2013

# CHRISTIAN HOSPITAL

## COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

*Our Mission*

*To help people enjoy life by improving their health*

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## I. EXECUTIVE SUMMARY:

Christian Hospital is a 485-bed; acute-care medical center located on 28 acres in unincorporated north St. Louis County. Located 6 miles west of Christian Hospital's main campus is an extension, Northwest Healthcare, which offers the community 24-hour emergency care and a variety of outpatient services in a convenient setting to complement the hospital services. Christian Hospital is a leader among hospitals in the St. Louis region and has experienced tremendous growth in the last few years.

Specifically, Christian Hospital is highly regarded for its excellence in heart services and lifesaving cardiothoracic surgery, emergency medicine, neurosurgery, spine surgery, cancer treatment, radiation oncology, psychiatric services and substance abuse programs, radiology, urology and pulmonary care.

Christian Hospital, a non-profit organization and founding member of BJC HealthCare, has more than 500 physicians on staff and a diverse workforce of more than 2,200 health-care professionals who are dedicated to providing the highest quality care with the latest technology and medical advances.

Our community counts on Christian Hospital as one of the largest employers and as a pillar in the community. Due to the complex nature of the health needs in our community, we provide 400-plus lectures, screenings, education and wellness programs, serve 11,000 community residents with health programs and provide 34,000 meals to the North County Meals On Wheels program.

In early 2012, an internal Christian Hospital committee was formed to oversee the Community Health Needs Assessment process mandated by the Patient Protection and Affordable Care Act (PPACA) passed in March 2010. Committee members were selected to reflect various areas of the hospital and various health expertises. Committee members included clinicians as well as administrative leaders in key areas such as asthma, mental health and emergency medicine.

In addition, a focus was group was held consisting of individuals who were experts in the field of public health to obtain additional primary data. Christian Hospital and SSM DePaul were the key initiators in this study.

Primary and secondary data was reviewed by the committee. Needs were grouped together based on relationships to each other and the resources used to address them, followed by identification of the top 10 needs for our community. A priority ranking system was used to put them in order of importance. The committee then evaluated current initiatives that address the needs and considered new initiatives to establish our implementation plan.

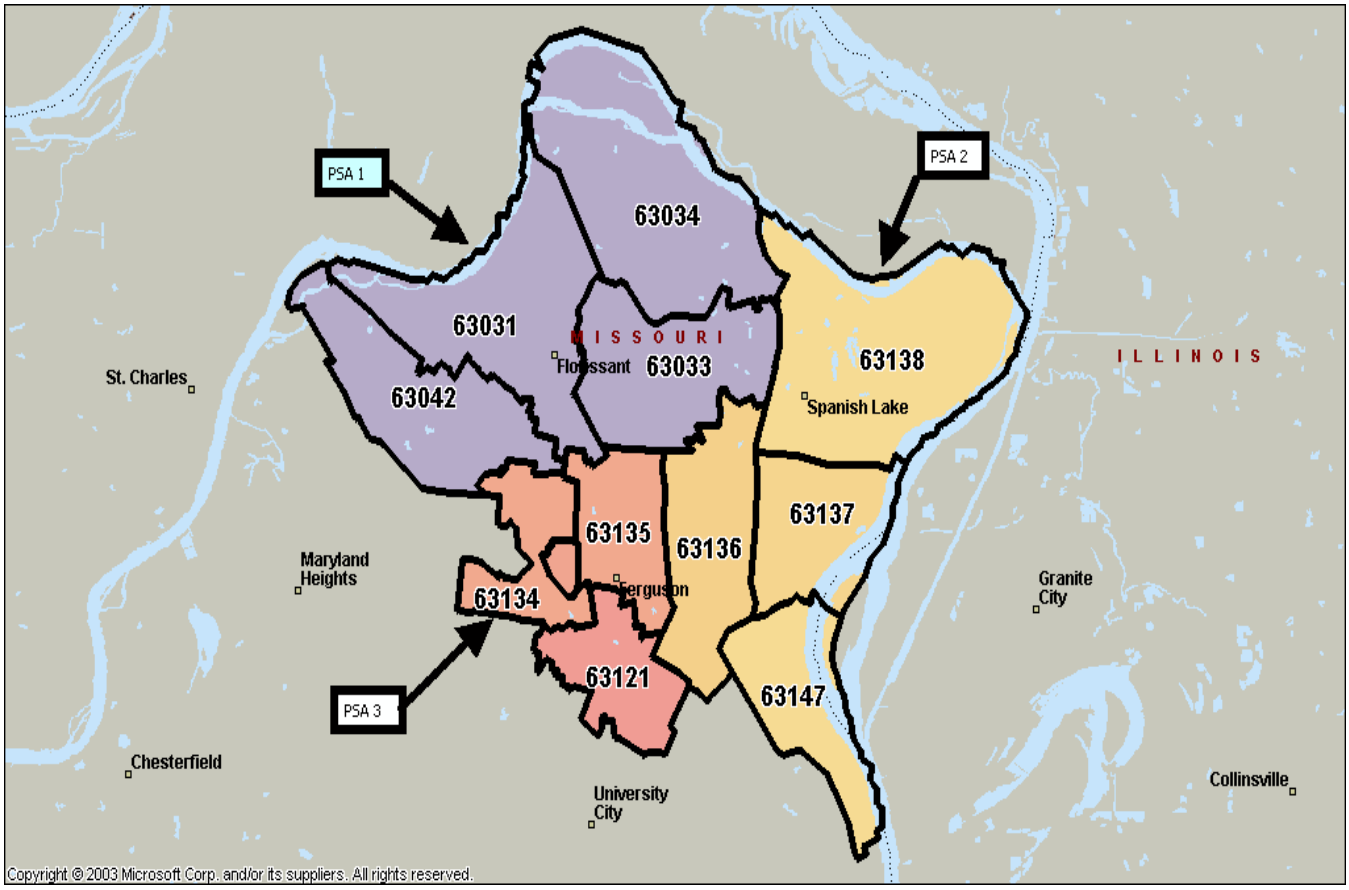
These findings have identified the top 10 health needs of the north St. Louis County community and the top three areas where focus is most needed.

## II. COMMUNITY DESCRIPTION

We defined our community as the Christian Hospital primary service area (PSA) and north St. Louis County.

# NORTH PSA MAP

Care for Life℠




The *2011 St. Louis County Health Needs Assessment* determined different findings and variations in north St. Louis County as compared to St. Louis County and Missouri overall. Further, the *Decade Review of Health Status for St. Louis City and County 2000-2010* released December 2012 provides additional information on health disparities. An explanation of a few of the findings:

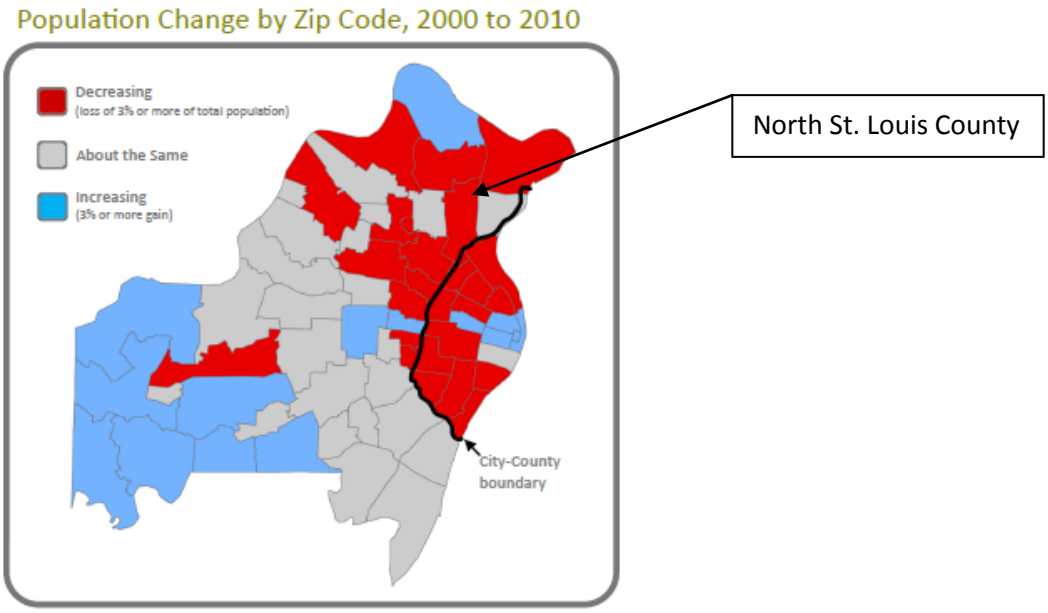
**Income:** St. Louis County has a relatively high median income ($57,502) compared with Missouri ($46,005), but this varies tremendously within the county; in North County, the median income ($44,919) is almost half that of the West County ($85,210).

**Unemployment:** The unemployment rate in St. Louis County (9.1%) is comparable to the Missouri rate (9.5%); however, several parts of the county (e.g. North and Mid County unemployment rates are 13% and 10%, respectively) have high rates of unemployment—well over 10%.

**Age and Race:** North County Population under the age of 18 (21%) is fairly comparable to that of St. Louis County; population 65 and over is identical to St. Louis County (15%). African-Americans comprise 45% of the North County community versus 20% in St. Louis County overall.

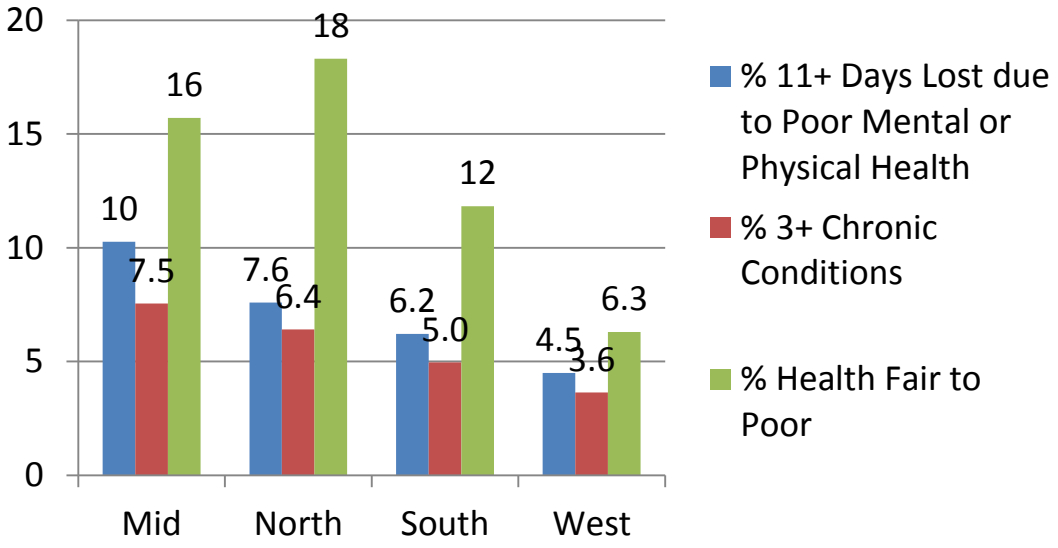
**Education and Uninsured:** The population (aged 25+) without a high school diploma trends much higher (15%) than that of St. Louis County (9.6%). This may also correlate to the number of uninsured members of the community. North County has 14% uninsured compared to 9.3% in St. Louis County.

**Population:** The population change reflects a loss of higher educated persons, higher wage earners and commercially insured persons in the North County community.



**Wellness:** Due to limited access to care and lack of insurance, the wellness of North County is significantly worse than that of south and west areas of St. Louis County.

Wellness of Sub-Counties
(per St. Louis County Health Needs Assessment)




As will become evident in the full demographic summary on the following two pages, the North County community has cultural, educational and socio-economic indicators that are different than that of the core of St. Louis County. The disparities in the community are dramatic and have an impact on health and wellness.

The demographics of North St. Louis County (per the St. Louis County Health Department *2011 Health Needs Assessment*) are as follows:

## Demographic Summary North County

| INDICATOR | NORTH COUNTY | ST. LOUIS COUNTY |
|---|---|---|
| **A. Demographics** | | |
| **Population:** 2009 Census Estimate | 249,807 | 992,412 |
| **Median Household Income :** 2005-2009 American Community Survey 5-Year average Estimates | $44,919 | $57,502 |
| **Age:** Population under the age of 18 | 21% | 23% |
| **Age:** Population age 65 and over | 15% | 15% |
| **Race** | White: 53%<br>Black: 45%<br>Other: 2% | White:76%<br>Black: 20%<br>Other: 4% |
| **Education:** Percentage of population (age 25+) without high school diploma | 15% | 9.6% |
| **Uninsured (all ages):** Percentage of population uninsured | 14% | 9.3% |
| **B. Health Status** | | |
| **3+ Chronic Conditions**: Percentage of adults diagnosed with three or more chronic Conditions | 6.4% | 5.6% |
| **Wellness Profile**: Percentage of adults within "well" category | 36% | 39% |
| **Health Fair to Poor**: Percentage of adults reporting fair to poor health status | 18% | 10% |
| **C. Primary Care** | | |
| **Access to Care:** Percentage of adults who did not have access to care due to cost | 11% | 9.2% |
| **ED visits – Ambulatory Care Sensitive (ACS) Conditions:** Emergency Department visits rate for ACS conditions per 100,000 population | 5,149 | 2,523 |
| **Regular Source of Care:** Percentage of adults reporting no regular source of care | 20% | 16% |
| **Hospital admissions - ACS Conditions:** Admission rate for ACS conditions per 100,000 Population | 2,903 | 1,947 |
| **D. Cardiovascular Health** | | |
| **High Blood Pressure:** Percentage of adults diagnosed with high blood pressure | 38% | 31% |
| **Acute Myocardial Infarction (AMI) Hospital Admissions:** AMI hospitalization rate per 100,000 population | 153 | 113 |
| **Heart Disease - Mortality:** Number of deaths due to heart disease per 100,000 population | 321 | 258 |
| **Current Smoking:** Percentage of adults who currently smoke | 17% | 15% |
| **Sedentary Lifestyle:** Percentage of adults without physical activity | 29% | 22% |
| **Obesity:** Percentage of adults reporting BMI greater than 30.0 | 36% | 27% |
| **Cholesterol:** Percentage of adults diagnosed with high cholesterol | 25% | 27% |
| **Stroke:** Hospital admissions rate per 100,000 population | 247 | 186 |
| **Rehab – Heart Attack:** Percentage of adults in rehabilitation after a heart attack | 40% | 40% |
| **Rehab – Heart Stroke:** Percentage of adults in rehabilitation after a stroke | 40% | 33% |
| **E. Respiratory Health** | | |
| **Current Asthma:** Percentage of adults that currently have asthma | 12% | 8.4 % |
| **Chronic Obstructive Pulmonary Disorder (COPD)**: Percentage of adults diagnosed with COPD | 3.2% | 2.4% |
| **F. Diabetes** | | |
| **Diabetes**: Percentage of adults diagnosed with diabetes | 12% | 9.4% |
| **Hemoglobin A1c Measurement**: Percentage of adults diagnosed with diabetes who reported a hemoglobin A1c measurement at least once in past year | 97% | 93% |
| **Diabetes - Hospital Admissions:** Hospitalization rate per 100,000 population | 306 | 168 |

## Demographic Summary North County

| INDICATOR | NORTH COUNTY | ST. LOUIS COUNTY |
|---|---|---|
| **G. Cancer Health** | | |
| **All Cancer** – **Incidence Rat**e: All cancer incidence rate per 100,000 population. | 602 | 556 |
| **Breast Cancer – Incidence Rate**: Breast cancer incidence rate per 100,000 female population | 171 | 162 |
| **Colorectal Cancer –Incidence Rate:** Colorectal cancer incidence rate per 100,000 population | 65 | 56 |
| **Prostate Cancer – Incidence Rate:** Prostate cancer incidence rate per 100,000 male population | 174 | 179 |
| **Lung and Bronchus Cancer – Incidence Rate:** Lung and bronchus cancer incidence rate per 100,000 population | 102 | 81 |
| **All Cancer – Mortality Rate:** Number of deaths due to all cancers per 100,000 population | 236 | 210 |
| **Pap Smear**: Percentage of females reported having a pap smear within the past two year | 63% | 62% |
| **Mammogram**: Percentage of females (age 40+) reported having a mammogram within the last year | 57% | 60% |
| **Colonoscopy:** Percentage of adults (age 50+) reported having colonoscopy within past 5 Years | 56% | 60% |
| **H. Mental Health** | | |
| **Depression**: Percentage of adults ever diagnosed with depression | 15% | 17%. |
| **Psychosis – Hospital Admission Rate:** Hospitalization rate per 100,000 population | 1,248 | 796 |
| **Major Depressive Disorder – Hospital Admission Rate:** Hospitalization rate per 100,000 population | 336 | 246 |
| **Schizophrenia – Hospital Admission Rate:** Hospitalization rate per 100,000 population | 363 | 191 |
| **Anxiety – Hospital Admission Rate:** Hospitalization rate per 100,000 population | 324 | 208 |
| **Suicide – Mortality rate:** Number of deaths due to suicide per 100,000 population | 13 | 11 |
| **I. Substance Abuse** | | |
| **Substance Abuse – Hospital Admission Rate:** Hospitalization rate per 100,000 population St. Louis County | 162 | 134 |
| **Alcohol-related Deaths – Mortality Rate**: Number of deaths due to alcohol per 100,000 population | 4.7 | 4.0 |
| **Motor-vehicle Accidents – Mortality Rate**: Number of deaths due to motor vehicle accidents per 100,000 population | 12 | 8.2 |
| **Binge Drinking**: Percentage of adults who reported binge drinking in past month | 9.1% | 13% |
| **J. Infectious Disease** | | |
| **Gonorrhea – incidence rate**: Gonorrhea per 100,000 population | 370 | 150 |
| **Chlamydia – incidence rate:** Chlamydia per 100,000 population | 1,194 | 501 |
| **K. Reproductive Health** | | |
| **High-Risk Pregnancy – Hospital Admission Rate:** Hospitalization rate per 100,000 female population, ages 10-44 | 980 | 539 |
| **Infant Mortality Rate:** Deaths to infants from birth through 364 days of age, per 1,000 live births | 12 | 8.0 |
| **Prematurity:** Percentage of births following a gestational period less than 37 weeks | 17% | 14 % |
| **Low Birthweight:** Percentage of live births weighing less than 2500 grams | 11% | 9.1% |
| **Teen Birth Rate:** Teen (10-17) birth rate per 1,000 females | 10.0 | 5.3 |
| **Inadequate Prenatal Care:** Percentage of pregnant women with inadequate prenatal care (Modified Kessner Index) | 14% | 8.5% |

## III. CONDUCTING THE NEEDS ASSESSMENT

**Organizational Structure**
The task force committee met several times over the course of a year in order to determine the essential needs in the North County community. They reviewed the data provided by the external focus group as well as data compiled through the St. Louis County Community Health Needs Assessment (2011). In addition, each member ranked the various community needs in priority based upon their expert opinion.

Christian Hospital Community Health Needs Task Force:
Manager, BJC Market Research
CH EMS Manager
CH Vice President, Patient Care Services and Chief Nurse Executive
BJC Vice President, Community Affairs
BJC Community Benefit Manager
Manager, Infection Prevention
Certified Asthma Educator
Program Director, Case Management
Chief, Emergency Medicine
Director Behavioral Health and CMR
Executive Director, CH Foundation
Nurse Manager, CH Hospitalist Services

In addition to the data collection completed through the committee, Christian Hospital partnered with SSM DePaul Health Center, St. Louis, MO and the St. Louis County Health Department to ensure that needs prioritization was done accurately. The meeting was held at Northwest HealthCare in Florissant. It was moderated by the Manager of Market Research for BJC HealthCare. Twelve individuals representing various North St. Louis County organizations were in attendance. The full focus group report, as well as the list of the attendees, can be found in **Appendix A**. Representatives from the following organizations attended the focus group:

### PARTICIPANT ROSTER

1. Community and Organizational Change Consultant
2. Executive Director, Emerson Family YMCA
3. Precinct Commander, St. Louis County Police Department
4. President, Spanish Lake Community Association
5. Alderman, City of Ferguson
6. Administrator, City of Maryland Heights
7. Representative, St. Louis County Dept. of Health
8. Representative, Serenity Women's Healthcare, Inc.
9. Representative, John Knox Presbyterian Church
10. Representative, Spanish Lake Community Association
11. Vice President, Clinical Services, People's Health Center
12. Site Manager, People's Health Center

**Primary Data Collection**
To fulfill the PPACA requirement to obtain input from experts in the area of public health and those who have a special interest in the population, the two north county hospitals (SSM DePaul Health Center and Christian Hospital) agreed to collaborate to conduct a focus group (primary data). Prior to this meeting, 19 individuals who were invited to attend were sent a worksheet designed to assess their perception of the greatest needs of North County residents, their knowledge of available resources to address these needs and the greatest "gap" that exists between need and available resources. Using this input, data on the needs of North County residents was shared at a meeting on April 4, 2012 along with secondary data that attempted to quantify the size of the need. After the presentation, the group was asked to re-evaluate their perception on the greatest needs in North County. These results were compiled and reported. Process and finding information regarding the focus group can be found in the attached report, *Perceptions of the Heath Care needs of North St. Louis County from the Perspective of Community Leaders* (**Appendix A**).

**Secondary Data Analyses:**
Secondary data included the *2011 St. Louis County Health Community Health Needs Assessment* (www.stlouisco.com/HealthandWellness); this report broke data down into county region (i.e. North County). In addition it provided a comparison of county region versus county region (i.e. North County vs West County) and county region versus state totals. Analysis also included MICA (Missouri Information for County Assessment) data that compared St. Louis County data to state data, and the *Decade Review of Health Status for St. Louis City and County 2000-2010* released in December 2012 by the St. Louis Regional Health Commission (STLRHC) (http://stlrhc.org/HealthStatusReport.aspx). Rankings for the St. Louis County Health Needs Assessment data were determined by incidence and mortality rates that were significantly higher in one county region compared to the county as whole and/or state rates. MICA data was ranked based on: Death Trends (significant compared to state), Hospital Days, Number of Hospital Admissions, Number of ED visits, Number of Deaths and Racial Disparity for Death (http://health.mo.gov/data/mica/PriorityMICA). STLRHC data was limited to those recognized nationally as leading causes of death and/or poor health outcomes and chief contributors to health care system costs.

**Prioritization of Health Needs:**
Community health needs were ranked by the April 4th Focus Group – in order of how many times participants mentioned the need, by incidence and mortality rates for North County when compared to County and/or State rates (STL County Health Department Health Needs Assessment), by the MICA prioritization tool and by a survey of our internal committee.

Our internal committee was asked to rank based upon their professional opinions of impact of need, prevalence, community resources and the organization's ability to address the need.

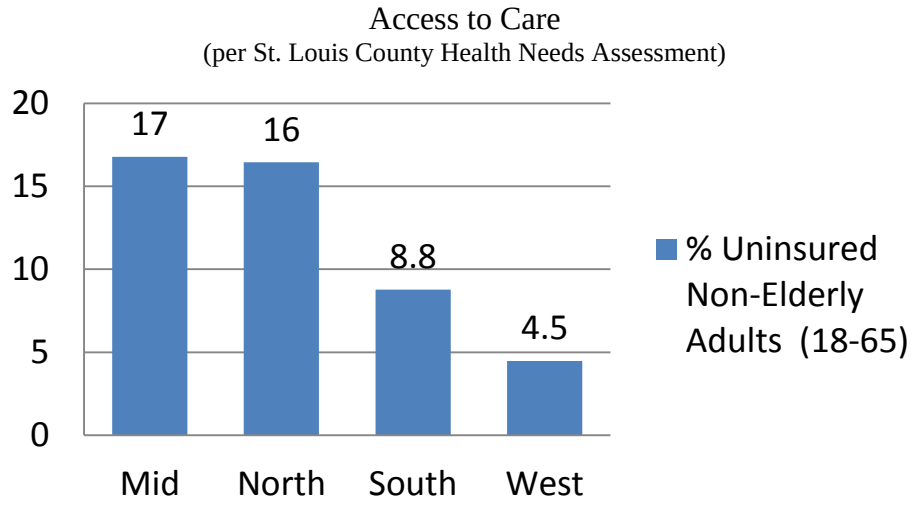
## Prioritization of Health Needs (in Alphabetical order)

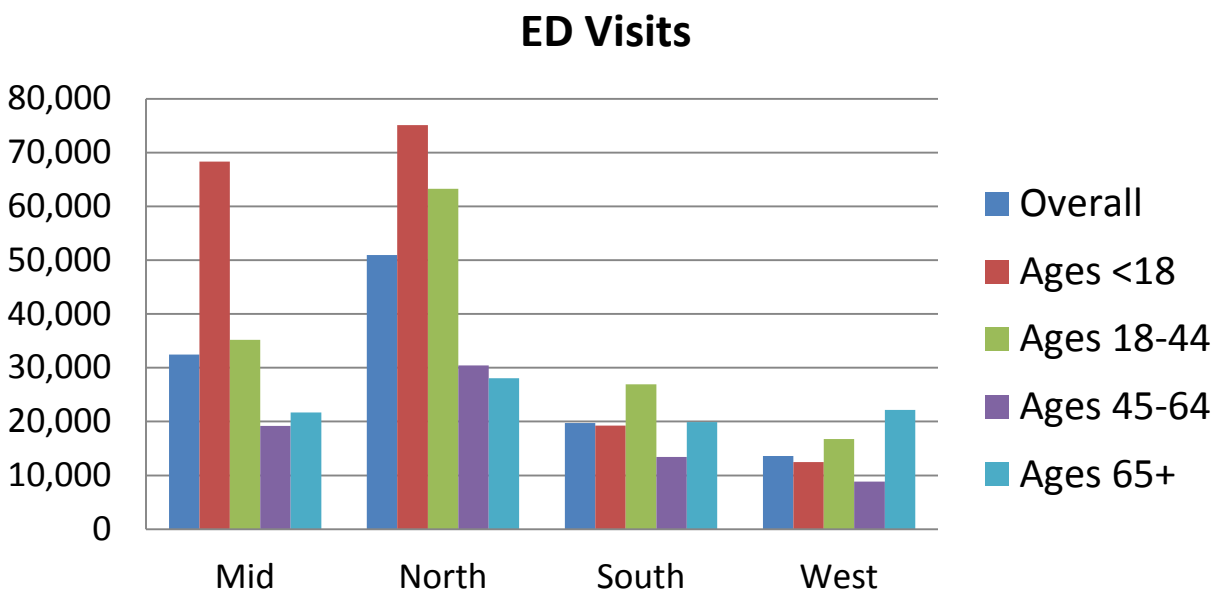
| | STL Co CHNA | Focus Group | MICA | Committee | Average | Final |
|---|---|---|---|---|---|---|
| Access to Care | 3 | 2 | NA | 1 | 1.6 | 2 |
| Cancer | 6 | 5 | 2 | 9 | 5.5 | 6 |
| Child Welfare | 7 | 7 | NA | 4 | 6 | 7 |
| Chronic Care | 1 | 1 | 1 | 2 | 1.25 | 1 |
| Dental Care | 8 | 9 | 7 | 10 | 8.5 | 10 |
| Infectious Disease | 2 | 6 | 5 | 5 | 4.5 | 4 |
| Mental Health/ Substance Abuse | 4 | 3 | 3 | 5 | 3.75 | 3 |
| Reproductive Health | 5 | 4 | 4 | 7 | 5 | 5 |
| Senior Care | NA | 9 | NA | 8 | 8.5 | 9 |
| Socio-economic factors | NA | 10 | 6 | 2 | 6 | 8 |

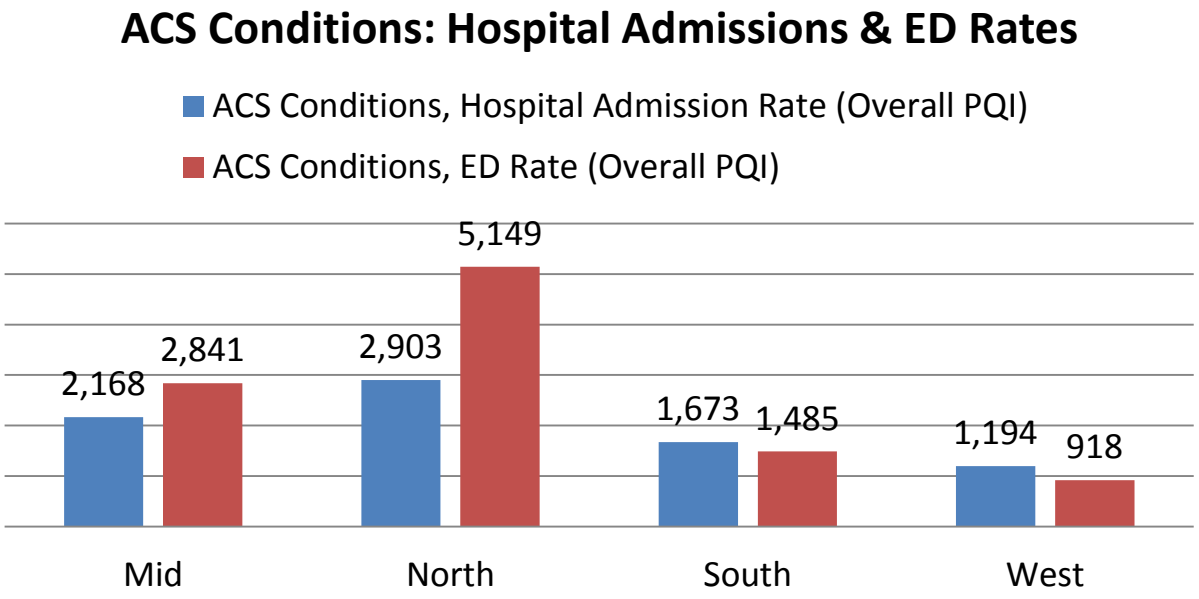
In addition, through the *St. Louis County Community Health Needs Assessment*, a number of issues were highlighted for large disparities as compared to surrounding communities.

**Primary Care Quality and Effectiveness**: Access to and availability of high quality primary care, especially for the population with chronic health conditions, is not consistent across St. Louis County. The county overall has low ED rates and in-patient hospital use rates for ambulatory care sensitive conditions (ACS) (2,523 per 100,000 population and 1,947 respectively). These are visits/admissions for conditions such as asthma and diabetes among others that are less likely to result in inpatient or ED use when treated on an outpatient basis with high quality primary medical care and patient adherence.

However, North County has very high ACSC ED rates (5,149) and hospital rates (2,903) relative to the rest of the county. This can indicate an inadequate availability of providers, lack of health insurance, or poor patient self-management, among other patient, health system, or population issues.

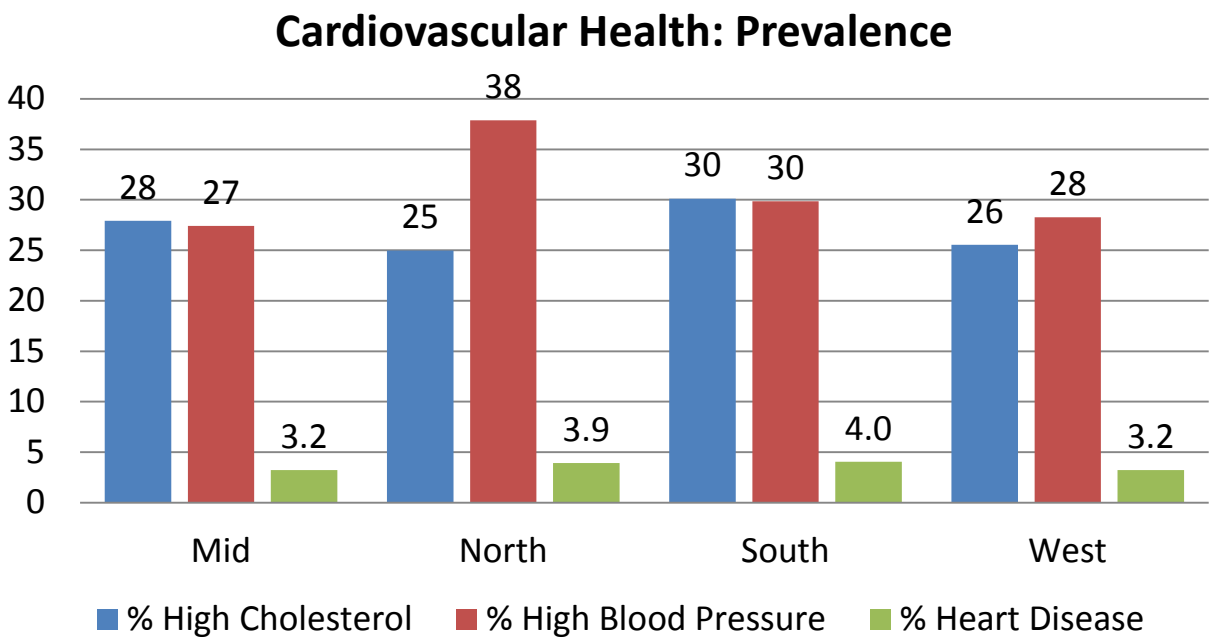




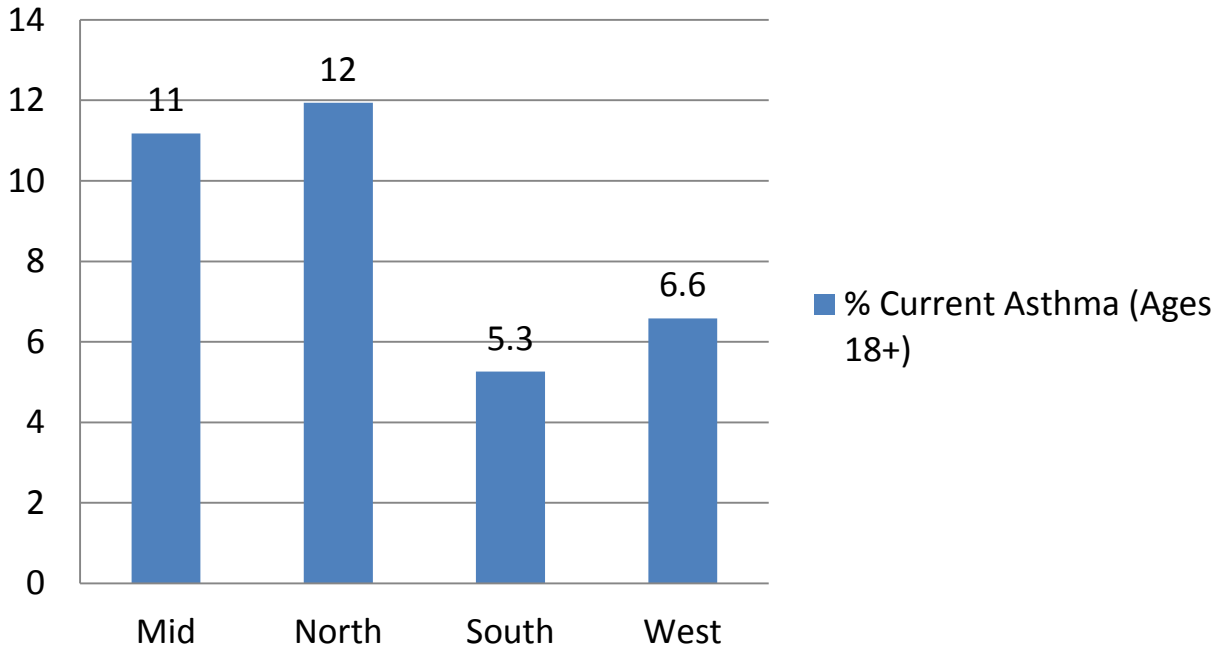




**Behavioral Risk Factors:** Behavioral health risk factors such as obesity (36%) and sedentary lifestyle (29%) in North County are higher than St. Louis County as a whole, (obesity 27%, and sedentary lifestyle 22%), the state of Missouri (obesity 31% and sedentary lifestyle 27%) and the U.S. rates (obesity 36% and sedentary lifestyle 24%).

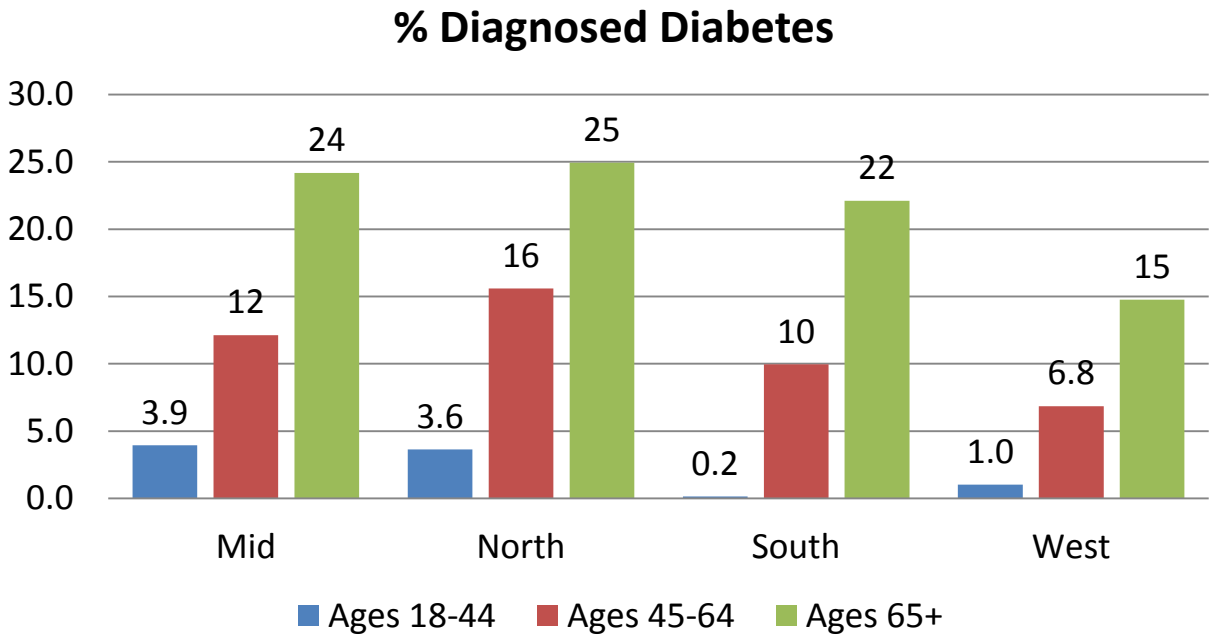
**Heart Health:** Prevalence rates of medical risk factors for cardiovascular disease are of some concern (County wide high blood pressure prevalence is 31%; high cholesterol prevalence is 27%), as are high rates of morbidity and mortality for select cardiovascular conditions in certain parts of the county (e.g. heart disease mortality rate is 321 deaths per 100,000 population in North County; by comparison, the state mortality rate for heart disease is 239 deaths per 100,000 population).




**Lung Health:** Adult asthma prevalence (diagnosed) is high in North (12%) and Mid County (11%), as are ED visits for asthma (2,080 per 100,000 population and 1,092, respectively).



**Diabetes:** The prevalence rate is especially high in Mid and North Counties (24% and 25%, respectively); the two sub-county areas have higher rates of obesity and sedentary lifestyles as well. Inpatient admissions and ED visit rates for diabetes also correlate with diabetes prevalence and risk factors, as do diabetes mortality rates.



In direct correlation with the findings and disparities listed above, the data was combined providing an average ranking. When all rankings were combined, needs were prioritized in the order below. Where applicable, illustrative data points are provided.

1. **Chronic Disease** includes, but is not limited to: diabetes, pulmonary disorders, obesity, cardiovascular health, stroke, arthritis/lupus, sickle cell anemia, wound care

   The focus group was greatly concerned with these issues:

   Obesity
   i) 36% of North County residents are obese compared to 27% in STL County and 31% in MO

   Diabetes
   i) ED visits and hospital admission rates due to diabetes complications are significantly higher in North County compared to STL County
   ii) For the past 6 years, 33%-35% of all Christian Hospital inpatients have been diabetic

   Asthma
   i) Asthma ED visit and hospitalization rates are significantly higher for North County residents compared to county and state totals
   ii) Hospital data and internal committee confirm the high rates of asthma
   iii) Asthma is among the top 5 reasons for emergency room visits and hospitalizations in North St. Louis County
   iv) ED visits and hospitalizations for asthma in North St. Louis County are higher than the rate for St. Louis County as whole

2. **Access to Care** – includes, but is not limited to: care for uninsured, primary care access, care coordination between providers (i.e. clinic, ED, hospital, primary care physician)
   - Mentioned more than any other issue by focus group
   - Between 14% and 27% of all North County respondents lack access to some type of basic medical care, which is higher than the rest of St. Louis County
   - Uninsured patient rate at CH is between 11%-13%
   - Internal committee often sees the negative effects of the lack of care continuity/coordination
   - The percentage of uninsured patients is higher in North County as compared to St. Louis County

3. **Mental Health/Substance Abuse** also includes: Alzheimer's and dementia
   - Hospital admission rates for psychoses, various mental disorders and drug/substance related disorders are significantly higher in North County compared to St. Louis County or MO

4. **Infectious Disease** – includes, but is not limited to: influenza, sexually transmitted disease, pneumonia, HIV/AIDS
   - Gonorrhea and Chlamydia rates are more than double in North County compared to St. Louis County or MO
   - HIV related admissions and mortality rates are more than double in North County compared to St. Louis County or MO

5. **Reproductive Health** includes, but Is not limited to: pregnancy complications, high risk pregnancy, teen pregnancy
    - Teen pregnancy rate is twice as high in North County compared to St. Louis County or MO
    - Low-birth weight, prematurity and infant/neonatal mortality rates are significantly higher in North County as opposed to St. Louis County or MO

6. **Cancer** includes all cancers
    - Incidence higher (602) in North County compared to St. Louis County (556) and MO (502) *rates per 100,000

7. **Child Welfare** includes, but is not limited to: health, abuse, neglect, development
    - Ranked by *St. Louis County Health Department Health Needs Assessment* and Focus Group in top 10

8. **Socio-economic Factors** include, but are not limited to: employment, neighborhood preservation, violence, crime, race relations
    - Ranked by the focus group and MICA in top 10

9. **Senior Care** (specific to needs of individuals 65+)
    - Senior care was identified as a top ten need by the focus group

10. **Dental Health**
    - Access to dental health services was ranked in the top ten by MICA. Practitioners in Christian Hospital's emergency departments see numerous cases of medical treatment needed to address dental concerns

## IV. IMPLEMENTATION PLAN

The North County community has health needs that are different from those of the remainder of the St. Louis County community. While North County residents need a number of different services based upon the rankings, Christian Hospital is positioned to provide excellent healthcare in the top two health needs; Chronic Disease and Access to Care.

The following programs have been selected as directly impacting the health of our community.

# A. NEEDS THAT WILL BE ADDRESSED BY CHRISTIAN HOSPITAL

### Chronic Disease - Diabetes Prevention Program

**Rationale:** Diabetes is the leading cause of new cases of blindness, kidney failure, and non-traumatic lower limb amputations among adults. Diabetes is also a major cause of heart disease and stroke. Diabetes was the seventh leading cause of death in the United States in 2011- overall, the mortality risk among people with diabetes is about twice that of people without diabetes of the similar age.

Diabetes affects 25.8 million Americans, or 8.3% of the United States population. The prevalence rate of diabetes in the hospital community is especially high in the Mid and North Counties (11% and 12%, respectively) compared to other areas of St. Louis, and the two sub-county areas have higher rates of obesity and sedentary lifestyles, both risk factors of diabetes. The diabetes mortality rate is also highest in North County and 14% of North St. Louis County residents are uninsured which impact their access to care and education about their disease.

Effective therapy can prevent or delay diabetes complications. However, seven million Americans with diabetes are undiagnosed, and another 79 million Americans have pre-diabetes which greatly increases their risk of developing diabetes in the next several years. Few people receive effective preventative care, which makes diabetes an immense and complex public health challenge. If the awareness of pre-diabetes and diabetes increases in North County, it will positively impact the health of the community, therefore the hospital will offer free community screenings and education programs. The screenings will help increase awareness about pre-diabetes and diabetes and ideally lead to earlier interventions by the patient's provider. Referrals will be made to the hospital's education program as appropriate. The formal education program will be available at the hospital to help patients and their families learn how to prevent or delay diabetes complications. The outcomes of the education program are positive: an average of one percent decrease in HgbA1c and 4 lbs. of weight lost by the end of the program. (A one percent decline in HgbA1c decreases the risk of micro-vascular complications by 35%, diabetes related deaths by 25%, and heart attacks by 18 %.)

***Program Goals:***

I. *Increase the awareness of pre-diabetes and diabetes in the primary services area of Christian hospital.*

*II. Increase the number adolescents and adults with pre-diabetes/diabetes who receive formal education in our community. (Healthy People 2020 –Objective D-14)*

***Program Objectives:***

***Goal I Objectives:***

*Increase the awareness of pre-diabetes and diabetes in the primary services area of Christian hospital.*

a. Maintain the number of glucose and HgbA1c screenings as prior year.
b. Increase the number of screening locations by 5% over prior year.
c. To seek that 30% of abnormal screenings seeks further medical evaluation and intervention during each screening.

***Program Action Plan: Pre-diabetes and Diabetes Screenings***

The Diabetes Screening Team (DST) provides free screenings at various locations four times per week from 9:30 AM – 12:30 PM. The screening locations are promoted through postcards mailed to 30,000 households quarterly, the hospital website, the Diabetes Institute, 314-747-WELL (9355) calls, posters within the hospital, and various hospital health fairs.

Any patient with an abnormal screening result will be recommended to follow-up with their physician for further testing and a copy of the result will be faxed to provider's office with the patient's consent. If the patient does not have a physician, they are given the BJC referral line, 314-747-WELL (9355); any uninsured patients will be referred to a clinic. The Christian Hospital Diabetes Institute staff will follow-up with all abnormal screening with a phone call a week or two after the screening to see if the patient has seen a physician or at least has plans to do so. If the patient is not able to be reached by phone, a letter is mailed with additional education information. Patients are also encouraged to attend the formal education classes for diabetes prevention or diabetes management at the outpatient center.

***Program Outcome:*** Early diagnosis of diabetes

***Program Outcomes Evaluation:***

The number of screenings will be tracked daily and the locations will be tracked annually. Abnormal glucose and HgbA1c screenings will also be tracked in addition to the number of follow-up calls or mailing related to abnormal findings. We will also track the number of individuals who stated that they received a medical care or intervention after they were screened.

***Program Goal II Objectives:***

*Increase the number of adolescents and adults with pre-diabetes/diabetes who receive formal education in our community.(Healthy People 2020-objective D-14)*

a. Increase the number of patients educated by 5% over prior year
b. Increase the number of uninsured patients educated by 5% over prior year.

c. Maintain a one percent decrease in HgbA1c from baseline to completion of the program.
d. Increase patient's goal achievement of a (4) or (5) rating from 50% to 55%.

***Program Action Plan: Pre-diabetes and Diabetes Self-Management Education Program***

The hospital will offer pre-diabetes and diabetes self-management classes to the hospital community to educate patients on lifestyle changes to prevent diabetes or improve their diabetes control. The program is recognized by the American Diabetes Association and is taught by a nurse and a registered dietitian who are both certified diabetes educators. Participants will attend an initial class with two follow-up visits at three months and one year. Weight and HgbA1c are tracked at each visit to monitor progress.

The program will be promoted through the screening outreach team, inpatient clinicians, social media, the hospital website, and mailers to physicians.

***Program Outcomes Evaluation:***

The education program will track the total number of participants as well as the number of uninsured patients that attend. Outcomes such as HgbA1C and weight at baseline and follow-up visits will be tracked as well as the patients' goal achievement at each follow-up visit.

## Chronic Disease - Obesity in our community

**Rationale:** Overweight/obesity remains a growing concern in the county, state and country. Obesity is linked to major chronic conditions such as heart disease, diabetes, arthritis, cancer and stroke. According to the community health needs assessment, North County's obesity rate is at 36 percent, compared to the St. Louis County rate of 27 percent, showing a great need in this area for education and assistance in losing weight. If the obesity rate in North County is reduced it will positively impact the health of the community; therefore, the hospital will offer the Just Lose It weigh loss challenge two times each year. Each session will last 12 weeks. Just Lose It does demonstrate a decrease in weight among participants by approximately 4% percent per round.

***Program Goals:***

*I. Reduce the incidence of overweight and obese individuals in North County.*
*II. Educate individuals on healthy lifestyle behaviors.*

***Program Objectives:***

***Program Goal I Objectives:***

*Reduce the incidence of overweight and obese individuals in North County.*

a. Increase "Just Lose It' participation by five percent from the prior session.
b. Increase adult participation completion rate from 30 to 40 percent from the prior session.
c. Increase group weight loss at each session by one percent from the number of the previous session.

***Program Action Plan: Just Lose It***

Since 2009, Christian Hospital marketing and communication department has offered the weight management program, in collaboration with these partners:

- City of Bellefontaine Neighbors – weigh-in site and offers free exercise classes to participants, from power walking to water aerobics as challenges in the program
- Christian Hospital Occupational Health – weigh-in site and offers free flu shots to participants
- Curves – weigh-in site
- Emerson Family YMCA – weigh-in site and offers free workout classes for challenges in the program
- Ferguson Bicycle Shop – weigh-in site and offers free bike rides for challenges in the program.
- Christian Hospital Outpatient Rehabilitation Services – weigh-in site
- City of Florissant – Both the James Eagan Center and JFK Center – weigh-in sites

- St. Louis County Parks – weigh-in site and offers the participants a free week of walking at their track for challenges for the program.

This program fills up with 400+ participants in each session. We have increased the number of participants accepted to meet the high demand. This will allow the program to increase by 5% each session. In 2011, challenges were added to encourage people who are not in the top 10 to continue to participate. We will continue to offer challenges with incentives of a chance to win prizes at the events finale to increase the percentage of participants to stay in the program. We have also recruited a physician champion that records inspiring messages that are sent out on a weekly basis. He communicates with participants through Facebook. A Facebook page has been created for participants to share their stories and connect with other participants. It also gives us a way to share additional tips, information and motivation with participants. A weekly newsletter is given to all participants at their weigh-in sites with tips and recipes as another incentive to keep them engaged. By keeping participants engaged and motivated, a higher percent should complete the 12-week session and be successful in losing weight. To help assist participants with their weight loss goals, a weekly workout class is offered. To maintain interest, additional programs will be conducted during the 12-week sessions. Attendees will be entered into prize drawings based on the number of programs attended. The top 10 individuals with the greatest percent of weight loss will be recognized and awarded prizes at the closing celebration. Before and after photos will also be displayed.

***Program Outcomes***: To decrease the incidence of obesity in North County

***Program Outcomes Evaluation:***

Participants and the program coordinator track weights during weekly weigh-in to determine the top 10 individuals at the end of the program as well as to measure the total group weight loss during session. The total group weight loss of each session will be compared to the previous session weigh loss number to determine if there was an improvement.

***Program Goal II Objectives:***

*Educate individuals on healthy lifestyle behaviors.*

a. The staff will set a baseline of overall response rate of class participants who will incorporate healthy life style change into their life.
b. Every year, over all participant response rates of those who incorporate a healthy life style change into their life will increase by 5% from the previous year response rates.

***Program Action Plan: Nutritional Education Programs***

Nutritional classes along with cooking demonstrations will be conducted during the 12-week program by registered dietitians. In these classes the participants will gain knowledge about the right and wrong foods to eat, how to prepare healthy food, how to change their lifestyle and diet and different methods to use to track what they are eating, from carb counting to reading labels. Questionnaires will be distributed at end of each class asking participants if they learned something new from the class, if they plan to make a change in lifestyle based on this knowledge and rate their motivation to make this change.

***Program Outcomes:*** To increase healthy lifestyle behavior among North County population

***Program Outcomes Evaluation:***

Both Just Lose It programs of North County will be evaluated by tracking data on the number of participants, completion rates, and average group weight loss.

Pre-and-Post survey will be given to participants at the beginning and the end of the sessions. The two surveys will be analyzed to determine if there is a change in the participant's response rate in order to measure the likelihood of participants to incorporate the educational aspects that they learned into their lifestyle.

## Access to Health Care

***Rationale:*** Access to healthcare is an ongoing and national concern. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It allows individuals to gain entry into the health care system, access a health care location where needed services are provided and find a health care provider with whom the patient can communicate and trust.

There are several components of access to health services, such as coverage, services, timeliness, and workforce. BJC HealthCare, as a system of hospitals, understands the importance of health insurance coverage, which helps patients get into the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Therefore, all BJC hospitals have a policy that focuses on the provision of insurance coverage as the principal means of ensuring access to health care among the underinsured and uninsured population.

***Program Goal:***

- *To improve access to comprehensive, quality health care services.*

***Program Objective:***

*Every year, Christian Hospital will offer Medicaid and financial assistance enrollment to 100% of eligible patients presented for medical care.*

***Program Action Plan:***

- Christian hospital provides a Patient Account Representative who works with a Case Manager and a Social Worker to identify patients in need of assistance and meets with uninsured patients to determine their eligibility for any insurance and financial assistance. Eligible patients receive assistance with enrollment.

***Program Outcome:*** *Increase access to health care services*

***Program Outcome Measurement:***

The number of individuals who receive assistance for insurance eligibility and the number of those who are enrolled in programs are tracked by the hospital.

## B. Needs that will not be addressed by Christian Hospital:

Christian Hospital is positioned to actively impact the top two community health needs as identified through this study. The health needs below are not currently being addressed through this study; however Christian Hospital has programs in place that allow us to influence five of the top 10 community health needs. (Listed in order of priority of needs 3-10)

**Mental Health** – The hospital does not currently have the financial ability to actively educate and screen the community. We offer support groups for substance abuse and other mental diagnosis through our outpatient mental health center.

**Infectious Disease** – The hospital does not currently have the financial ability to actively educate and screen the community for infectious disease. We do however, provide funds for free flu shots given in the community.

**Reproductive Health** – The hospital does not currently offer clinical support for obstetrics, thus a focus on reproductive health is minimal.

**Cancer** – Community benefit programs are currently funded that allow us to address cancer education and prevention such as the Men's Healthy Happy Hour where we conduct PSA screenings and the Mammo-thon, providing mammograms for underinsured women in the community. However, we do not actively coordinate a program outside of our Komen grant. The greater community is actively involved with events through the American Cancer Society.

**Child Welfare** – The hospital does not currently have a pediatric unit and outside of seeing children in the ED, they are transferred to a facility that can accommodate them. Our hospital and EMS trucks are considered a "safe place" and we partner with Youth In Need to ensure our youth have access to basic needs outside of medical treatment.

**Socio-economic Factors** – The hospital partners with organizations within the community to positively impact the growth of this area. We are a leading employer in the county and partner with various Community Development Corporations and community development organizations in an effort to improve the neighboring communities.

**Senior Care** – The hospital does not currently offer senior care outside of the management of Village North Retirement Home.

**Dental Health** – The hospital does not currently have the clinical opportunities to provide dental care to our community members.

## Specific Input from the St. Louis County Health Department

**Health Department Representative:** Jamie Opsal

**Title/Department Name:** Public Health Coordinator, St. Louis County Health Department

**Source of Need Information:** St. Louis County 2011 Health Needs Assessment

**Public Health Department Identified Need #1:** Access to Care and Quality of Care

Christian Hospital will address this need by targeting uninsured asthma patients to increase primary care referrals, provide prescription assistance and asthma equipment, when needed.

The anticipated impact of these activities will be to reduce emergency room visits and hospitalizations related to asthma while at the same time, ensuring that uninsured asthma patients have access to appropriate levels of care, medications and treatments.

The effectiveness of these programs will be evaluated by monitoring the number of ER visits and hospitalizations for uninsured asthma patients compared to previous time periods. The hospital will also track the number of new patients seen, as well as the number of patients to whom it provides prescription assistance, asthma equipment, and primary care physician referrals.

**Public Health Department Identified Need #2:** Chronic Disease Prevention and Management

Christian Hospital offer programs to screen individuals for diabetes and pre-diabetes and will encourage follow-up of abnormal results. The hospital will also provide education to those in the community with diabetes so they can be more attentive to their condition.

The anticipated impact of these activities will be to reduce the impact of diabetes by increasing awareness of it, and offering education about its prevention and management.

The effectiveness of these programs will be measured by tracking the number of participants and by tracking measures such as HgbA1C both before and after program participation.

**Public Health Department Identified Need #3:** High Cancer Incidence, Particularly for Breast and Prostate Cancers

Christian Hospital will not address this need because it does not have sufficient resources to address all of the identified needs, and this need was identified as a lower priority.

**Public Health Department Identified Need #4:** High Incidence of women at risk for poor birth outcomes

Christian Hospital will not address this need because it is beyond the scope of services provided by the hospital.

**APPENDIX A**

# PERCEPTIONS OF THE HEALTHCARE NEEDS OF NORTH ST. LOUIS COUNTY FROM THE PERSPECTIVE OF COMMUNITY LEADERS

**PREPARED BY:**

Angela Ferris Chambers

Manager, Market Research

BJC HealthCare

**MAY 15, 2012**

## BACKGROUND

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

## RESEARCH OBJECTIVES

The main objective for this research is to solicit input from experts in the area of public health and those who have a special interest in the population served by DePaul Health Center (DPHC) and Christian Hospital (CH) in the northern part of St. Louis County.

## METHODOLOGY

To fulfill the PPACA requirements, the two north county hospitals (DPHC and CH) agreed to collaborate to obtain input from area residents and public health experts. Because of the time constraints imposed on DePaul, hospital representatives agreed to gather this information in a single focus group. Prior to this meeting, 19 individuals who were invited to attend were sent a worksheet designed to assess their perception of the greatest needs of North County residents, their knowledge of available resources to address these needs and the greatest "gap" that exists between need and available resources. (See Appendices B, C and D). 13 worksheets were returned for a 68% response rate.

Using this input, data on the needs of North County residents were shared at a meeting on April 4, 2012 along with secondary data that attempted to quantify the size of the need. That presentation can be found under separate cover.

The meeting was held at Northwest HealthCare in Florissant. It lasted two hours and was moderated by Angela Ferris Chambers, Manager of Market Research for BJC HealthCare. 12 individuals representing various North St. Louis County organizations were in attendance. (See Appendix B.) These organizations were identified collectively between DPHC and CH.

After presenting the information, the group was then asked for their reaction and whether it had an impact on their perception of the greatest needs in North County. Community leaders were asked to re-evaluate the identified health care needs in terms of their priority within the community as well as the ability for community resources to collaborate around them. Those results were compiled by the SSM Health Care – St. Louis, Department of Strategic Services.

Sean Hogan, President of DPHC, welcomed participants at the beginning of the meeting. Ron McMullen, President of CH, brought the meeting to a close and thanked them for attending.

## KEY FINDINGS

The transcript of the focus group was analyzed in conjunction with the completed worksheets that were returned. The following needs were identified in the work sheets and are listed from those most frequently mentioned to least.

**Access to Affordable Care/Care of the Uninsured: (9 mentions)**

- Non-emergency room services for the uninsured
- Access to public health/safety net health centers
- Inability to pay for medications
- Transportation challenges
- Affordable health insurance

**Obesity: (6 mentions)**

- Childhood obesity should not be overlooked
- Wellness training and education

**Continuity of Care/Care Coordination: (4 mentions)**

- Continuity of care between PCPs and hospital doctors
- Collaboration between FQHCs and hospitals regarding admission and discharge of patients
- Coordination of care, especially specialty care
- Communication challenges between all types of care, especially for lower income patients

**Diabetes: (3 mentions)**

- Including education about the role of a healthy diet

**Asthma: (2 mentions)**

- Incidence of asthma in North County compared to other areas

**Cancer: (2 mentions)**

- Education and early detection

**Mental/Behavioral Health (2 mention)**

- Substance abuse treatment

**Maternal and Infant Health: (2 mentions)**

- Teenage pregnancy
- Vaccination among young children, especially those from non-English speaking cultures

The secondary data also identified several other areas of concern that were not raised by the participants in their completed worksheets, but which were brought to their attention:

**Sexually Transmitted Diseases (STDs):**

- Higher rates of STDs in North County

**Heart and Vascular Disease:**

- Higher rates of heart and stroke in North County

**Child Neglect and Abuse:**

- Based on emergency department visits and inpatient admissions attributed to child neglect and abuse, the rates were higher in North County than in St. Louis County.

Other issues that were mentioned include:

- Geriatric care
- Economic development/jobs
- Summer/after school activities for youth
- Violent crime
- Race relations
- Preservation of neighborhoods

## DETAILED FINDINGS

## FEEDBACK FROM THE COMMUNITY PARTICIPANTS

**Access to health care:** Access to health care is affected by access to health insurance, and the new healthcare legislation was mentioned as addressing that in part. However, several community members felt that each individual has a personal responsibility to address their own health by committing to a healthier lifestyle. Having access to health education and understanding the importance of a healthy diet and preventive health behaviors would contribute to this.

> *I don't know about having access to Obama care is the whole answer, though, because we also need for the community to take responsibility for their health as well. Many of them I think are inter-related - lack of a healthy diet around obesity, around dental, around heart and other medical issues.*

Access also involves transportation and being able to get off of work to seek medical care. Having care available at times that are convenient for working adults also raised the issue of a lack of available urgent care services.

> *You cannot afford taking off two times within seven days to go see your doctor, because you're concerned about paying the bills.*
>
> *As you have a "food desert," you have an "urgent care desert" in North County.*

Access is also affected by the capacity of those primary care physicians in the community to see their patients in a timely manner.

> *We get patients all day long who walk in and say they have a private doctor. They can't get into the private doctor, so they came to us.*
>
> ***M: And what was the reason why they couldn't get into their own doctor?***
> *The cost, or the hours that their private doctor [inaudible] …we get them in the after-hours.*

**Financial Barriers to Access:** Financial barriers limit access to health services, even for those with health insurance. They often cannot afford their co-pays and deductibles and are therefore reluctant to seek care.

> *Patients who are employed, who have insurance, will many times hesitate to come in because they don't have the funds in order to pay their co-pay or their co-insurances. Even now, there's even more patients who have inadequate healthcare, but they're insured. The deductibles are steadily climbing every year to the point where many patients don't get any coverage from their insurances until they've paid thousands of dollars out of their own pockets.*

There are financial barriers for those who cannot afford their medications. Even though some of the drug companies offer reduced costs for some medications, the application process is complicated and not easy to complete.

> *The affordability of medications is a problem as well. Mhm, [inaudible] get a prescription to medication, they can't afford it. So what do they do in the meantime?*

*I have a full-time social worker that assists the patient with filling out the applications, and we mail them off. …But it's still a cumbersome process.*

**Healthy Food Options:** The lack of nutritional food available in the local area was a surprise to some people. Others talked about the need to educate children about healthy food options as a way to establish life-long patterns of healthy eating that will sustain them when they are older. The need to educate their parents was also addressed, as well as the expense involved in buying fresh food.

*When you talk about public schools, almost all of those kids are on free lunch. We did a survey with the American Heart Association to find out where these 'deserts' were, and North County lit up like a light because everybody's on free lunch, they don't know how to eat right, they tend to be more obese from kindergarten on. To me, putting in gardens, maybe having a community garden or a school garden where the kids can learn not only the science of the planting, … maybe taking extras home, and the responsibility of some of those things I think would be a great project for North County.*

*That would be a great project, …. But until the parents are educated about healthy eating [didn't finish].*

*You have to hit the parent where it affects them. Because they see the fruits and they see the vegetables, but in their mind they're always thinking, 'it's too expensive to buy that stuff or it's too much time to actually prepare a food to do that.'*

*The churches are one of the leading places for community gardens right now. So the food pantry is based at one of the places where there's a community garden. Vegetables from the garden were given to people at the food pantry with somebody there talking about how to prepare it. So it's a small example of what works.*

**Sexually Transmitted Diseases:** Many participants were surprised at the high rates of sexually transmitted diseases in North County. There were concerns about the amount of education going on in the schools on this topic. However, it was pointed out that many of the new cases are occurring in individuals over age 55.

*Well, near the end when you were talking about the sexually transmitted diseases, that certainly was an extraordinary number. That's a public health crisis there.*

*In the end of the 1998 to 2000 era, the… ' just say no' mentality (was) very conservative, and we no longer had funding to do the education … It needs to be a comprehensive program to educate children, to educate these students on decisions that they're making and have all the information when making a decision to be sexually active.*

*A lot of the STD cases are older than fifty-five.*

*A part of educating the people and having a twenty-year old daughter who told me at one point that she couldn't get …said we make too much money to get HIV. One of the things that we did was (at) her high school where we had folks who actually had the disease, their age, come in and talk to them about having HIV and how it has wrecked their lives …We can talk all day, but it's real life… 'I have HIV and this is what it's like.' That's what people learn from. … hands on, feeling, touching, reaction. You can talk all day but until I see it, it's not real.*

**Child Neglect and Abuse:** There was a question regarding the data that were presented on rates of childhood neglect and abuse. They reflected emergency department encounters and hospital admissions that were attributed to neglect and abuse. There was a concern that these two items should not be

combined and that neglect is a separate issue from abuse. By combining them, they cannot be appropriately addressed.

**Geographic Analysis:** When looking at the data, several individuals suggested trying to look at it within smaller geographic units than North St. Louis County. Doing so will make it easier to identify more specific markets where these problems occur, and easier to direct solutions toward them.

> *And North County is extremely diverse, so if you were looking at smaller geographical areas, I think you could do more with what you're seeing because then you can pinpoint some of the income issues. Then you could take that data and … look for the differences and the similarities. I think you could learn more from that exercise.*

> *It really masks the disparity because when you're comparing North St. Louis County to St. Louis County, North St. Louis County's data is included. If you were comparing North St. Louis County to the rest of the county, the disparities would be much more severe.*

**Soliciting additional community input:** When the group was asked their opinion about how the health needs of the community should be prioritized, some felt that the residents of the area should be asked for their input. There were also several comments about bringing services into the communities where people live as a better way to reach them. However, those whom we most need to reach may not be the ones who will participate at the local level.

> *Well, we host the County Police [inaudible] Bi-Monthly Neighborhood Watch meeting where we have in attendance somewhere up to a hundred people that attend. However, the people that come to that meeting are the ones who are somewhat educated…The ones that we're talking about are probably not going to attend those meetings.*

> *You need more of a grass-root approach where you go into the neighborhoods.*

> *But you've got to do something that's going to be sustainable. …You can …knock on doors and tell people to come to meetings, but unless you've got something for them to continue to come, a one-day educational or [inaudible] is not going to get the solution done. So how do you get them to continue to come to educate them?*

**Change at the neighborhood level:** The idea of making changes at the local level and through individual interactions was again mentioned. The importance of education was also reinforced.

> *We have to figure out what's in our circle of influence. We have to do something today that's actually going to affect tomorrow.*

> *In Ferguson we have Sunday Parkways [phonetic] where we close down the streets three times out of the year… we actually provide healthy activities in the neighborhoods. We have YMCA here, we have hospitals come in, we have St. Louis County of Health that comes in and provides those activities where you get people outside of their homes and actually coming into the streets and doing healthy activities and getting that one-on-one education.*

> *And we do the community gardens to actually do some of that stuff. We do have the schools come in and actually do it. It's helping a little bit, but it's not the total solution. I think it goes back to education, education, education, education.*

*Providing numbers like that in your face, in your face, in your face every time that you see it and you say if you eat this or if you don't do that, then it could possibly lead to something else. That's what's in our circle of influence. If we do that in a combined effort where it's not Ferguson doing this, but its Ferguson and Spanish Lake and it's Maryland Heights that are all doing this, so every time you see it or every time you go into another community you see it, it's going to help.*

*I'm not into systemic change. I'm here to talk on what we can do tomorrow to save three people. So I think it would be much more helpful if we start focusing on small things that organizations, including the hospitals, are good at and do something a little bit better and a little bit more and improve any one of those a little bit rather than spending a lot of time thinking about how do we save all of North County from all of the problems.*

# CONCLUSIONS/RECOMMENDATIONS

### WHAT ROLE SHOULD THE HOSPITAL PLAY?

Participants were asked what role they feel hospitals could play in this process.

Some suggested that it is important to identify "best practices" that have already been implemented and to learn from them, rather than "reinventing the wheel."

> *I'm wondering if there are similar communities around the country that have found ways to address, say, the education issue or some of the other issues. Why start from scratch when you can look at [inaudible]?*
>
> *Perhaps combining the two hospitals and the public health service, you've identified a series of problems perhaps through [inaudible] doing some research and putting together sort of a workbook filled with ideas from around the country of small projects that people have done. Make it available to the community.*
>
> *Also, looking at the best practice, that idea I think is really important. But there has to be some entity out there that is doing that.*

Another suggestion is that the hospitals should identify resources that already exist within the community and work with them.

> *Another thing is to understand what already exists in this community that's working and build on that. Spanish Lake is working with CAASTL, Community Action Agency of St. Louis County, and has several community gardens. It's working on a farmer's market. So those kinds of things could be built on and if the hospitals support them, that would be outstanding, to get them going.*

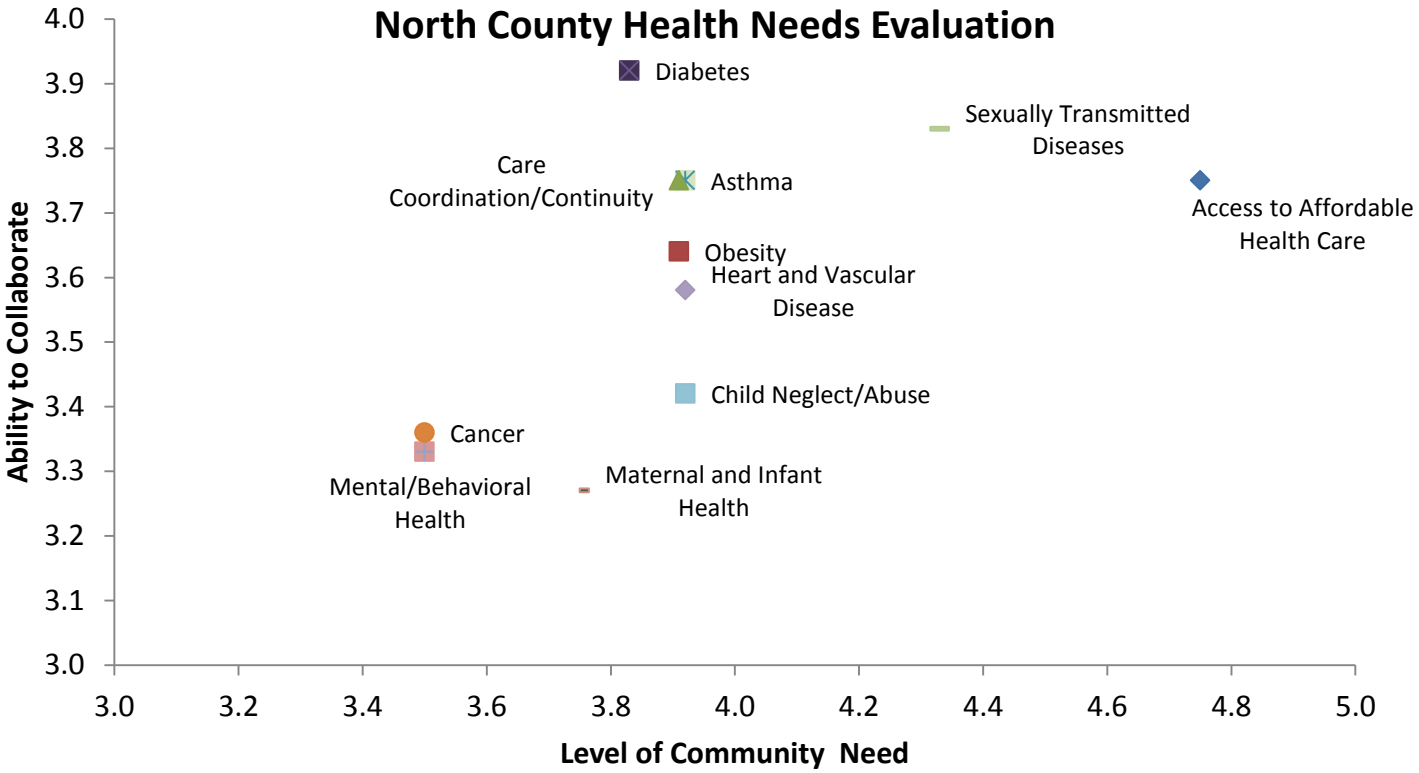
Others suggested that the hospital's best chance of engaging the public is to go into the areas where people live. This also includes putting additional services in neighborhood locations away from the hospital proper.

> *The hospital, connected with the food pantry, where people are going to come every week, whatever the schedule is.*
>
> *Every summer I team up with 104.9. We do a series of community block parties throughout North St. Louis County. That could be an excellent opportunity for both BJC and Christian to set up like their own booths to be able to hand out literature and educate the people at those [inaudible] to get a high turnout at those events.*
>
> *More off-campus sites…You've got two huge hospitals that are surrounded by highways and everything, and how in the heck do you get to them? Why not have other places in the communities where people could access care?*
>
> *We definitely need more primary care physicians, and not just physicians but physician extenders, nurse practitioners, physician assistants, in order to accommodate.*
> ***M: Okay, I see lots of heads nodding**.*
> *And I was going to say not just putting those providers at the hospital, in the medical buildings, but making sure that they're scattered about in the community.*

The hospital can also serve a leadership role in its ability to pull several organizations together to collaborate on addressing these issues.

> *To accomplish any of these things as close to optimum as possible, there has to be some sort of steering or leadership entities. That seems to be an appropriate role for the two hospitals. In fact, you're coming together makes that even more possible. If that could happen and then if you all could in some way work with other organizations to kind of spearhead the information gathering that [inaudible] was talking about, what's going on, what's working.*
>
> *I think it's the hospital's responsibility or the County Health Department, as a team, to make sure that people can get in to be seen, makes sure we can help them with medications. That's what we're good at.*
>
> *I'd like to see it help us avoid worst practice… Right, there's a lot of money being spent and wasted by a whole lot of organizations thinking they're doing something that research says has no value whatsoever. So if we could stop spending money the wrong way, we could use the resources we have to be a little bit more effective…. I want somebody who will tell me stop wasting your money on a wellness program that doesn't change behavior.*

## RE-EVALUATION OF HEALTH NEEDS




**Access to affordable health care** and **Sexually Transmitted Diseases** were ranked highest in terms of community need, and was among the highest relative to the ability of organizations to collaborate around it.

**Diabetes** ranked highest on their ability to allow collaboration among organizations and among the highest in the area of greatest need.

Also ranked among the highest on need and ability to collaborate are **care coordination and continuity**, **asthma, obesity** and **heart and vascular disease.**

Ranking lower in terms of need and collaboration are **child neglect and abuse**, **cancer, mental and behavioral health** and **maternal and infant health.**

## APPENDIX B

## PARTICIPANT ROSTER

| | |
|---|---|
| 1. Brenda Bobo-Fischer | Community and Organizational Change Consultant |
| 2. Shelly Butler | Executive Director, Emerson Family YMCA |
| 3. Troy Doyle | Precinct Commander, St. Louis County Police Department |
| 4. Dora Gianoloukis | President, Spanish Lake Community Association |
| 5. Dwayne James | Alderman, City of Ferguson |
| 6. Mark Levin | Administrator, City of Maryland Heights |
| 7. Jamie Opsal | St. Louis County Dept of Health |
| 8. Dr. Carolyn Pryor | Serenity Women's Healthcare, Inc. |
| 9. Rance Thomas | John Knox Presbyterian Church |
| 10. Lottie Wade | Spanish Lake Community Association |
| 11. Vickie Wade | Vice President, Clinical Services, People's Health Center |
| 12. Karen Walker | Site Manager, People's Health Center |

BJC/Christian Hospital attendees:

1. Bret Berigan
2. Angela Chambers facilitator)
3. Debra Denham
4. Karley King
5. Alicia LaPorte
6. Ron McMullen
7. Dr. Kim Perry
8. Rebecca Sellers

SSM/DePaul attendees:

1. Kim Bakker
2. Tina Garrison
3. Sean Hogan
4. Jamie Newell
5. Valerie Stricker
6. Monica Wohlberg
7. Lorraine Yehlen

## APPENDIX C

## NEEDS ASSESSMENT WORKSHEET

1. In your opinion, what are the three greatest health needs or challenges that exist within the North St. Louis County population?

1.)

2.)

3.)

2. To your knowledge, what resources are currently available in North St. Louis County for addressing each one of them? Who/what organization is trying to address them?

1.)

2.)

3.)

3. In your opinion, when thinking about healthcare needs of North St. Louis County, where is the largest gap between an existing need and available services?

# APPENDIX D

## RESOURCES AVAILABLE

**Access to Affordable Care/Care of the Uninsured:**

Christian Hospital

People's Health Center

St. Louis County Department of Health

SSM DePaul Health Center

**Obesity:**

Christian Hospital

SSM DePaul Health Center

SSM Weight Loss Institute

YMCA

**Diabetes:**

Christian Hospital

SSM DePaul Health Center

**Continuity of Care/Care Coordination:**

Health Centers including:

Betty Jean Kerr People's Health Centers

Grace Hill Health Center

Myrtle Hillard Davis Comprehensive Health Centers

St. Louis County Health Department

**Diabetes:**

Christian Hospital

SSM DePaul Health Center

**Asthma:**

Christian Hospital

**Cancer:**

Christian Hospital

SSM DePaul Health Center

**Mental/Behavioral Health:**

Private doctors

**Maternal and Infant Health:**

Nothing listed specifically for addressing teenage pregnancy

# APPENDIX E

## FEEDBACK ON GREATEST GAPS

## BETWEEN NEEDS AND AVAILABLE RESOURCES

Access and affordability of services (8 mentions)

- Services for the uninsured
- Increasing awareness within the community about service availability
- Affordability and continuity of care
- Affordable primary care
- Universal coverage being in jeopardy
- Direct admissions without PCP having hospital privileges
- Access to transportation

School-age community outreach (2 mentions)

- Youth activities

Obesity

Spanish Lake

Vaccinations for young children, especially those who are non-English speaking