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CITY OF ST. LOUIS DEPARTMENT OF HEALTH

2014 – 2017 COMMUNITY HEALTH IMPROVEMENT PLAN

"It is both my mission and passion to ensure that St. Louis strives to be a great and prosperous city; one that is healthier, cleaner, safer, better educated, more open to diversity and more fun."

- Francis G. Slay
  Mayor, City of St. Louis

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City of St. Louis Department of Health

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Acknowledgements

The City of St. Louis' Department of Health would like to thank the efforts and hard work of Dr. Laverne Morrow Carter of Research, Evaluation, and Social Solutions, Inc. (REESSI) in creating the first draft of this Plan and conducting the initial partner engagement. The DOH would also like to thank the many City, County, regional, and state partners that spent significant time, effort, and resources to ensure that the strategies identified in this Community Health Improvement Plan were appropriate, evidence-based, and needed. Without the selfless dedication of all these individuals and organizations, the St. Louis City CHIP would not be the comprehensive plan it is today.

Forward

Comprehensive planning is a relatively new concept in public health but an extremely important one. Recognizing this, I have directed my staff to create a Community Health Improvement Plan (CHIP) – both for the purpose of accreditation through the Public Health Accreditation Board and for improving our City's health systems and residents' health.

Understanding the complex relationship between health, the environment, policy, and systems is necessary to understand where and how to intervene to improve our community's health and happiness. Through a rigorous engagement process in 2012 and followed up by supplemental engagement and data collection in 2013, the City of St. Louis' Department of Health has identified the most pressing health and health-related priorities for the next four years. My hope and expectation is that when we assess our progress in 2017, we will see a healthier, happier, and more productive City.

Finally, as with all things, our CHIP does not exist in isolation. The City of St. Louis also released its Sustainability Plan in 2013, of which a major component is to improve the health, well-being and safety for all residents and visitors. The City of St. Louis is also dedicated to reducing youth violence and released its Youth Violence Prevention Community Plan of which components are interwoven into the 2014 CHIP. And the State of Missouri has pursued its own strategic planning initiative, the State Health Improvement Plan, to which we align our own efforts when appropriate.

The City of St. Louis' Department of Health, under my direction, has begun implementing the strategies in this Plan in the spring of 2014 and will continue to implement, revise, and monitor these efforts through 2017 when a revised CHIP will be conducted and released. The Department, City, and all partners mentioned in the following pages are dedicated to improving the health of all City residents through the identified evidence-based strategies. I and my staff are dedicated to this Plan and this process and look forward to a healthier, happier, more sustainable St. Louis.

Pamela Rice Walker, MA, CPHA
Director of Health
City of St. Louis Department of Health

Updated 6/9/14

INTRODUCTION

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 *a healthy St. Louis community every day, all of the time*. 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 1832 and has delivered outreach and prevention services to the City for 182 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.

The CHIP process began in early 2012 with the identification and retention of a consultant (REESSI) who assembled existing epidemiological data and conducted supplemental focus groups with residents and partners resulting in a Community Health Assessment (CHA). The consultant then conducted in-depth meetings with a group of residents and a group of partners to explore the data compiled in the CHA to create this document, the Community Health Improvement Plan (CHIP).

In 2013, a full-time coordinator was brought on board to evaluate, revise, and implement the final CHIP objectives and strategies. The end result was a revised CHIP based on resident and partner feedback both in the construction of the initial objectives and the

final implementation plan based on the research literature, local priorities, and partner and departmental capacity.

CONTEXT FOR THE COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

Figure 1 - Core Public Health Functions/Essential Services

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.

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.

OVERVIEW OF THE PROCESS

THEORETICAL FRAMEWORKS

Three theoretical models guided the planning process–1) Precede-Proceed[4], 2) Community Health Assessment and Group Evaluation (CHANGE)[5] and 3) Mobilizing Action through Planning and Partnership (MAPP)[6].

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.

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 community-driven strategic planning.
- Through MAPP, communities seek to achieve optimal health by identifying and using their resources wisely, taking account their unique circumstances and needs 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. 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 2. Local Public Health System 3. Community Health Assessment 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		

GOALS, STRUCTURE AND 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.**

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.**

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 ➢ 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 ➢ 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.**

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.

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, Goals and 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.**

KEY OUTCOMES

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.

CHRONIC DISEASE MORTALITY

Issue Overview

The work group and residents identified three types of mortality to address– (Cardiovascular Disease, Cancer, and Diabetes). In the United States, chronic disease is the leading cause of health care costs (three-quarters of our health care costs go to the treatment of chronic diseases[7]) and mortality (7 out of 10 deaths in the US are from chronic diseases[8]) and the situation is similar in Missouri and St. Louis. The three leading causes of death in the City of St. Louis from 2006-2008 were heart disease, cancer, and cerebrovascular disease (most often caused by hypertension)[9]. Heart disease and cancer alone accounted for over 40% of deaths in the City in the same time period.

The major modifiable risk factors for chronic diseases are well defined: lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption[10]. Those four 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.[11]

There are also groups more at risk for specific chronic diseases. The poor are more vulnerable for several reasons, including greater exposure to risks and decreased access to health services. Racial and ethnic minorities also have higher levels of prevalence for various chronic disease. Non-Hispanic blacks have the highest rate of obesity (44.1%), followed by Mexican Americans (39.3%)[12]. Diabetes is another chronic disease burden that is carried disproportionately by ethnic and racial minorities: diagnosis of diabetes is 18% higher among Asian Americans, 66% higher among Hispanics/Latinos, and 77% higher among non-Hispanic blacks[13].

During the planning process, the CHIP work group developed four initial objectives and related strategies to respond to this issue area. The first strategy will involve the implement of the City's Obesity Plan (APPENDIX H). The majority of the Plan's tactics, activities, and evaluation will be conduct through the HEAL (Healthy Eating, Active Living) Partnership – a collective of partners working in the City of St. Louis to reduce obesity and obesity-related risk factors. The HEAL Partnership is organized into five distinct Work Groups:

1) Active Living – supporting physical activity through programs, advocacy, and environment, policy, and system change.
2) Healthy Eating – focused on improving access to healthy eating opportunities for all City residents through education, advocacy, and environment, policy, and system change.
3) Healthcare Access – partners engaged in increasing access and use of preventative care by residents, specifically preventative care designed to reduce obesity and support individuals with obesity-related health issues (e.g. hypertension, diabetes).

4) Social Marketing – provide support to the Department of Health's JumpN2Shape initiative as well as providing technical support to other Work Groups around how best to market interventions and change behavior through media/marketing.
5) Data and Evaluation – responsible for the overall monitoring and evaluation of the Obesity Plan as well as technical assistance to the other Work Groups around identifying best practices and monitoring implementation of interventions.

The second strategy is designed to ensure equitable access to health screenings across the City and across all racial/ethnic populations. Currently, a variety of healthcare, nongovernmental, and charity groups do screenings for several different cancers in different areas of the City of St. Louis. The frequency, location, and type of screenings, however, are not centrally collected or analyzed and as such, are likely inefficiently or inequitably distributed throughout the City. In order to reduce cancer mortality – currently higher than mortality rates in both Missouri and United States – early detection and treatment is paramount. Specifically, through the cataloguing of current detection efforts and subsequent collaboration with partners to be more intentional about screenings in an equitable fashion, the City will work to meet Healthy People 2020 goals for colorectal, breast, and prostate cancer screening.[14]

The third strategy is the continued support and implementation of tobacco control efforts. Specifically, the expansion of a successful model in the City of tobacco cessation campaigns at health centers – places where residents can receive both the support, education, and medication to stop using tobacco products. The Department of Health will also continue to monitor and advocate the phasing out of all smoking ban exemptions in the City of St. Louis by 2016.

Objectives and Strategies

Table 4–Mortality Objectives 1-2 and Related Strategies

Issue	Chronic Disease Mortality				
Goal	To reduce the mortality rate from cancer, diabetes, and cardiovascular disease.				
Program Objectives		**Strategy 1**	**Strategy 2**	**Measures**	**Target**
Objective 1	Develop, implement, and support an obesity reduction partnership	Convene HEAL (healthy eating, active living) Partnership	Implement social media campaign (JumpN2Shape) to encourage City residents to engage in physical activity & improve nutrition	1. Documented HEAL Partnership meetings. 2. Documented monthly Work Group meetings. 3. Number of residents who have joined JumpN2Shape website 4. Number of residents logging information on JumpN2Shape website	1. Four HEAL Partnership by 3/1/15 2. Twelve Work Group Meetings by 5/1/15 3. 1,000 registered residents on JumpN2Shape by 10/31/14 3. 250 residents logging information on a monthly basis by 10/31/14
Objective 2	Ensure the equitable distribution of cancer screenings throughout the City of St. Louis to increase overall cancer screening rates	Identify all regular (e.g., annual, monthly, or weekly) colorectal, breast, and prostate cancer screening locations and events by: 1) Location 2) Cost 3) Frequency 4) Type of screening	Support the expansion of cancer screening efforts into areas identified in Strategy 1 .	1. Proportion of individuals receiving colorectal, breast, and prostate cancer. 2. Monitor ethnic/racial rates of cancer screenings	1a. 70.5% of residents receiving colorectal screenings 1b. 81.1% of female residents received colorectal screenings 1c. 15.9% of male residents received advantages and disadvantages of PSA test

Table 5–Mortality Objectives 3 and Related Strategies

Issue	Chronic Disease Mortality				
Program Goal	To reduce the mortality rate from cancer, diabetes, and cardiovascular disease.				
Program Objectives		**Strategy 1**	**Strategy 2**	**Measures**	**Target**
Objective 3	Reduce smoking prevalence in the City of St. Louis	Expand availability of smoking cessation programs at health care centers (i.e., FQHCs, Hospitals, Urgent Cares)	Support and advocate for the planned removal of smoking ban exemptions in the City of St. Louis	1. Number of new smoking cessation classes 2. Number of media impressions of smoking prevention and control messages (e.g., media at bus stops, letters to the editor, radio spots)	1. At least one new smoking cessation program at each identified health care center by 1/1/2016 2. All smoking ban exemptions in the City expired by 1/1/2016 3. Reduce adult smoking rates in the City to 25% by 6/1/2017

EDUCATION AND PIPELINE TO SUCCESS

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.[15] [16]

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.[17] In 2006, there was a 55 percent graduation rate; 19 percent of students dropped out; and cumulative debt had reached $25 million.[18] 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 Community Health Assessment's focus groups in February, 2012, residents stated that a successful public school system was key in preventing several poor outcomes: families leaving the City public school system for other districts and private schools, high dropout, and low academic attainment:

> *...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 dropout 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

After reviewing the state of education in the City of St. Louis, three groups were identified as having the potential to make the greatest impact on education through their current efforts, expertise, and experience working on education in St. Louis. For the youngest children, the St. Louis Regional Early Childhood Council – made up organizations such as Head Start, SLPS, and other child-serving institutions – focuses on addressing the "full range of early childhood needs for all St. Louis area children."[19] For school-aged students in public schools, the St. Louis Public Schools Foundation works to support collaboration and innovation in the SLPS system. Finally, for older youth, the St. Louis Graduates organization works to "to increase the proportion of low-income students in the St. Louis region who earn a postsecondary degree."[20] This group, a network of youth-serving college and vocational access organizations, provides support to youth in seeking postsecondary degrees or vocational training as well as helping to reduce drop-off during the "summer melt" – when students, after graduation, do not follow-through with their plans to enroll in a vocational or postsecondary program.

Because of the strong, robust, and experienced nature of these groups, the Department of Health will not engage in specific interventions in improving education. However, through the biannual Understanding Our Needs report, the City will continue to monitor educational attainment and take further steps if educational outcomes do not continue to improve.

YOUTH VIOLENCE

Issue Overview

The Centers for Disease Control and Prevention (CDC) considers violence to be one of the most serious health threats facing the nation today, jeopardizing the public's health and safety. It is a leading cause of injury, disability and premature death and disproportionately affects youths between the ages of 10 and 24 in the United States, particularly young people of color. Homicide is the second leading cause of death in this age group.

Homicide is not the only type of violence experienced and perpetuated by young people. Other violent and delinquent acts such as sexual assault, robbery, assault, fighting, bullying, and verbal abuse are both key symptoms and causes of violent behavior among young people. In 2010, 738,000 youth were treated by emergency departments for assault-related behavior.[21]

Youth violence's impact extends far beyond the immediate physical harm caused to victims and/or perpetrators. Entire neighborhoods, communities, municipalities and regions are impacted by violence. Healthcare costs, safety, social services, and even property values are disrupted by youth violence The CDC estimates that as much of $14 billion is lost each year due to medically treated youth violence.[22] And in 2007 the CDC estimated that the cost of violence in the United States exceeds $70 billion every year.[23]

St. Louis' rates of violence is far higher than most other places in the United States – ranking 9th in the nation for number of youth murdered with guns in 2012. With 50 youth gunshot deaths for every 100,000 people – a rate more than three times the national average of 15 deaths per 100,000 – the relative social, financial, and physical burden in St. Louis' metropolitan area for violence is amongst the highest in the nation.[24]

Public Health & Youth Violence

In order to reduce youth violence and the many social, physical, and financial ills it brings to communities, the CDC has made violence prevention a priority focus. In 1979, the Surgeon General's Report stated that "the health community cannot ignore the consequences of violent behavior in efforts to improve health."[25] Over the past several decades, the CDC has collected data on the prevalence of youth violence, assessed factors that increase risk and factors that protect youth, evaluated programs and strategies, and supported the adoption of evidence-based programs and practices throughout the United States.

Building on the successes that public health has had in preventing injury and death in such areas as obesity prevention, smoking cessation, and vehicle

accidents, the CDC has identified the needed strategies for reducing youth violence. Specifically, a comprehensive prevention strategy that addresses the complex factors that lead to violence among youth in communities. This strategy must address and promote: "(1) skills youths need to avoid violence, (2) supportive relationships for youths, (3) health and safety of the communities in which they live."[26]

In 2013 the St. Louis Regional Youth Violence Prevention Task Force concurred, identifying prevention as one of its core PIER strategies: (p)revention, (i)ntervention, (e)nforcement, and (r)e-entry (Appendix J). Public health expertise, strategies, data collection and evaluation tools are a central component in ensuring that youth violence is prevented and – when higher risks for violence are identified – are intervened with in a professional, evidence-based manner.

Department of Health's Role

Mayor Francis Slay has instructed the City's Department of Health (DOH) to continue to support the prevention and intervention work of the St. Louis Regional Youth Violence Prevention (YVP) Task Force through its core public health functions of assessment (i.e., monitoring, diagnosing, and investigating), policy development (i.e., educating, mobilizing, and developing policies and plans), and assurance (i.e., enforcement, linking, and evaluating).

Proposed DOH activities include:

Assessment

1. Track child and teen fatal and non-fatal violence-linked injuries on a regular basis and share data with appropriate agencies;

2. Create an asset map for the YVP Community Plan work currently happening in the City of St. Louis;

3. Create a network analysis to identify connections between YVP resources, opportunities for alignment, investment, and divestment;

4. Serve on the child mortality review panel and co-chair a Maternal Child and Family Health Coalition initiative to eliminate infant mortality;

5. Initiate the development of a Community Safety Scorecard that increases understanding of the causes, conditions and consequences of youth crime and violence;

Policy Development

6. Actively participate with CDC to continue to identify and implement evidence-based prevention and intervention strategies;

7. Develop an appropriate violence prevention public health social marketing campaign;

8. Identify project champions to carry forward the YVP plan priorities and strategies;

9. Meet with potential project managers and key project stakeholders to establish roles and responsibilities;

Assurance

10. Link programs that incorporate violence prevention strategies and goals into all City and partner program activities and outcome measures;

11. Evaluate progress on the YVP Plan to date based on asset map, network analysis, and other data collection activities;

12. Seek supplemental funding to carry out above goals.

Next Steps

The DOH will lead the creation of a partnership comprised of participants in the Mayor's Youth Violence Prevention Plan. This partnership will be comprised of work groups, organized conceptually around specific cross-cutting themes, as well as supportive groups that provide expertise in areas of social marketing, data, and evaluation. Other partners will be included as identified in order to have a comprehensive cross-section of effective organizations in St. Louis working on primary and secondary prevention of youth violence as well as developing and implementing evidence-based or novel interventions designed to reduce violence by youth (an initial service provide, gap analysis, and network analysis can be found in Appendix J). Each work group will create action-oriented work plans to begin identifying and implementing the relevant evidence-based tactics and activities selected by partners.

DOH will follow the CDC process (see Appendix I) which includes:

1. Identifying additional risk and protective factors, and then
2. Develop, test, and assess existing prevention/intervention strategies.

Throughout all this, the CDC will provide the DOH with support. The CDC has contracted with American Research Institute (AIR) - one of the world's largest behavioral and social sciences research and evaluation organizations – to provide technical assistance to cities and local governments grappling with high

rates of violence, including the City of St. Louis. The DOH will work with the AIR technical assistance providers to bring credibility and validation to the prevention and interventions strategies identified and implemented by partners and City agencies to reduce youth violence.

DOH will regularly present progress back to the Mayor and the YVP Task Force in order to gain support from key stakeholders, partners, and the wider community. These reports will include membership, work plans and revisions, and benchmarks and objectives achieved. As objectives are achieved and progress is made, the partnership, DOH, and key City departmental partners will pursue supplemental funding to increase the impact of this work in the City of St. Louis.

Objectives and Strategies

Table 10–Youth Violence Prevention Objectives 1-4 and Related Strategies

Issue	**Youth Violence Prevention**				
Program Goal	Develop, implement, and monitor youth violence prevention activities throughout the City of St. Louis				
Program Objectives		**Strategy 1**	**Strategy 2**	**Measures**	**Target**
Objective 1	Develop Community Safety Scorecard	Identify key indicators for youth violence (e.g., crime, dropout)	Collect data on key indicators from Strategy 1	1. Identified list of indicators 2. Data collected for each indicator	1. Publish first scorecard on City's website by 12/1/15
Objective 2	Develop Youth Violence Prevention Partnership	Convene partners regularly to implement youth violence prevention (YVP) plan.	Link existing YVP efforts with related, City-run programs and initiatives	1. Number of YVP Partnership meetings 2. Number of identified City initiatives linked to Plan	1. Six meetings of partnership by 6/1/15
Objective 3	Align assets (e.g., services) and needs (e.g., crime rates) by geography	Develop asset map for City of St. Louis	Develop need map for City of St. Louis	1. Completed asset map 2. Completed need map	1. Document listing all assets and needs by 12/31/14
Objective 4	Develop and identify universal, measurable outcomes for assets	Survey partners to identify current outcome measures	Develop consensus among partners of universal measurable outcomes	1. Completed partner survey 2. Identified list of universal measurable outcomes	1. Documented consensus by partner group on measurable outcomes by 12/31/14

SEXUAL AND REPRODUCTIVE HEALTH

Issue Overview

HIV/AIDS and Sexually Transmitted Diseases

The HIV/AIDS epidemic is not evenly distributed across states and regions in the United States.[27] 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.[28] 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.[29]

HIV prevalence is higher than average in the City of St. Louis according to the biannual Understanding Our Needs – there were 900.2 infections per 100,000 of the population in 2010, compared to 181.4 in Missouri and 469.4 in the United States during the same time period. Incidence – or new diagnoses – is also high, with the City counting 27.7 new cases per 100,000 population over 2006-2009 compared to 7.0 in Missouri and 16.7 in the United States during the same time. And STD rates, again documented in Understanding Our Needs, are similarly high in the City of St. Louis (2006-2010 average):

	Cases / 100,000 Population		
	City	Missouri	U.S.
Syphilis	14.0	3.2	3.8
Gonorrhea	588.4	141.9	112.4
Chlamydia	1272.5	417.4	369.7

The Department of Health's trained investigators conduct disease intervention activities in the City of St. Louis which includes notifying individuals of their exposure or diagnosis of Chlamydia, Gonorrhea and HIV and referrals for

patients for prompt examination, testing and treatment. When necessary, investigators also provide testing in the field to prevent and control the spread of STDs/HIV in the City. Currently, Missouri State Department of Health and Senior Services is responsible for Syphilis case investigations state-wide. While DOH offers a strong program in STD prevention and control, due to limited resources, DOH works with their network of providers in the City to bolster education, STD testing, and other treatment and care services to at risk populations: Men who have sex with Men (MSM), & Black Hetero Sexual Females and Males (HRH).

There are several organizations that have been providing screenings and providing education around STDs to at risk populations including Project Ark, Williams and Associates and St. Louis Effort for AIDS for several years. Safety net clinics such as Planned Parenthood and Casa de Salud reach a large number of individuals to provide screenings and treatment services to at-risk populations in the City and region. Federally Qualified Health Centers (FQHC) and private providers have also played an important role in testing and treatment for STDs.

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.[30] 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.[31] Many of the racial and ethnic differences in infant mortality are without explanation.[32]

During the planning process, the CHIP work group developed three objectives and related strategies to respond to this issue area. After consultation with partners and experts, it was reduced to one objective with two strategies. Specifically, to collaborate more effectively with the Fetal Infant Mortality Review, facilitated and convened by the Maternal, Child, and Family Health Coalition. This group "examines the social, economic, cultural, safety and health system factors associated with fetal and infant deaths through case review. FIMR findings are used to develop interventions that improve access to quality care and services."[33] The Department will also develop and implement a smoking cessation campaign targeted at pregnant women and mothers in order to reduce children – and their families – to the deleterious effects of smoking.

Finally, the Director of the City's DOH and the Director of St. Louis County's DOH will co-chair a regional infant mortality prevention leadership council. This council, funded by the Missouri Foundation for Health and staffed by the Maternal, Child, and Family Health Coalition (MFHC) will develop a regional infant mortality prevention framework by the end of 2014. This framework will help guide the above strategies as well as partners' efforts to reduce infant mortality in the greater St. Louis area.

Objectives and Strategies

Table 10–Sexual and Reproductive Health Objectives 1-4 and Related Strategies

Issue	**Sexual and Reproductive Health**				
Program Goal	Reduce STI/HIV incidence and infant mortality.				
Program Objectives		**Strategy 1**	**Strategy 2**	**Measures**	**Target**
Objective 1	Reduce STD/HIV incidence through improved screenings and presumptive treatment	Increase availability of appropriate screenings for at risk populations (e.g., pharyngeal and rectal screenings)	Improve provider (private, FQHC, ER) education on screenings, treatment, EPT, and reporting process	1. Number of providers reporting increased pharyngeal/rectal screenings 2. Number of providers trained on screening, EPT, and STD/HIV reporting	1. 10 providers trained by 6/1/15 2. 20 providers trained by 12/31/15
Objective 2	Reduce STD/HIV incidence through improved outreach efforts	Increase screenings for HIV in "Hot Spots" identified by EPI Data / Mapping and link new positives to care	Identify alternative sites for condom distribution in "Hot Spots" identified by EPI Data / Mapping	1. Completed analysis of health centers for at risk populations in "Hot Spots" 1. Number of screenings conducted in "Hot Spots" by health centers and DOH staff 2. Number of condom packets taken during intake or visit?	1. Completed analysis presented in report to Communicable Disease Bureau Chief by 12/31/14 2. 10 screening events conducted at each "Hot Spot" by 12/31/15
Objective 3	Reduce STD/HIV incidence through improved marketing strategies	Identify reasons that residents are currently seeking testing services	Develop marketing campaign and promote through social media based on Strategy 1	1. Through screenings at "funded sites" track reason for testing (e.g., symptoms, partner, DOH, Social Media)	1. Disseminate testing reasons to partners by 9/1/15. 2. Collaborate with partners to develop new

					marketing strategy by 12/31/15.
Objective 4	Reduce infant mortality through improved preconception and prenatal health	Support and collaborate with Fetal Infant Mortality Review (FIMR)	Develop and implement smoking cessation campaign for pregnant women and mothers	1. Number of FIMR sessions attended 2. Number of FIMR projects/initiatives with DOH assistance 2. Number of media impressions	1. Attend 90% of all FIMR sessions by 1/1/16 2. Assist with at least 1 FMIR project/initiative by 3/31/15 3. Track media impressions/resident engagement in campaign (dependent on type of campaign)
Objective 4	Reduce infant mortality through improved preconception and prenatal health	**Strategy 3** Co-chair regional infant mortality prevention leadership council		1. Number of council meetings attended	1. Attend 90% of all council meetings by 6/1/15

SUBSTANCE ABUSE AND ADDICTION

Issue Overview

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.[34] 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).[35]

Unfortunately, there is very little data available at the local level around substance abuse and addiction for the City of St. Louis. The CDC reports that in 2011, 13.1% of City residents considered themselves to be "Heavy drinkers." For men that meant having more than 2 drinks per day and for women having more than 1 drink per day. However, that does not necessarily mean they have alcohol addiction problems – but it is the best adult data that exists. For youth in grades 9-12, the Youth Risk Behavior Survey reports that 25.3% of youth in Missouri in 2009 consumed five or more drinks in a row within a couple of hours on at least one day.[36] For youth, 34.9% had used marijuana, 5.0% had used cocaine, 10.2% had sniffed glue or some other inhalant, 2.8% had used heroin, 3.7% had used methamphetamine, and 5.7% had used ecstasy in 2009 in Missouri. The numbers may be higher or lower in the City of St. Louis, but unfortunately no local data exists.

During the planning process, the CHIP work group developed five objectives and related strategies to respond to this issue area. Again, these were refined based on partner feedback and best practices. The resulting three objectives were designed to reduce substance abuse and addiction among the most at-risk populations as well as improve the capacity of organizations working directly or indirectly with individuals with substance abuse or addiction.

III.F.2. Objectives and Strategies

Table 12–Substance Abuse & Addiction Objectives 1-3 and Related Strategies

Issue	**Substance Abuse & Addiction**			
Program Goal	In St. Louis, reduce substance abuse and addiction rates among all residents.			
Program Objectives		**Strategy 1**	**Measure**	**Target**
Objective 1	Reduce Substance abuse and addiction among pregnant women	Support and collaborate with Perinatal Substance Abuse Prevention Group	1. Number of meetings attended by DOH staff 2. New interventions or modified DOH interventions designed to support substance abuse/addiction among pregnant women	1. Attended 4 meetings by 12/31/14 2. 1 new intervention or 2 existing DOH interventions modified to include substance abuse/addiction interventions
Objective 2	Train DOH staff on assessment and referral to treatment	Train Department of Health staff on assessment and referral to treatment	1. Number of DOH staff trained 2. Number of referrals made by DOH staff	1. 75% of all DOH staff trained by 3/31/15 2. Documented all referrals made. If less than 10 referrals in a calendar year, evaluation report will be delivered by 12/31 of each year (starting in 2015)
Objective 3	Support St. Louis Regional Heroin Task Force	Collaborate with Heroin Task Force through regular meetings and membership	1. Number of Task Force meetings attended by DOH representative	1. 75% of all Task Force meetings attended by DOH representative

IV. Implementation Plan

The City of St. Louis' Community Health Improvement Plan (CHIP) will be implemented in concert with residents, community partners, and regional, state, and federal agencies. Whenever possible, the goal will be to identify gaps in services, identify best practices/evidence based interventions and strategies not currently being use, and aim to support and help those City residents most vulnerable due to illness and death. Partnerships will be integral to the success of the CHIP – both for those priorities that will be tackled directly through a formal partnership and for those that will depend on existing partnerships and collaborative.

The CHIP assessment activities and summary in the previous sections outlined five priority areas for the City Department of Health to focus on over the next four years:

1) Chronic Disease Mortality
2) Education
3) Youth Violence
4) Sexual and Reproductive Health
5) Substance Abuse and Addiction

Throughout the implementation of this Plan, the Department of Health will engage in periodic review of these priorities, their corresponding objectives, and progress to date. Based on these reviews, the Department will update, revise, or otherwise change the approaches taken, partners enlisted, and resources allocated.

Each of these five priorities will be monitored but two, Education and Violence Prevention, are not directly under the purview of the Department of Health. Because of recent strong local and regional efforts, there are now existing plans and organizations working on the issues identified by residents and partners during the formation of the CHP. In order not to duplicate efforts but rather support existing ones, the Department will monitor and support as requested the work done by these groups.

Violence prevention was the topic of a recent community task force representing the St. Louis region. This St. Louis Regional Youth Violence Prevention Task Force engaged with hundreds of stakeholders, partners, and residents to create a Community Plan in June of 2013. This Plan (located here: https://stlouis-mo.gov/government/departments/mayor/news/Youth-Violence-Task-Force.cfm) outlines an evidence-based map for reducing youth violence (and overall violence) in the region through a PIER framework:

(P)revention by: Ensuring that more young people have access to job readiness, training and employment programs

(I)ntervention by: Expanding access to high quality programs that build youth resiliency, teach positive social skills, and impart practical skills around how to cope with peer pressure, gangs, violence, drugs etc. Increasing youth's access to and receipt of mental and behavioral health supports and services and extending the availability and accessibility of safe places for youth during evenings, weekends and summers.

(E)nforcement by: Increasing alternatives to youth incarceration and detention. Enhancing and expanding diversion initiatives to reduce the juvenile jail population and prevent crime. Strengthening collaboration and active community policing among law enforcement, youth, families, schools and other community stakeholders. Reducing youth's access to and use of firearms and illegal weapons.

(R)e-entry by: Strengthening aftercare services that work to keep reentering youth from being arrested or convicted of future crimes, including mental health, substance abuse and independent living supports.

The Department of Health will support this Community Plan through the modification of its existing programs and initiatives to incorporate anti-violence interventions and materials into service delivery. In addition, the Department will provide epidemiological and data analysis support to the Community Plan implementers.

While there is no strategic plan for improving educational outcomes and opportunities for City of St. Louis residents, there are three organizations currently engaged in improving education for young children, youth and adolescents, and then those seeking post-secondary education.

The youngest children's needs are being identified and addressed through the St. Louis Regional Early Childhood Education, while school-aged youth are supported by the St. Louis Public Schools Foundation, and older youth and young adults are supported in pursuing vocational and postsecondary education through St. Louis Graduates. The Department of Health will monitor educational indicators and provide support as needed.

Chronic Disease mortality will be addressed through the strategies highlighted above – coordinated by the Department of Health in conjunction with the HEAL Partnership its diverse membership. The Obesity Plan (Appendix H) and HEAL Partnership Work Plan has measures and indicators as relate to individual goals, tactics, and activities. Additionally, one Work Group (the Data & Evaluation Work Group) will be continually

monitoring and evaluating the Partnership's actions and providing support around best practices. This Partnership began work in February, 2014, and will continue indefinitely although the initial goal is to reduce obesity in the City of St. Louis by 5% by December, 2015. The HEAL Partnership will re-evaluate its work and present a report by the end of 2016 to judge if it met that goal and other short-term objectives as identified in the Obesity Plan.

Sexual health and reproductive health, identified by residents as a major health concern and buttressed by epidemiological data, will be addressed through three objectives:

1) Improve screenings for HIV and STDs in the City through increased provider training and increased usage of pharyngeal and rectal screenings for MSM – a population with a high risk of new infections;
2) Develop new and improve existing outreach efforts through the identification of key safety net clinics for high-risk populations and "Hot Spots" or geographic areas with increased rates, relative to the City, of new STD and HIV infections; and,
3) Reduce infant mortality through improved preconception and prenatal health for all mothers and children – specifically through interventions identified in the FIMR and through increased programming for pregnant and new mothers who use tobacco products.

The first two objectives will be done primarily by the Department of Health in close partnership with the safety-net health care providers as well as those organizations that engage in outreach and education efforts in St. Louis around HIV and STDs (The SPOT/Project Ark, St. Louis Effort for AIDS, Casa de Salud). The third objective will be done in partnership between the FIMR's convener, The Maternal Child and Family Health Coalition, and the Department of Health.

The last issue, reducing substance abuse and addiction, will build off partners and work to identify and implement novel best practices and support existing efforts around supporting individuals with substance abuse and addiction challenges. There are three objectives in this issue:

1) Reduce substance abuse and addiction among pregnant women through collaboration and support of the Perinatal Substance Abuse Prevention Group;
2) Increased training of Departmental staff around the assessment and referral to treatment of individuals with substance abuse or addiction;
3) Support the St. Louis Regional Heroin Task Force through meeting and event participation, data analysis support, and other services as requested

REFERENCES

[1] National Research Council. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press, 2002.
[2] Last, J.M. (1988). A Dictionary of Epidemiology. 2nd Ed. New York, NY; Oxford University Press.
[3] World Health Organization. 1946. [www.who.int/bulletin/archives/80(12)981.pdf. WHO definition of Health], Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19– 22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948
[4] This model was developed by Lawrence Green and Marshall Kreuter (2005, 1999, 1991)
[5] This model was developed by the Centers for Disease Control and Prevention (CDC).
[6] The National Association of County and City Health Officials (NACCHO) developed this model.
[7] Centers for Disease Control and Prevention: Chronic Disease Prevention and Health Promotion. Information accessed on 3/10/14 at http://www.cdc.gov/chronicdisease/
[8] Kung HC, Hoyert DL, Xu JQ, Murphy SL. Deaths: final data for 2005. National Vital Statistics Reports 2008;56(10). Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf
[9] City of St. Louis, Department of Health. *Understanding Our Needs: 2012*.
[10] Centers for Disease Control and Prevention: Chronic Disease Prevention and Health Promotion. Information accessed on 3/10/14 at http://www.cdc.gov/chronicdisease/
[11] World Health Organization, Chronic Diseases and their Common Risk Factors. 2005. Last accessed 4/14/31 at http://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf .
[12] Racial and Ethnic Approaches to Community Health, Centers for Disease Control and Prevention. Information accessed on 3/14/14 at http://www.cdc.gov/nccdphp/dch/programs/reach/
[13] *Ibid*.
[14] Department of Health and Human Services. Healthy People 2020. Last accessed on 2/10/14 at http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=5 .
[15] Cutler, D.M. and Lieras-Muney, A. (2007*). Education and Health; Policy Brief Nine*. Ann Arbor, Michigan: National Poverty Center.
[16] Ross, C.E. and Wu. C. (1995). Education and Health. *American Sociological Review*. (60)5; 719-745
[17] Gay, M. State Takes Control of Troubled Public Schools in St. Louis. New York Times. March 23, 2007. http://www.nytimes.com/2007/03/23/us/23missouri.html?
[18] Missouri State Board of Education. Information accessed on 9/12/2012 at http://dese.mo.gov/news
[19] Vision for Children at Risk (2011). Last accessed on 3/1/14 at http://visionforchildren.org/news/561-stlouisregionalearlychildhoodcouncillaunched

[20] St. Louis Graduates (2013). Last accessed at 3/1/14 at http://www.stlouisgraduates.org/community/who-we-are
[21] Centers for Disease Control and Prevention. (2012). Web-based Injury Statistics Query and Reporting System (WISQARS) [Data file]. Retrieved from http://www.cdc.gov/injury/wisqars/nonfatal.html
[22] Corso, P. S., Mercy, J. A., Simon, T. R., Finkelstein, E. A., & Miller, T. R. (2007). Medical Costs and Productivity Losses Due to Interpersonal Violence and Self-Directed Violence. American Journal of Preventive Medicine, 32, 474-482.
[23] *Ibid*.
[24] City of St. Louis (2013). *St. Louis Regional Youth Violence Prevention Task Force: Community Plan*. Available at https://stlouis-mo.gov/government/departments/mayor/documents/Youth-Violence-Prevention-Plan.cfm
[25] Centers for Disease Control and Prevention. (2013). A Timeline of Violence as a Public Health Issue. Retrieved from http://www.cdc.gov/violenceprevention/overview/timeline.html
[26] Centers for Disease Control and Prevention. (2012). National Academic Centers of Excellence in Youth Violence Prevention. Retrieved from http://www.cdc.gov/violenceprevention/pdf/ace_one_pager-a.pdf
[27] CDC. (2012). HIV and AIDS in the United States by Geographic Distribution. Accessed on August 19 at http://www.cdc.gov/hiv/resources/factsheets/geographic.htm
[28] Centers for Disease Control and Prevention. HIV Among Youth. Accessed on August 19, 2012 at http://www.cdc.gov/hiv/youth/index.htm
[29] Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2010. Atlanta: U.S. Department of Health and Human Services; 2011.
[30] National Center for Health and Health Statistics. *Infant Mortality Statistics from the 2007 Period.* Retrieved on August 20, 2011 from www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_06.pd.
[31] MacDorman M.F., Mathews T.J. (2008). *Recent Trends in Infant Mortality in the United States.* NCHS data brief, no 9. Hyattsville, MD: National Center for Health Statistics.
[32] Centers for Disease Control and Prevention. (2008). New Infant Mortality Data. Retrieved on August 20, 2011 at www.cdc.gov/media/pressrel/2008/r081015.htm.
[33] Maternal, Child, and Family Health Coalition. Fetal Infant Mortality Review. Last accessed, 3/1/14 at http://stl-mcfhc.org/wp/programs/healthy-mothers-babies-programs/
[34] Substance Abuse and Mental Health Services Administration. (2008). Results from the 2007 National Survey on Drug Use and Health: National Findings. Office of Applied Studies, NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD. Available at http:// oas.*samhsa*.gov
[35] Centers for Disease Control and Prevention. Youth Behavioral Risk Surveillance, United States, 2011. MMWR 2012. (61)4.
[36] Centers for Disease Control and Prevention (CDC). 1991-2011 High School Youth Risk Behavior Survey Data. Available at http://apps.nccd.cdc.gov/youthonline. Accessed on 3/1/14.