 & 6/ 19 | 20-Jun-12 | Done | Casa de Salud (House of Health), 3200 Chouteau Avenue, St. Louis, MO 63103 |
| **July-12** | | | | |
| Partner Meeting 7 | Linking Strategies to Issues, Goals, and Objectives using Educational and Ecological Assessments | 12-Jul-12 | Done | Employment Connections, 2838 Market Street St. Louis, MO 63103 |
| Citywide Residents' Meeting 4 | Review of partner meetings outcomes from July 12 | 16-Jul-12 | Done | Casa de Salud (House of Health), 3200 Chouteau Avenue, St. Louis, MO 63103 |

Updated 9/18/12

# APPENDIX F
# Partners CHIP Meeting Agendas and Outcomes

F.1

# Community Health Improvement Plan

Partner Orientation Meeting

Tuesday, March 27, 2012

12:30–4:30 p.m.

1520 Market Street

Community Meeting Room

St. Louis, MO

# AGENDA

| Time | Activity | Who |
|---|---|---|
| 12:30 p.m. | Welcome and Introductions | **Pamela R. Walker, MPA, CPHA**<br>Acting Director of Health<br>**Melba R. Moore, MS, CPHA**<br>Commissioner of Health |
| 12:50 p.m. | Review of Meeting Goals and Objectives<br><br>Overview of the Accreditation Process | **Laverne Morrow, Carter, Ph.D., MPH**<br>President/Chief Project Director<br>Research and Evaluation Solutions, Inc. (REESSI) |
| 1:15 p.m.<br><br>1:45 p.m. | Presentation of Select Indicators by Zip Code<br>Questions/Answers<br><br>Break | **Jeanine S. Arrighi, MS, MPPA**<br>Health Services Manager, Health Department<br>**Megan Terle, MPH**<br>Epidemiologist, Health Department |
| 2:00 p.m. | 1) Presentation of Outcomes from Residents' Focus Groups (20 minutes)<br>2) Models for Developing Community Health Improvement Plans (CHIP) (20 minutes)<br>3) Assessment of Partners' Experience and Resources (45 minutes)<br>4) Future working meetings, goals, and process/on-site commitments (15 minutes) | **Laverne Morrow Carter** |
| 4:15 p.m. | Closing Remarks | **Pamela R. Walker, MPA, CPHA**<br>**Melba R. Moore, MS, CPHA** |

# Meeting Goal and Objectives

- **Goals:**
  - To introduce our public health partners to the national public health accreditation process.
  - To unveil the current community health assessment results.
  - To secure the commitment of our public health partners to participate in an in-depth process for developing a community health improvement plan for the City of St. Louis.

- **Objectives:**
  - Each participant will be able to describe the goal of the national public health accreditation process.
  - Each participant will be able to list at least two benefits of the national public health accreditation process.
  - Each participant will be able to describe at least four health issues that emerge from the current community health assessment data.
  - Each participant will be able to name at least three models for developing community health improvement plans.
  - Each participant will be able to describe the collective experiences and resources of the meeting participants
  - Each participant will be familiar with the proposed planning structure, dates, and goals for the eight planning meetings between April and July 2012.

F.2

# Community Health Improvement Plan (CHIP) Work Group

## Thursday April 12, 2012

12:30–4:30 p.m.

Harris Stowe, Childhood Education Center

Room EC204

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - *To address any emerging questions from the orientation.*
  - *To understand the mutual expectations for the work group and the planning process.*
  - *To understand the key tools and theoretical frames used in public health.*
  - *To establish  broad ideas and concepts about a community vision.*

- **Objectives:**
  - Each participant will be able to list at least two outcomes of the March 27th orientation meeting.
  - Each participants will be able to define at least one health department and one partner expectation for the CHIP Work Group activities.
  - Each participants will be able to list the *five* components of a primary health promotion model.
  - Each participant will be assigned to a MicroGroup with at least three other members.
  - Each participant will contribute at least one idea for the creation of a broad healthy *St. Louis vision.*

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# April 12, 2012 Agenda



| Time | Activity |
|---|---|
| **12:30 p.m.** | Introductions and Expectations<br>Review of Meeting Goals and Objectives |
| **12:40 p.m.** | Summary of March 27th Orientation<br>Any Emerging Questions?<br>MicroGroup Assignments and Rules of Engagement |
| **1:00 p.m.** | *Let's Get on One Accord:* ***Public Health Mini Toolkit for Action*** |
| **1:45 p.m.** | Break |
| **2:00 p.m.** | ***Visioning Exercise*** in MicroGroups |
| **3:00 p.m.** | MicroGroup Reports |
| **3:30 p.m.** | Building a Consensus on a Vision Statement (s) |
| **4:15 p.m.** | Session Review and Closure |

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**Results of April 12, 2012 Visioning Exercise**

| Group by Facilitator | Cross | Desai-Ramirez | Herbers | Schmid |
|---|---|---|---|---|
| | | | | |
| **Five Signs of a Health Community** | An increase in community health centers | When public policies are in place (and enforced) around community health that are supported by political will and action. | Equal access to healthcare (physical, mental, dental) and other community resources that promote health (e.g., healthy and affordable foods, sidewalks, recreation facilities and parks). | Safety |
| | An increase in affordable recreational centers | When our health system transitions from a "clinical/critical" paradigm to one that promotes comprehensive and culturally competent "primary/preventative" care. | Opportunities for engagement of residents of all ages, particularly youth. | Infrastructure |
| | Decrease in Crime | When regional morbidity and mortality rates are reduced to, at or below national benchmarks. | Residents feel safe in their homes and neighborhoods (reduction in person-person crime). | Access to affordable, coordinated healthcare |
| | Education and Awareness (available to residents) of health issues | When the regional socioeconomic status improves to, at or above national benchmarks. | Access to quality education in all phases of life. | Access to adequate jobs, education and housing |
| | Job creating with availablitity of goods and services in all areas of the City. | When health disparities are eliminated and we have constructed a "competent" community. | Positive improvements in health-related indicators (e.g., poverty, teen pregnancy, violence, infant mortality). | Achieving the mind set of healthier lifestyles and chronic disease management |
| | | | | |
| **Top Three Characteristics of a Healthy Community** | Health care services and Education with easy access to those without resources. | Effective and sustainable | Health is viewed as a priority and invested in by civic leaders. | Residents are biking or walking to the gym or park, spending time doing activities with their children, not smoking, Going home to prepare meals and have family time. |
| | Jobs and the availability to goods and services | Accessible | Equal access to care and all other resources that promote health. | |
| | Safety and reduced crime | Coordinated, competent and accountable | Positive environment that promotes a healthy and safe community. | |
| | | | | |
| **Health Department Actions within the next five years** | | | | |
| | Take an active role in assuring residents have available health services, recreational facilities, crime prevention resources and accessibility to job training. They would also promote the creation of jobs, goods and services. | The DOH should drive the "healthier community" initiative; the DOH should take ownership of this issue…function as the convening/coordinating/lead organization in the region across all the players at the table who are already working towards similar public health oriented goals. | Focus on 2-3 bold goals, convene partners, have a strong marketing plan, and make an impact (e.g., Milwaukee Dept. of Health). Identify opportunities for integration of services for city and county health departments. Serve as a voice for health in the city, in work with other departments, particularly related to policy decisions (e.g., health impact assessments). Regular engagement of residents, community leaders, and policy makers in decisions. Monitor health indicators and hold organizations accountable for their contribution to the needs of a healthier community and implementing an effective public health system. | Recruit health care providers to provide health care to under served regions; Prevention, promotion and education; Engage the community in "best practices". |

F.3

*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP) Work Group

## Thursday May 10, 2012

12:30–4:30 p.m.

Employment Connections

2838 Market

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - Final approval of a mission statement and "values" for improvement of health in the City of St. Louis.
  - To review the residents' focus group results and begin constructing community themes and strengths.
- **Objectives:**
  - Each participant will understand where the group is in the planning process.
  - Each participant will offer input and approval of a final mission statement and a final set of values that complement the approved vision.
  - Each participant will contribute to the MicroGroup activities that develop community themes and strengths based the city wide focus groups outcomes.
  - Each participant will be able to describe at least two activities of the Regional Health Commission and one achievement of the organization.

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# May 10, 2012 Agenda



| Time | Activity |
|---|---|
| **12:30 p.m.** | Remarks from Health Department<br>Introduction of new members<br>Review of Meeting Goals and Objectives<br>Assignment of new participants to MicroGroups |
| **12:45 p.m.** | Summary of April 17th Meeting |
| **1:00 p.m.** | *MicroGroups–Work on Values*<br>Review and final approval of Mission Statement and Guiding Values |
| **1:45 p.m.** | Break |
| **2:00 p.m.** | The importance of Constructing Community Themes and Strengths (CTS)<br>Questions and Comments: Residents' Input (Focus Group) Report |
| **2:15 p.m.** | *MicroGroups Activity*<br>CTS: Issues, Perceptions, Assets |
| **3:40 p.m.** | MicroGroup Reports |
| **4:00 p.m.** | Partner Exchange: An Overview of the **Regional Health Commission**<br>*Ryan Sterling*<br>Questions |
| **4:15 p.m.** | Logistics and Information for the ***May 15 Windshield Survey Tour*** |
| **4:30 p.m.** | Closure |

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**Community Health Improvement Plan**
**Community Themes Outcomes**
From Partners' Assessment of Residents' Focus Groups Results
May 10, 2012 Meeting

***1) Overarching issue themes from all focus groups.***

| |
|---|
| a) Accessible, Affordable, & Quality Health Care |
| b) Teen Pregnancy |
| c) Education and Jobs |
| d) Substance Abuse |
| e) Safety and Security |

***2) Overall perceptions about the quality of life from all focus groups.***

| |
|---|
| a) Residents lack knowledge about health services and the health care system. |
| b) Residents disrespected by a "system" more focused on revenue than quality services. |
| c) Residents lack access to quality education. |
| d) Youth are unprepared of the responsibilities of adulthood. |
| e) Residents lack jobs and economic opportunities. |
| f) Many environments in the city are unsafe. |

City of St. Louis Department of Health
CHIP Work Group
Windshield Survey Tour
May 15, 2012

A windshield survey involves structured observations of a community, neighborhood, or specific environment from a moving vehicle. This survey concept was originally developed to locate environments that were most amenable to the incubation and spread of infectious diseases in the early 1960s.[1] This type of survey offers multiple benefits in the community health assessment process:

1) It is the easiest and most expedient way to get an overview of an entire community.
2) Participants get a first hand look at particular neighborhoods/communities and the residents in the natural and normal setting.
3) Participants may gain new knowledge and perspectives about particular areas of a community.
4) The "seeing" experience gives a greater "meaning" to and understanding of the data and residents' feedback.
5) Participants can get a visual of both issues and assets in the community.
6) It provides a mechanism to compare different sections of a community.

**Purpose of the 5/15/2012 Tour:** To offer the CHIP Work Group members an opportunity to see the *issues and assets* in a *sample* of neighborhoods across the City of St. Louis.

[1] Callan, L.B. (1971). Adapting the Windshield Survey Model to Health Education. *HSMHA Health Reports*, (86)3, 203.

# THE JOURNEY

**Neighborhood Navigators:** Robin Boyce, Paula Gaertner, Alderman Craig Schmid, and Alderman Charles Quincy Troupe
**Transportation:** Metro Transit (Thanks to Alderman Troupe and Theresa Chambers for making these arrangements and to Robin Boyce for planning the route.)

## Key Sites:

| Location | Neighborhoods |
|---|---|
| 1-Downtown St. Louis–Market Street | Old Mill Creek |
| 2-West on Market to Compton South | Industrial Area |
| 3-Compton to Park–East to Jefferson | The Gate District/Lafayette Square |
| 4-Jefferson South to Cherokee | Fox Park/McKinley Heights/Benton Park/West Benton Park |
| 5-South Jefferson to Broadway to Meramec | Gravois Park/Marine Villa |
| 6-West on Meramec to Grand | Dutchtown/Mount Pleasant |
| 7-Grand South to Loughborough | Holly Hills/Carondelet Park/Lyle Mansion |
| 8-Loughborough to Kingshighway North | Boulevard Heights/Bevo Mills |
| 9-Kingshighway north to Eichelberger West | Southampton(SOHA)/North Hampton |
| 10-Eichelberger to Hampton North | SOHA/Macklind |
| 11-Hampton North to Chippewa East | SOHA/Macklind |
| 12-Chippewa East to Kingshighway | Tower Grove South/ South City/Tower Grove Park |
| 13-Kingshighway North to MLK Drive | CWE/Fountain Park/Academy |
| 14-MLK East to Annie Malone Dr. | The Ville/Homer G Phillips |
| 15-Annie Malone to North Market West | The Ville/Sumner High/Turner Middle |
| 16-North Market to Newstead South | Greater Ville |
| 17-Newstead South to MLK West | Greater Ville |
| 18-MLK West to Kingshighway North | Kingsway East |
| 19-Kingshighway North to Hwy 70 | Penrose |
| 20- Kingshighway North to West Florissant | O'Fallon Neighborhood |
| 21-West Florissant East to O'Fallon Park | O'Fallon/College Park |
| 22-West Florissant to Grand South | Fairgrounds Park/Jeff Vander Lou |
| 23- Grand South to Lindell–Olive | Covenant Blue-Grand Center |
| 24- East on Lindell/Olive to 21st Street | Midtown |
| 25- 21st South to Market East to 16th | Downtown |


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## PERSONAL OBSERVATIONS & NOTES

★= My perception is positive-no issues; ↕ = I see some positive and negative. It's OKAY;

✉=My perception is not positive. *Write* somebody with power for help; ☎ =OMG. *Call* somebody with power immediately for help.

| Site/Area | People and their well-being | Race & Ethnicity Mix | Housing, Other Buildings, & Infrastructure | Public Spaces, Parks, & Recreation and Cultural Facilities |
|---|---|---|---|---|
| **Locations 1-3** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 4-6** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 7-9** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 10-12** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 13-15** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 16-18** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 19-21** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 22-25** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |


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## PERSONAL OBSERVATIONS & NOTES 2 (continued)

★= My perception is positive-no issues; ↕ = I see some positive and negative. It's OKAY;

✉=My perception is not positive. *Write* somebody with power for help; ☎ =OMG. *Call* somebody with power immediately for help.

| Site/Area | Commercial Activities & Jobs | Schools and Higher Education | Health & Social Service Providers; Private doctors and dentists | Supermarkets, Retail, and Pharmacies |
|---|---|---|---|---|
| **Locations 1-3** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 4-6** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 7-9** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 10-12** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 13-15** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 16-18** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 19-21** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |
| **Locations 22-25** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ |


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## PERSONAL OBSERVATIONS & NOTES 3 (continued)

★= My perception is positive-no issues; ↕ = I see some positive and negative. It's OKAY;
✉=My perception is not positive. *Write* somebody with power for help; ☎ =OMG. *Call* somebody with power immediately for help.

| Site/Area | Safe and Secure | Street Use and Streetscape | Public Transportation and Public Services | Other Observations |
|---|---|---|---|---|
| **Locations 1-3** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 4-6** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 7-9** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 10-12** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 13-15** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 16-18** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 19-21** | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | ★ ↕ ✉ ☎ | |
| **Locations 22-25** | ★ ✌ ✉ ☎ | ★ ✌ ✉ ☎ | ★ ✌ ✉ ☎ | |


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## POST TOUR QUESTIONS:

1) *What differences did you observe between the community sites?*

2) *What evidence of health issues did you observe?*

3) *What "assets" did you observe?*


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City of St. Louis Department of Health
CHIP Work Group
Windshield Survey Tour
May 15, 2012

## POST TOUR QUESTIONS:

1) *What differences did you observe between the community sites?*

-Although most of the homes were similar in size, age and build, many of the homes (# of home-owners) on the south side were cleaner, groomed lawns, flowers etc.
- More private restaurants on the south side and mid town.
- Although schools are closed down across the city (parochial, charter and public), there are still more catholic schools on the south and mid-town.
-More recreation centers and after school programs (Boys and Girls Club, Harambee, etc.) in the north, however the Catholic schools offer sports activities through the schools.

2) *What evidence of health issues did you observe?*

-Small doctor and dentist offices scattered on the south side and mid-town. Little to no evidence of the same on the north side.
-The private restaurants on the south side and mid-town could offer healthier eating than the fast food chains that dominate the north.
- The bars and smoke shops seem to be on the south and north ends of the city, with few (unless food is also served) in midtown.

*What "assets" did you observe?*

-City parks and recreation centers throughout the city.
-Variety of beautiful brick homes throughout the city.
-Main streets (Grand, Kingshighway, Chippewa, Compton) all seem to flow nicely through the city and are cared for equally north to south.
-Pride in individual neighborhoods.


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F.5

*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP) Work Group

## Thursday June 14, 2012

12:30–4:30 p.m.

Employment Connections

2838 Market

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - Construct community assets and forces of change per MAPP Model.
  - Prioritize City Health Issues and Identify Risks per Precede-Proceed Model.
  - Conduct Changeability Assessment per Precede-Proceed Model.
- **Objectives:**
  - Each participant will understand where the group is in the planning process.
  - Each participant will contribute to the MicroGroup activities that identify community assets/strengths and the forces of change.
  - Each participant will contribute to the MicroGroup activities that prioritize health issues and identify risks.
  - Each participant will contribute to the MicroGroup activities that assess the risks that are most amenable to change through intervention.

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# June 14, 2012 Agenda



| Time | Activity |
|---|---|
| **12:30 p.m.** | Review of tasks for final three meetings (6/19, 7/12 & 7/17)<br>Review of goals and objectives for meeting |
| **12:40 p.m.** | Summary of May Meeting activities |
| **12:50 p.m.**<br>**1:00 p.m.** | Introduction to Assets and Forces of Change (10 minutes)<br>***Microgroups Activity***<br>What are the assets/strengths in the City of St. Louis?<br>What are the Forces of Change that Impact the City of St. Louis? |
| **1:45 p.m.** | Break |
| **2:00 p.m.** | MicroGroup Reports |
| **2:20 p.m.** | ***MicroGroups Activity***<br>Prioritize Health Issues, the Risk Factors, & Changeability |
| **3:45 p.m.** | MicroGroup Reports |
| **4:10 p.m.**<br>**4:30 p.m.** | Summary of Outcomes<br>Adjourn |

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F.6

*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP) Work Group

## Tuesday June 19, 2012

12:30–4:30 p.m.

St. Louis City Department of Health Community Meeting Room

1520 Market

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:** To develop realistic overarching goals and objectives for each health issue and the poverty project.

- **Objectives:**
  - Each participant will understand where the group is in the planning process.
  - Each participant will be able to list the six key components of Green's Health Promotion Model.
  - Each participant will contribute to the MicroGroup activities that identify overarching goals and objectives for the key issues.
  - Each participant will contribute to the MicroGroup activities that assess the feasibility of the constructed goals and objectives.

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# June 19, 2012 Agenda



| Time | Activity |
|---|---|
| **12:30 p.m.** | Review of July Tasks ( 7/12 & 7/17)<br>Review of goals and objectives for meeting |
| **12:40 p.m.** | Summary of June 14th meeting activities<br>Review of Priority Health Issues and Poverty Project |
| **12:50 p.m.**<br>**1:00 p.m.**<br><br>**1:00** | Tools: Health Promotion Concepts<br><br>**MicroGroup Activity:** *Overarching Program Goal and Objectives* |
| **2:00 p.m.** | Break |
| **2:15 p.m.** | MicroGroup Reports |
| **2:40 p.m.**<br><br>**2:50 p.m.** | Tools: Feasibility Concepts<br><br>**MicroGroup Activity***: Feasibility & Reality Check* |
| **4:00 p.m.** | MicroGroup Reports |
| **4:20 p.m.**<br>**4:30 p.m.** | Summary of Outcomes<br>Adjourn |

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Community Health Improvement Plan Outcomes for Program Goals and Objectives
June 19, 2012

**Issue: M4–Mortality from Diabetes, Cardiovascular Disease, Cancer, and Murder**

**1–Discuss and finalize an overall *Program* goal statement for the problem. Refer back to Slide 8. The goal statement should reflect an overall statement of what your program will accomplish. Keep it simple.**

| |
|---|
| Provide a supportive environment and structured activities for St. Louis residents to decrease the *morbidity and mortality* burden of leading chronic health diseases, including murder. |

**2–Now discuss and finalize at least 2-4 Program Objectives. Refer back to Slide 8. These objectives should be *measureable and focused on population level changes in outcomes.* Do not focus on behavioral, environmental, or social factors. Focus on aspects of the problem.**

| |
|---|
| 1- Reduce the incidence of uncontrolled diabetes. (Need the rate and time frame) |
| 2-Reduce the average rate of uncontrolled hypertension. (Need the rate and time frame) |
| 3-Increase screenings for cancer types that place the most burden on St. Louis City Residents. (Need cancer types, screening rates and timeframes). (Need the rate and time frame) |
| 4-Reduce the murder rate in the City of St. Louis. (Need the rate and time frame) |


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Community Health Improvement Plan Outcomes for Program Goals and Objectives
June 19, 2012

**Issue: Violence**

**1–Discuss and finalize an overall *Program* goal statement for the problem. Refer back to Slide 8. The goal statement should reflect an overall statement of what your program will accomplish. Keep it simple.**

| |
|---|
| To prevent and deter violence through creating a community environment of "homeness", a sense of belonging, and constructive outlets that allow residents to release passion; dream dreams; and live out promises. |

**2–Now discuss and finalize at least 2-4 Program Objectives. Refer back to Slide 8. These objectives should be *measureable and focused on population level changes in outcomes.* Do not focus on behavioral, environmental, or social factors. Focus on aspects of the problem.**

| |
|---|
| 1-Seek and attain increased funding (20%) for innovative after school interventions for youth by 2014. (What is the current level-baseline of funding for youth programs in the City). |
| 2-Establish "Youth Homes" in each Zip Code of the City by 2014. |


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Community Health Improvement Plan Outcomes for Program Goals and Objectives
June 19, 2012

**Issue: Education System/Pipeline**

**1–Discuss and finalize an overall *Program* goal statement for the problem. Refer back to Slide 8. The goal statement should reflect an overall statement of what your program will accomplish. Keep it simple.**

| |
|---|
| Through the creation and activation of a coalition of parents that demand excellence---every child in St. Louis has access to high quality education and a pipeline to success. |

**2–Now discuss and finalize at least 2-4 Program Objectives. Refer back to Slide 8. These objectives should be *measureable and focused on population level changes in outcomes.* Do not focus on behavioral, environmental, or social factors. Focus on aspects of the problem.**

| |
|---|
| 1-By July 2013, create a structured citywide coalition of parents and advocates who will pursue the goal. |
| 2-Develop a plan and strategies for obtaining feedback from parents/guardians that serves as an alternative to in-person meetings. (Not measurable) |
| 3-The coalition will focus on empowering teachers, facilitate acquiring and allocating resources, and ensuring model curriculums are followed. (Not measurable) |
| 4-Completion of a long-term strategic plan that restructures the current system. (Not measurable) |


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Community Health Improvement Plan Outcomes for Program Goals and Objectives
June 19, 2012

**Issue: Infant Mortality**

**1–Discuss and finalize an overall *Program* goal statement for the problem. Refer back to Slide 8. The goal statement should reflect an overall statement of what your program will accomplish. Keep it simple.**

| |
|---|
| The most recent data shows that fetal infant mortality is at 10.8% in the City of St. Louis. This rate will be reduced by 10% at the end of 2017. |

**2–Now discuss and finalize at least 2-4 Program Objectives. Refer back to Slide 8. These objectives should be *measureable and focused on population level changes in outcomes.* Do not focus on behavioral, environmental, or social factors. Focus on aspects of the problem.**

| |
|---|
| 1-Clinical Care-work with medical providers to offer education. (Not measurable) |
| 2-Community services-educate agencies and facilitate collaboration. (Not measurable) |
| 3-Policy-Increase insurance coverage and access. (Not measurable) |
| 4-Health Equity- Develop a health equity model with trusted advocates who are trained in culturally appropriate service delivery. (Not measurable) |


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Community Health Improvement Plan Outcomes for Program Goals and Objectives
June 19, 2012

**Issue: Poverty**

**1–Discuss and finalize an overall *Program* goal statement for the problem. Refer back to Slide 8. The goal statement should reflect an overall statement of what your program will accomplish. Keep it simple.**

| |
|---|
| In St. Louis, improve the possibilities for a more equitable distribution of wealth. |

**2–Now discuss and finalize at least 2-4 Program Objectives. Refer back to Slide 8. These objectives should be *measureable and focused on population level changes in outcomes.* Do not focus on behavioral, environmental, or social factors. Focus on aspects of the problem.**

**Note: These are sub goals**

| |
|---|
| 1-Gain knowledge of responsibilities, as well as, to use current skills set |
| 2-Identify, accentuate, increase, and reinforce positive attitudes and behaviors. |
| 3- Ensure access to basic needs for all. |
| 4-Gain and increase knowledge of financial responsibilities and possibilities. |


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*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP) Work Group

## Thursday July 12, 2012

12:30–4:30 p.m.

Employment Connections

2838 Market

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - To revisit and reconstruct the priority health issues.
  - To fine-tune the program goals and objectives.
  - To link strategies to the objectives.
- **Objectives:**
  - Each participant will contribute to the general group activities to reconstruct the priority health issues.
  - Each participant will contribute to the MicroGroup activities to construct final goals and objectives.
  - Each participant will contribute to the MicroGroup activities to link the objectives to possible strategies.

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# July 12, 2012 Agenda



| Time | Activity |
|---|---|
| **12:30 p.m.** | Review of goals, objectives, and agenda for meeting |
| **12:40 p.m.** | Summary of June meeting activities |
| **12:50 p.m.**<br>**1:00 p.m.** | Review of summary documents from prior meetings<br>Discussion and activities to revisit and reconstruct the priority health issues |
| **2:00 p.m.** | Break |
| **2:15 p.m.** | MicroGroup activities to finalize Goals and Objectives |
| **2:45 p.m.** | Sharing and Large Group Consensus |
| **3:00 p.m.** | MicroGroup activities to link Strategies to the Objectives |
| **4:00 p.m.** | MicroGroup Reports on Strategies |
| **4:20 p.m.**<br>**4:30 p.m.** | Next Steps from Health Department<br>Adjourn |

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City of St. Louis
Community Health Improvement Plan
Issue, Goals, and Objectives

| Issue | Response Goal | Objective 1 | Objective 2 | Objective 3 | Objective 4 |
|---|---|---|---|---|---|
| | | | | | |
| **M4–Mortality from Diabetes, Cardiovascular Disease, Cancer, and Murder** | Provide a supportive environment and structured activities for St. Louis residents to decrease the *morbidity and mortality* burden of leading chronic health diseases, including murder. | 1-Reduce the incidence of Type II Diabetes to meet the Healthy People 2020 goals. (Get percent of change numbers). | 2-Reduce the rate of hypertension to meet the Healthy People 2020 goals. (Get percent of change numbers). | 3-Increase screenings for colorectal, breast, and prostate cancer to meet Healthy People 2020 goals. | 4-Reduce murder rate in the City of St. Louis by 5% (4/100,000 per year) by 2020. |
| **Education System/Pipeline** | Through the creation and activation of a coalition of parents/guardians and other advocates that demand excellence–every child in St. Louis has access to high quality education and a pipeline to success | 1-By January 2014, create and convene a structured citywide coalition representing parents/guardians and other advocates of public, private, parochial and charter schools. | 2- By July 2014, the coalition will create a document that describes its vision of high quality education and identifies measures for tracking progress towards achievement of the vision. | 3-By January 2015, the coalition and administrators of educational systems will document short and long-term strategies that work toward the achievement of the vision. | 4-By July 2015, transparency of he coalition will be promoted through creation of a website that ensures the vision and implementation plans are publicly available and progress on goals is annually updated. |
| **Violence** | To prevent and deter violence through creating a community environment of "homeness", a sense of belonging, and constructive outlets that allow residents to release passion; dream dreams; and live out promises. | 1-Seek and attain increased funding (20%) for innovative after school interventions for youth by 2014. (What is the current level-baseline of funding for youth programs in the City). | 2-Establish functional youth opportunities centers in each Zip Code by 2014, that support 15-21 year olds and their families. | 3-Decrease reports of domestic and relationship violence by 5% by 2015. | None |
| **Self-Destructive Behaviors** | Decrease self-destructive behaviors by encouraging positive life choices. | 1-Decrease substance abuse/addiction by 50% (5% per year for 10 years). Measure by decrease of court ordered rehab, addicted births, and overdoses seen in ER. | 2-Decrease rate of STD/HIV by 50% (5% per year for 10 years). Measure by health department STD rates. | 3-Increase the number of healthy babies born through exceptional pre-conception and pre-natal care. Measure by birthrate mortality, addiction of infants at birth, and pre-term birth rates. | None |
| **Poverty Project** | in St. Louis, foster a more equitable distribution of wealth through increasing avenues of economic/financial autonomy. | 1-Increase access to grants and funding for entrepreneural activities. Measured by the annual income of businesses in five years and the number of businesses in five years. | 2-Increase access to scholarships for post high school education and access to specialized grants for extracurricular learning activities. Measured by the number of scholarships, the number of college graduates, and the number who receive funds. | 3-Subsidize tuition to transitional vocational job training with an emphasis on training veterans and minority groups. Measured by the number of subsidies given to veterans and minorities, and the number of persons completing the training. | 4-Create an apparatus to assist the uninsured and underinsured residents who have experienced unforeseen traumatic events. Measured by the amount of funds acquired for the program, the number of beneficiaries, and the number of beneficiaires who reenter the workforce. |

# APPENDIX G
# Residents CHIP Meeting Agendas

G.1

# Community Health Improvement Plan

Residents Meeting

Tuesday, March 27, 2012

6:00–7:45 p.m.

**Harris Stowe State University**
**3026 Laclede**
**AT&T Library and Technology Research Building-Seminar Room**
**St. Louis, MO**

# Meeting Goal and Objectives

- **Goals:**
  - To offer an opportunity for residents across the City to meet and network.
  - To provide residents with the health indicators from all city Zip Codes.
  - To allow residents to complete the community health survey
  - To share the results of the seven city wide focus groups.
  - To share the process for development of the Community Health Improvement Plan (CHIP).

- **Objectives:**
  - Each participant will meet at least two new City residents that he/she did no know prior to the meeting.
  - Each participant will be able to describe at least two issues that are evident in all City Zip Codes.
  - Each participant will complete the four page residents' community health survey.
  - Each participant will be able to describe at least two issues and two solutions that emerged from all seven city wide focus groups.
  - Each participant will be familiar with the proposed planning structure, dates, and goals for the eight planning meetings between April and July 2012 and the associated four residents' response meetings

# AGENDA

| Time | Activity | Who |
|---|---|---|
| 6:00 p.m. | Welcome | **Pamela R. Walker, MPA, CPHA**<br>Acting Director of Health<br>**Melba R. Moore, MS, CPHA**<br>Commissioner of Health |
| 6:15 p.m. | 1-Meet & Greet Activity (20 minutes)<br>2-Review of Meeting Goals and Objectives (5 minutes)<br>3-Presentation of Select Indicators by Zip Code Questions/Answers (15 minutes)<br>4-Community Health Survey (15 minutes)<br>4-Presentation of Outcomes from Residents' Focus Group (20 minutes)<br>5-Future working meetings, goals, and process (10 minutes) | **Laverne Morrow, Carter, Ph.D., MPH**<br>President/Chief Project Director<br>Research and Evaluation Solutions, Inc, (REESSI) |
| 7:45 p.m. | Meeting Ends | |

G.2

# Community Health Improvement Plan (CHIP)
# Residents' Advisory Group
# Wednesday April 18, 2012

6:00–8:00 p.m.

Harris Stowe State University

# + Meeting Goal and Objectives



- **Goals:**
  - To update new attendees on the March 27th meeting outcomes.
  - To complete the Visioning Exercise.
  - To provide feedback on the **Vision Statement** and **Values** created by the Partners' Group.
  - To receive information on the *"human trafficking"* issue in St. Louis
- **Objectives:**
  - Each new participant will receive information from the March 27th meeting.
  - Each participant will offer his/her input into the three questions in the Visioning exercise
  - Each participant will provide his/her opinion and feedback on the Vision Statement and Values developed by the Partners.
  - The residents' will endorse or reject the Vision Statement and Values created by the Partners' Group.
  - Each participant will be able to list at least two things he/she learned about *human trafficking* in St. Louis.

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# April 18, 2012 Agenda



| Time | Activity |
|---|---|
| **6:00 p.m.** | Introductions<br>Review of Meeting Goals and Objectives |
| **6:10 p.m.** | Summary of March 27th Meeting<br>Questions??? |
| **6:20 p.m.** | Small Group Visioning Exercise |
| **6:45 p.m.** | Large Group Discussion on Visioning Exercise<br>Review of Outcomes of Partners' Visioning Exercise and Feedback |
| **7:00 p.m.** | Lessons on Vision and Values (5 minutes)<br>Review of Partners' Vision Statement and Values (5 minutes)<br>Discussion (10 minutes)<br>Vote/Consensus to Accept or Reject |
| **7:30 p.m.** | Presentation on Human Trafficking (10 minutes)<br>Discussion (10 minutes) |
| **8:00 p.m.** | Closure |

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RESEARCH & EVALUATION SOLUTIONS, INC.
There Can Be No Health With No Wealth

Community Health Improvement Plan Worksheet
Visioning Exercise
April 18, 2012 Resident's Meeting

**1– I will see the City of St. Louis as a "healthy community" when I see the following five things:**

| |
|---|
| a) |
| b) |
| c) |
| d) |
| e) |

**2–The top three important characteristics of a "healthy community" for the people who live, work and play there are:**

| |
|---|
| a) |
| b) |
| c) |

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Community Health Improvement Plan Worksheet
Visioning Exercise
April 18, 2012 Resident's Meeting

**3–In the next five years, to assure a "healthier community", the City of St. Louis Health department should:**

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G.3

*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP)
# Residents' Advisory Group
# Wednesday May 16, 2012

6-8 p.m.

Casa De Salud (House of Health)

3200 Chouteau

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - **Final approval of a mission statement and "values" for improvement of health in the City of St. Louis.**
  - **To review the residents' focus group results and identify overall themes.**

- **Objectives:**
  - Each participant will understand where the group is in the planning process.
  - Each participant will offer input and approval of a final mission statement and a final set of values that complement the approved vision.
  - Each participant will contribute to the MicroGroup activities that reviews and identifies overall themes from the Focus Groups.
  - Each participant will contribute the brainstorming session on July and beyond.

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# May 16, 2012 Agenda



| Time | Activity |
|---|---|
| **6:00 p.m.** | Review of Meeting Goals and Objectives<br>Assignment of New Members to MicroGroups |
| **6:10 p.m.** | Summary of April 18th Meeting |
| **6:15 p.m.** | Review and Approval of Final Values |
| **6:30 p.m.** | MicroGroup Activity<br>Residents' Focus Group Results and Themes |
| **7:15 p.m.** | Group Reports |
| **7:30 p.m.** | Ideas-July and Beyond |
| **8:00 p.m.** | Closure |

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Community Health Improvement Plan Worksheet 5A
Themes from Residents' Focus Groups
Residents' Advisory Group
May 16, 2012

**1–List Names of MicroGroup Members**

| Name | Role |
|---|---|
| Rachel Culberson | Facilitator |
| Marissa Jones | Recorder |
| George Crow, Sr. | Time Keeper |
| Brenda C. Weaver | |
| Precious Bourrage | |
| Lupe Rodriquiez | |
| Cynthia Clinton | |

**2) Four overarching issue themes from all focus groups.**

| |
|---|
| a) Lack of Communication: Lack of community meetings |
| b) Education: Need for community outreach programs and job fairs |
| c) Seniors and Youth: Need for food programs and outreach |
| d) Policy and Law Makers: Place money and power over people. |

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**3) Three overall perceptions about the quality of life from all focus groups.**

| |
|---|
| a) Poor people and poor health |
| b) Unaccredited schools |
| c) Very low community awareness |

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RESEARCH & EVALUATION SOLUTIONS, INC.
There Can Be No Health With No Wealth

Community Health Improvement Plan Worksheet 5A
Themes from Residents' Focus Groups
Residents' Advisory Group
May 16, 2012

**1–List Names of MicroGroup Members**

| Name | Role |
|---|---|
| Tina Hardin | Facilitator |
| Amy Heitkamp | Recorder |
| Isaias Perez | Time Keeper |
| Crystal Bennett | |
| Carolynn Mabens | |
| Lessie Street | |
| Roberta Laws | |
| Isiah Hardin | |
| Kym Dupree | |

**2) Four overarching issue themes from all focus groups.**

| |
|---|
| a) Drug abuse |
| b) Lack of quality education |
| c) Community input into health care issues are lacking |
| d) Lack of structured activities for youth |

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Community Health Improvement Plan Worksheet 5A
Themes from Residents' Focus Groups
Residents' Advisory Group
May 16, 2012

**3) Three overall perceptions about the quality of life from all focus groups.**

| |
|---|
| a) Lack of security (health, fitness, safety) |
| b) Substantial inequalities to access of healthcare |
| c) Concern for the welfare of youth (health, education, safety) |

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*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP)
# Residents' Advisory Group
# Wednesday June 20, 2012

6-8 p.m.

Casa De Salud (House of Health)

3200 Chouteau

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - **To gain knowledge about the health care system in the St. Louis region and how it works.**
  - **To review and approve the health issues priorities identified by the partners.**

- **Objectives:**
  - Each participant will understand where the group is in the planning process.
  - Each participant will be able to describe three new things he/she knows about the St. Louis health care system.
  - Each participant will share his/her opinion about the health issues and accept/reject them as priorities.

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# June 20, 2012 Agenda



| Time | Activity |
|---|---|
| **6:00 p.m.** | Review of Meeting Goals and Objectives |
| **6:10 p.m.** | Summary of April 18th Meeting |
| **6:15 p.m.** | The St. Louis Health Care System<br>Bethany Johnson-Javois<br>Chief Executive Officer |
| **6:45 p.m.** | Break |
| **6:55 p.m.** | Presentation of the Health Issues selected by Partners<br>Discussion & Approval/Disapproval |
| **7:15 p.m.**<br>**7:30 p.m.**<br>**7:45 p.m.**<br>**8:00 p.m.** | Linking Issues to Risk Factors (Information & Group Exercise)<br>Reports<br>Meeting Dates for July<br>Closure |

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G.4.a

Community Health Improvement Plan (CHIP)
Health Issues and Overarching Goal (June 2012)

The partners approved a set of four issues, a special project on poverty and overarching improvement goals on June 19, 2012.

| Health Issues | Improvement Goals |
|---|---|
| 1) The Mortal Four: Cardiovascular Disease; Diabetes; Cancer; & Murder | Provide a supportive environment and structured activities for St. Louis residents to decrease the *morbidity and mortality* burden of leading chronic health diseases, including murder. |
| 2) Violence | To prevent and deter violence through creating a community environment of "homeness", a sense of belonging, and constructive outlets that allow residents to release passion; dream dreams; and live out promises. |
| 3) Education System/Pipeline | Through the creation and activation of a coalition of parents that demand excellence---every child in St. Louis has access to high quality education and a pipeline to success. |
| 4) Infant Mortality | The most recent data shows that fetal infant mortality is at 10.8% in the City of St. Louis. This rate will be reduced by 10% at the end of 2017. |
| *The Poverty Project* | In St. Louis, improve the possibilities for a more equitable distribution of wealth. |

*St. Louis, the city where healthy living matters.*

# Community Health Improvement Plan (CHIP)
# Residents' Advisory Group
# Monday July16, 2012

6-8 p.m.

Casa De Salud (House of Health)

3200 Chouteau

St. Louis, MO

# + Meeting Goal and Objectives



- **Goals:**
  - **To review and approve the health issues priorities objectives & strategies identified by the partners.**
  - **To construct additional strategies for each objective.**

- **Objectives:**
  - Each participant will share his/her opinion about the health issues identified by the partners and accept/reject them as priorities.
  - Each participant will share his/her opinion objectives & strategies identified by the partners and accept/reject them as priorities.
  - Each participant will work in a small group and contribute to the identification of at least one strategy for each objective.

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# July 16, 2012 Agenda



| Time | Activity |
|---|---|
| **6:00 p.m.** | Review of Meeting Goals and Objectives<br>Dr, Carter's Comments on Next Steps |
| **6:10 p.m.** | Summary of June 20th Meeting |
| **6:15 p.m.** | Review of Refinement of Health Issues; The Overarching Goal; and the Objectives; Discussion; Approval/Rejection |
| **6:45 p.m.** | Break |
| **6:55 p.m.** | Additional Strategies from Residents for the Objectives<br>Small Group Exercise |
| **7:20 p.m.**<br>**7:40 p.m.**<br>**8:00 p.m.** | Reports<br>Remarks from Health Department on Next Steps<br>Closure |

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