# 2023 – 2027 St. Louis Regional CHIP

## Community Health Improvement Plan

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## Introductory Letter

Dear Colleagues,

It is with gratitude that we present the 2023 – 2027 Community Health Improvement Plan (CHIP) focused on addressing the public health needs of residents of the St. Louis region. The City of St. Louis Department of Health and the St. Louis County Department of Public Health are, along with numerous partners, leading an effort to address health inequities and improve health outcomes for all residents in the region. This document reflects the concentrated effort of many organizations and individuals.

Over the past few years, the St. Louis Partnership for a Healthy Community, in conjunction with local partners, has worked to refocus the region's public health efforts, evaluate where we stand through the 2022 Community Health Assessment (CHA) process, and develop the region's strategic community plan through the 2023 – 2027 CHIP. Epidemiology teams at both public health departments, together with academic and other community partners, collected and analyzed public health data to develop a CHA for the St. Louis region.

The CHA and stakeholder input were analyzed to identify priorities for the 2023 – 2027 CHIP. Once the advisory committee and leadership confirmed these priorities, Community Health Action Teams were formed to develop goals and objectives for the selected priorities and establish a collective impact approach to improving population health. Implementation and success of the new CHIP will require alignment of efforts throughout the region to address policy changes and programs that support a healthier and more equitable region. We look forward to continuing to work with you toward the Vision of "St. Louis, an Equitable Community achieving optimal health for all."

Dr. Matifadza Hlatshwayo Davis, MD, MPH, FIDSA

Dr. Kanika A. Cunningham, MD, MPH

Updated 11/16/23

# Acknowledgments

We sincerely thank the St. Louis Partnership for a Healthy Community, as well as the individuals and organizations that are part of the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) Advisory Team. We wish to recognize the CHIP Action Teams, Kulik Strategic Advisors, Inc. (Tracy Kulik and Marcos Alcorn), the stakeholder group, public health leadership and staff at St. Louis County Department of Public Health and City of St. Louis Department of Health, and all who participated in the Mobilizing Action through Planning and Partnerships (MAPP) process that made this 2023 – 2027 CHIP possible.

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# Dedication

The St. Louis Regional Community Health Improvement Plan (CHIP) is dedicated to the memory of Cora Faith Walker, JD, MPH, whose untimely passing on March 11, 2022, at age 37, left a profound void in the region's hearts. An exemplary public servant, Walker was a champion for the welfare of women, children, newborns, seniors, and the underserved in the Ferguson community. She tirelessly advocated for reproductive rights, victims of sexual violence, health equity, social justice, and frontline workers.

Walker served as a Missouri State Representative for the 74th district from January 2017 to July 2019; she fought for Medicaid expansion and equity in health care, including efforts to eliminate racial and economic disparities in maternal mortality rates. As the policy director for County Executive Dr. Sam Page, Walker played a pivotal role in shaping health care policies in St. Louis County. Her academic achievements included a Bachelor of Arts and master's degree in public health from Washington University, a Juris Doctorate from St. Louis University, and a certificate in health law.

Cora Faith Walker leaves a legacy as a dedicated advocate and compassionate leader, inspiring current and future public servants to walk in her footsteps.

# Executive Summary

The St. Louis region, consisting of the City of St. Louis and St. Louis County, is a community brimming with unique historical and contemporary assets, resources, and opportunities, making the region unique within Missouri and the United States. Our community's rich history, charming neighborhoods, beautiful parks, extraordinary food scene, and talented and diverse population make the St. Louis region a wonderful place to live, work, and play.

At the same time, the St. Louis region faces numerous challenges in ensuring optimal health outcomes. Recent events such as the COVID-19 pandemic have shown that the region must address health disparities in order to improve the public health.

The health of individuals is impacted by where and how individuals live, work, learn, play, worship, and experience community. Additionally, historical social and structural determinants of health in the St. Louis region have created and promoted long-standing health inequities that disproportionately affect marginalized groups, including people of color, those of lower socio-economic status, immigrants, refugees, LGBT+, and others. Understanding how social and structural factors impact the health of individuals in the St. Louis region is the first step in creating strategies to address health inequities, improve health, and create a more equitable community for all.

To better understand and address these social and structural determinants of health in the St. Louis region, our community has developed a Community Health Assessment (CHA) and this Community Health Improvement Plan (CHIP) to measurably improve the health of all residents.

The St. Louis Partnership for a Healthy Community includes a diverse team of public health leadership, a 25-member advisory team representing various sectors in the St. Louis region, and 65 community stakeholders. The CHA and CHIP process undertaken by the St. Louis Partnership for a Healthy Community was grounded in a common vision and utilized the following guiding principles, as shown in Figure 1.

**Figure 1. Vision & Guiding Principles**

| Vision | Guiding Principles |
| --- | --- |
| "St. Louis, an equitable community achieving optimal health for all." | • Equity<br>• Respect<br>• Integrity<br>• Data + Results Driven<br>• Community Engagement + Inclusion<br>• Systems-level Change + Regional Shared Plan<br>• Resources |

A Community Health Improvement Plan (CHIP) defines the strategic vision for the health of the community through a collaborative process that addresses the strengths, weaknesses, challenges, and opportunities that exist to improve the health status of that community. This is done by setting priorities, coordinating and targeting resources, developing policies, and defining actions to direct efforts that promote health.[1]

While guiding the future of health in the St. Louis region, this CHIP builds on the progress and lessons learned from the first regional CHIP developed in 2019. Completion of both the CHA and the CHIP reflects a data-driven public health culture that values community direction and partnerships and requires a massive time-coordinated effort by all partners.

This latest process began by working with a consultant (KSA, Inc.) to facilitate the CHA in the winter of 2021/2022. It utilized the Mobilizing for Action through Planning and Partnerships (MAPP) framework developed by the National Association of County & City Health Officials (NACCHO) to guide the process. As part of a six-step process, this collaboration performed four assessments, outlined on p. 10, highlighting the key issues facing our region. The results of these assessments, beginning on p. 11, contributed to the selection of five priority issues that will be the focus of this CHIP: the Intersection of Health and Economic Mobility, Chronic Disease, Maternal & Child Health, Violence Prevention, and Behavioral Health. This report describes the CHA and CHIP processes undertaken by the St. Louis Partnership for a Healthy Community and presents goals, objectives, implementation activities, and responsible parties for each priority issue. The St. Louis Partnership for a Healthy Community routinely updates and revises the CHA and CHIP via www.thinkhealthstl.org.

**Figure 2. CHIP Priorities & Themes**

# Pulse of the Region

This section provides insight into how the health of the St. Louis region has changed since 2016 by highlighting various public health priorities with large-scale impacts on health and known effective strategies to address them.[5] By identifying best-practice strategies, setting clear goals and objectives, and working closely with community partners, progress has been made to reduce the burden of disease in our community—yet more work remains. The table below displays selected health outcomes, displayed by their priority areas from the 2019 – 2024 CHIP, and tracks the progress made in improving these health outcomes from 2016 – 2020. If applicable, the Healthy People 2020 goal is also displayed to compare local values and national goals.

**Table 1. Pulse of the Region: 2016 – 2020**

**✓= Health Outcomes that Improved** **● = Health Outcomes that did not Improve**

| Priority Area 2019-2024 | Health Outcome (Rate per 100,000) or (%) | City 2016 | City 2020 | County 2016 | County 2020 | Status | HP2020 Goal (Rate or %) |
|---|---|---|---|---|---|---|---|
| Improving Access to Community Health | Families below the poverty level (%) | 21.3% | 15.1% | 7.4% | 6.5% | ✓ | - |
| | Mental health provider rate | 272 | 386 | 240 | 303 | ✓ | - |
| Chronic Disease Prevention and Management | Food Insecurity (%) | 25.1% | 15.8% | 14.7% | 9.8% | ✓ | 6.0% |
| | Child food insecurity (%) | 23.3% | 29.4% | 14.8% | 14.9% | ● | 0.2% |
| | Households with children as a percent of SNAP beneficiaries | 43% | 42% | 53.8% | 50.4% | ✓ | - |
| *Source: Think Health STL* | | | | | | | |
| Violence Prevention | Homicide mortality | 43.2 | 59.5 | 12.9 | 20 | ● | 5.5 per 100,000 |
| Maternal, Child, and Family | Infant mortality | 8.8 | 9.0 | - | - | ● | 6.0 per 1,000 |
| | Infant mortality | - | - | 6.0 | 4.3 | ✓ | |
| | Prenatal visit in first trimester (%) | 64.1% | 59.0% | 70.3% | 66.7% | ● | 84.8% |
| | Preterm births (%) | 15.4% | 14.2% | - | - | ✓ | 9.4% |
| | Preterm births (%) | - | - | 13.1% | 13.5 | ● | |
| *Source: MODHSS, Bureau of Vital Records Data, 2016-2020* | | | | | | | |
| Sexual Health | Chlamydia incidence rate | 1,297 | 1,236 | - | - | ✓ | - |
| | Chlamydia incidence rate | - | - | 570.6 | 609.9 | ● | - |
| | Gonorrhea incidence rate | 760.7 | 860.1 | 262.7 | 343.0 | ● | - |
| | Syphilis incidence rate | 67.1 | 147.2 | 19.0 | 40.5 | ● | - |
| *Source: MODHSS, Sexually Transmitted Diseases Dashboard, 2016 and 2020* | | | | | | | |

**Table 2. Pulse of the Region: Looking Forward**

| Priority Areas 2023-2027 | Health Outcome (Age-Adjusted Rates per 100,000) | 2020 (City/County) | | 2020 (Region) | HP2030 Goal (Rate per 100,00 or %) |
|---|---|---|---|---|---|
| **Chronic Disease** | Cancer mortality | 161.0 | 142.0 | 146.0 | 122.7 |
| | *Source: MODHSS, Bureau of Vital Records Data, 2020* | | | | |
| | Food environment index (score out of 10) | 6.0 | 7.6 | - | - |
| | Adults with obesity | 34.0% | 28.0% | - | 36.0% |
| | *Source: County Health Rankings, 2020* | | | | |
| | Food insecurity rate | 15.8% | 9.8% | - | 6.0% |
| | *Source: Feeding America, 2020* | | | | |
| **Maternal & Child Health** | Prenatal visit in 1st Trimester (%) | 59.0% | 66.7% | 64.7% | 80.5% |
| | Preterm births (%) | 14.2% | 13.5% | 13.7% | 9.4% |
| | Infant mortality (rate per 1,000 live births) | 9.0 | 4.3 | 5.5 | - |
| | *Source: MODHSS, Bureau of Vital Records Data, 2020* | | | | |
| | Babies with low birthweight (rate per 100 live births) | 12.55 | 10.01 | 10.68 | - |
| | *Source: MODHSS, MOPHIMS, Birth MICA, 2020* | | | | |
| | Congenital syphilis rate | 291.6 | 38.0 | - | 33.9 |
| | *Source: WebServ, 2020* | | | | |
| **Violence Prevention** | Firearm-related mortality | 61.0 | 26.0 | 35.0 | 10.7 |
| | Homicide mortality | 59.5 | 20.0 | 29.9 | 5.5 |
| **Behavioral Health** | Suicide mortality | 9.5 | 13.2 | 12.3 | 12.8 |
| | Overdose mortality | 91.0 | 41.0 | 53.0 | 20.7 |
| | Opioid overdose mortality | 82.0 | 37.0 | 48.0 | 13.1 |
| | *Source: MODHSS, Bureau of Vital Records Data, 2020* | | | | |
| **The Intersection of Health & Economic Mobility** | People living in poverty | 20.4% | 9.3% | - | 8.0% |
| | People with health insurance | 89.8% | 93.9% | - | 92.4% |
| | Percent spending 30% of income or more on housing | 34.1% | 26.6% | - | 25.5% |
| | *Source: US Census Bureau, American Community Survey, 5 Year Est. 2016-2020* | | | | |



While Table 1 reflects on the progress made from 2016 – 2020 and the work that remains in the St. Louis region, Table 2 looks toward the future. Table 3 shows selected health outcomes, displayed by their priority areas from the 2023 – 2027 CHIP, and provides baseline data for the City, County, and region for 2020. This data will be used as a reference point as the St. Louis region works toward the Healthy People 2030 targets for these health outcomes.

# Community Health Assessment (CHA) Overview

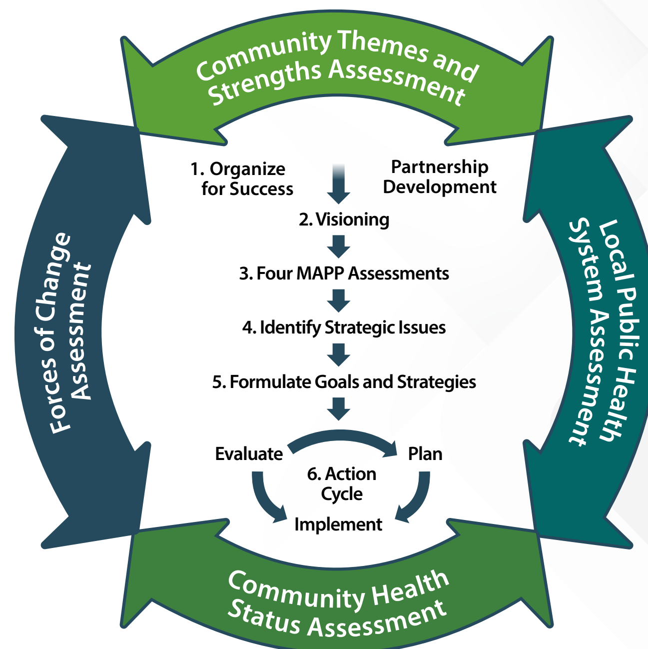
## Introduction & Process

The CHA aims to determine the health status of residents in the St. Louis region, understand the factors that contribute to health issues, identify areas for health improvement, and establish the assets and resources that can be mobilized to address the health of these populations. This partnership began working on the CHA in 2021 and utilized the Mobilizing for Action through Planning and Partnerships (MAPP) framework developed by the National Association of County and City Health Officials (NACCHO) to guide the assessment. The MAPP process has six phases, shown in Figure 3.

In the third phase of this six-phase process, this partnership completed four assessments: the Forces of Change Assessment (FOCA), the Community Health Status Assessment (CHSA), the Community Themes and Strengths Assessment (CTSA), and the Local Public Health System Assessment (LPHSA). Each unique assessment was used to better understand our region's assets, challenges, and key issues. The CHA process is noteworthy as it resulted in a collaborative mobilization and identification of many community partnerships and resources that contribute to the community's health and serve as the foundation for the CHIP. This assessment process is displayed visually in Figure 4, and the following pages will describe each of the four assessments and their findings. Health outcomes from the 2022 CHA are compared to the 2017 CHA in the Pulse of the Region section on page 8.

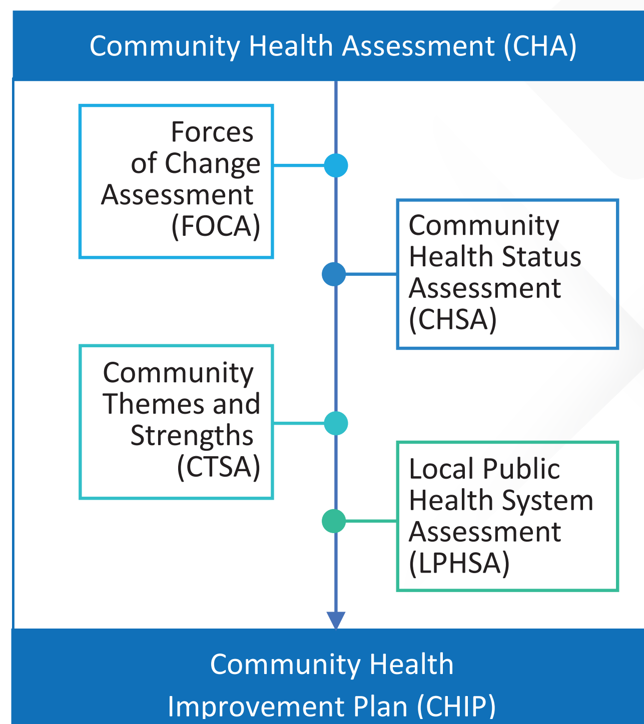
The community partners identified and involved in the CHA spanned a large spectrum of organizational sectors, including public health and private health care; law enforcement; local, regional, and state government; community-based non-profit entities; academic institutions; and other sectors that impact the health and well-being of the St. Louis region.

**Figure 3. MAPP Process – 6 Phases**




Source: Adapted from NACCHO

**Figure 4. MAPP Process**

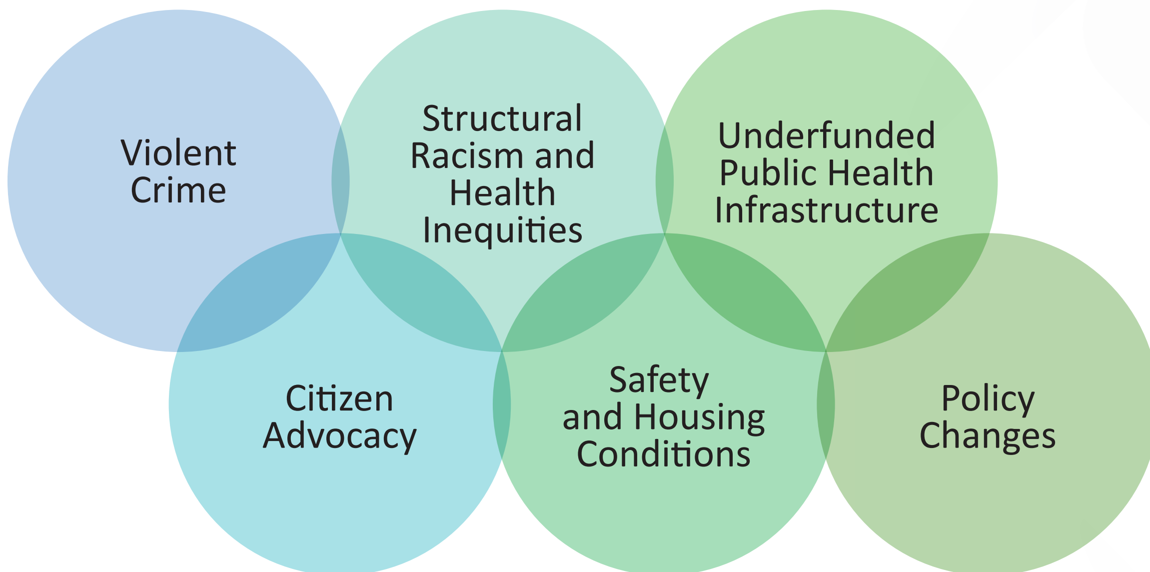


## Forces of Change Assessment (FOCA)

The first of the four assessments completed as part of the CHA MAPP process was the Forces of Change Assessment (FOCA). The FOCA is a qualitative assessment outlining the environmental forces that affect the context in which the community and its public health system operate. Qualitative methods of assessment yield results that cannot easily be measured by or translated into numbers. These methods seek to answer questions about complex issues, such as how or why certain actions occur. This data can be collected by observation, interview, focus group, or community meeting.[2]

Presenting both opportunities and challenges, the FOCA contextualized the political, economic, social, and technological/scientific forces that influence the regional public health system. A wide array of local, state, and national forces were identified as key influences on quality of life and positive health outcomes for the community and local public health system. Some of the major forces identified included increases in violent crime, citizen advocacy, structural racism, health inequities, safety and housing conditions, underfunded public health infrastructure, and political changes.

**Figure 5. Forces Identified in the FOCA**



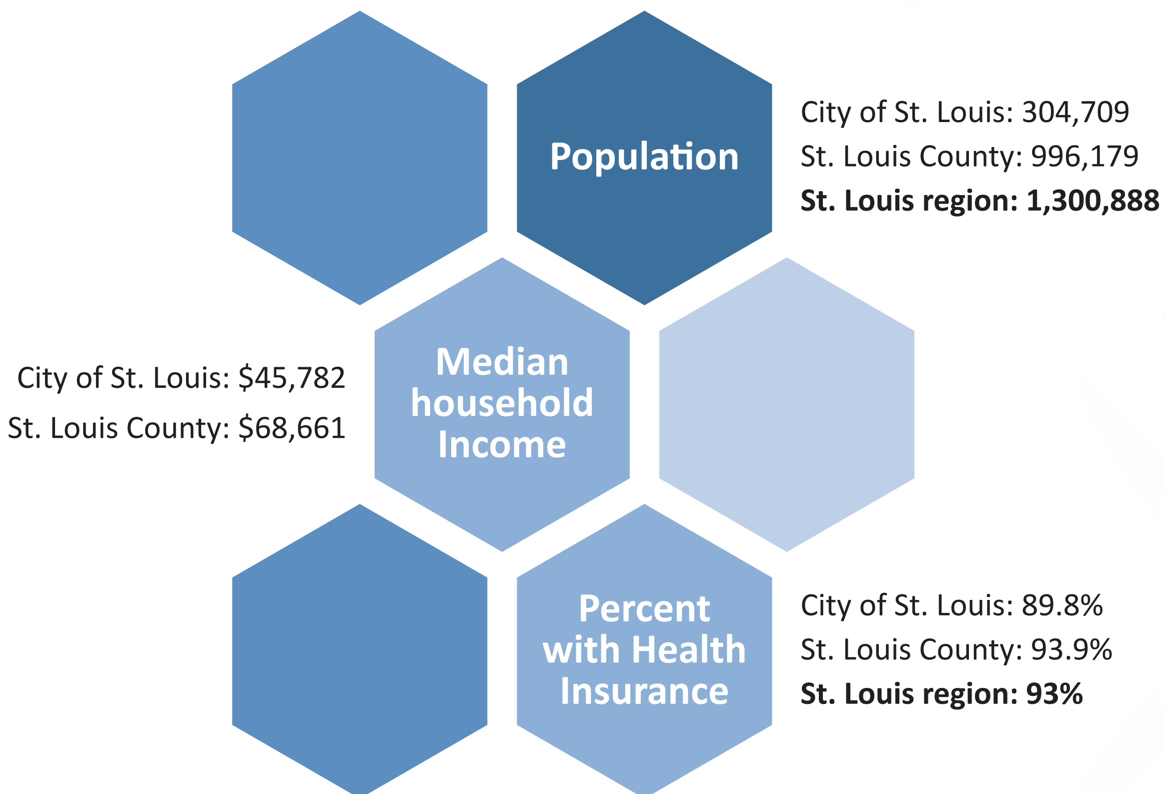

These themes highlight the forces with the most significant impact on the context in which the community and its public health system operate.

## Community Health Status Assessment (CHSA)

The second assessment completed as part of the CHA MAPP process was the Community Health Status Assessment (CHSA). The CHSA is a quantitative assessment that numerically describes the health of the region for various health outcomes. Quantitative methods express results in numbers by answering questions like, "How many?" or "How much?" or "How often?"[2] The results of quantitative assessments are displayed numerically in ways that most people recognize, such as counts, rates, charts, and graphs.

The CHSA analyzed quantitative population health data from nine topical areas. These areas were demographics and social determinants of health, access to care, accidental and intentional injury, behavioral health, chronic diseases, communicable diseases, COVID-19, environmental health, and maternal and child health. This data was disaggregated to identify critical health issues and disparities across age, gender, race, population subgroups, and geography in the St. Louis region compared to Missouri and the United States. Disaggregation is critical for public health efforts to assess disparities and inequities hidden in aggregated values such as city- or county-wide data. The findings from this assessment helped guide the development of the CHIP, providing insights into which populations and locations should be prioritized to promote equitable health outcomes in the St. Louis region. Figure 6 provides basic demographic information on the St. Louis region for 2016 – 2020. Complete findings from the CHSA are available in the 2022 Community Health Assessment.[6]

**Figure 6. Demographics**



## Community Themes and Strengths Assessment (CTSA)

The third assessment completed as a part of the CHA MAPP process was the Community Themes and Strengths Assessment (CTSA). The CTSA captured City of St. Louis and St. Louis County residents' perceptions of quality of life, strengths, assets, and needs of the region through organized focus groups and the use of a community needs assessment conducted by hospitals in the region. Focus groups yield small-group discussions guided by a trained leader and are used to learn about group or community opinions on a designated topic to guide future action.[3] Focus groups were used to learn from area residents about their lived experiences and the health of the St. Louis region. Specifically, the CTSA included 16 focus groups involving 135 individuals to gather information regarding nine participating populations or issues listed in Table 3.

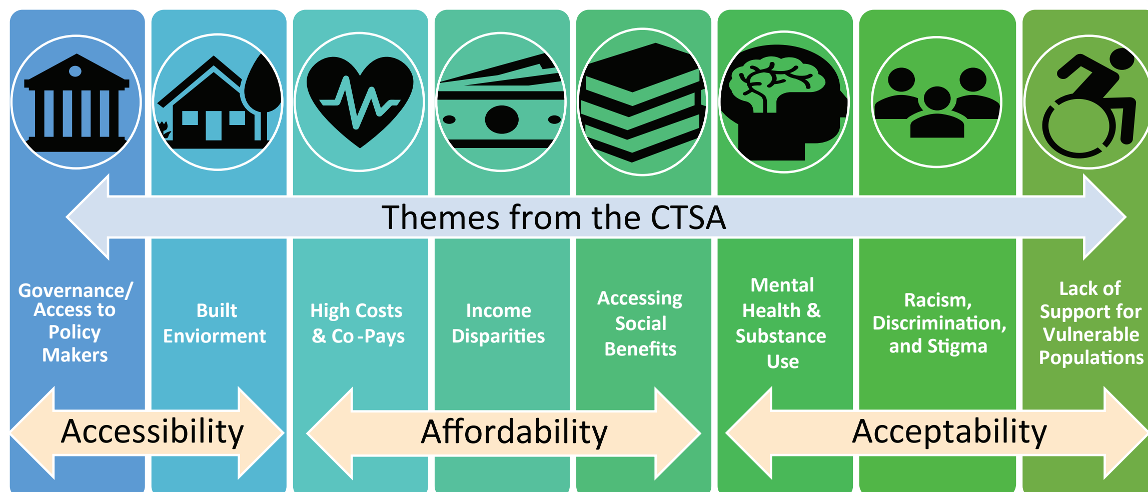
The CTSA results were divided into three categories: accessibility, affordability, and acceptability. Regarding accessibility, the built environment and governance/access to policymakers were identified as key factors critical to improving quality of life in the St. Louis region. Barriers to accessing social benefits, high costs and co-pays, and income disparities were commonly raised issues of affordability. Common concerns regarding acceptability in the region were racism, discrimination and stigma, mental health and substance use, and lack of support for vulnerable populations.

**Table 3. CTSA Participating Populations**

| | | |
|---|---|---|
| Black/ African American residents | People with substance use disorder | Youth and students: 13-26 years old |
| People with disabilities | Immigrants and refugees | LGBT+ residents |
| Low Income and uninsured | Seniors: 65+ | Maternal and child health |

The CTSA results were divided into three categories: accessibility, affordability, and acceptability. Regarding accessibility, the built environment and governance/access to policymakers were identified as key factors critical to improving quality of life in the St. Louis region. Barriers to accessing social benefits, high costs and co-pays, and income disparities were commonly raised issues of affordability. Common concerns regarding acceptability in the region were racism, discrimination and stigma, mental health and substance use, and lack of support for vulnerable populations.

**Figure 7. CTSA Themes**



## Local Public Health Systems Assessment (LPHSA)

The final assessment of the CHA MAPP process was the Local Public Health Systems Assessment (LPHSA). The LPHSA is an inward-looking assessment of the local public health system in the St. Louis region, encompassing the City of St. Louis and St. Louis County. It also looked at all public and private health care providers, including the four regional health care systems: public and private clinics, emergency services, and the numerous community-based organizations that provide social, educational, recreational, arts, economic, environmental, and philanthropic services. The LPHSA measured the capacity of the St. Louis regional public health system to provide the ten essential public health services and meet equity standards.[4] Results of the LPHSA, shown in Figure 8, identify the strengths and weaknesses of the region's public health system and highlight opportunities for improving services through a health equity framework that builds upon the top five prioritized Equity Standards.

During the assessment, many areas of opportunity were identified as critical to improving the local public health system. They are listed below. These results were invaluable in prioritizing and planning for the future of the region's local public health system. Goals and action plans to address priority issues will be developed, aligned, and implemented to improve the local public health system, thereby improving the community's health.

**Figure 8. LPHSA Findings**

## Identifying Priorities

The health priorities identified from three of the MAPP assessments—the Forces of Change Assessment (FOCA), the Community Health Status Assessment (CHSA), and Community Themes and Strengths Assessments (CTSA)—were reviewed by stakeholders as part of the LPHSA in order to identify which of the identified health priorities would be the focus of the 2023 – 2027 CHIP for the St. Louis region. The table below displays the various health outcomes or issues identified as priorities in the MAPP assessments.

**Table 2. MAPP Priority Areas**

| Health Outcomes / Issues | CHSA | FOCA | CTSA |
|---|---|---|---|
| **1) Behavioral Health:** Substance use and mental health | ✓ | ✓ | ✓ |
| **2) Maternal-Child Health:** Black infant mortality and Black maternal morbidity/mortality | ✓ | ✓ | ✓ |
| **3) Upward Economic Mobility:** Financial empowerment and economic development | ✓ | ✓ | ✓ |
| **4) Violence Prevention:** Gun safety and child mortality | ✓ | ✓ | ✓ |
| **5) Chronic Disease:** Root causes and prevention | ✓ | ✓ | ✓ |
| **6) Built Environment**: Transportation and safety | ✓ | ✓ | ✓ |
| **7) Environmental Health**: Abandoned or unsafe housing and unsanitary or unsafe living conditions | ✓ | ✓ | ✓ |
| **8) Communicable Diseases:** Sexually transmitted infections, influenza, and COVID-19 | ✓ | ✓ | ✓ |
| **8) Food Security:** Availability and Affordability of healthy food | ✓ | ✓ | ✓ |
| **10) Youth Development**: Personal and Professional Development | | | ✓ |
| **11) Early Childhood Health & Education:** Access and Affordability | | | ✓ |
| **12) Seniors and Aging in Place:** Housing, Health Care, and Safety | | | ✓ |

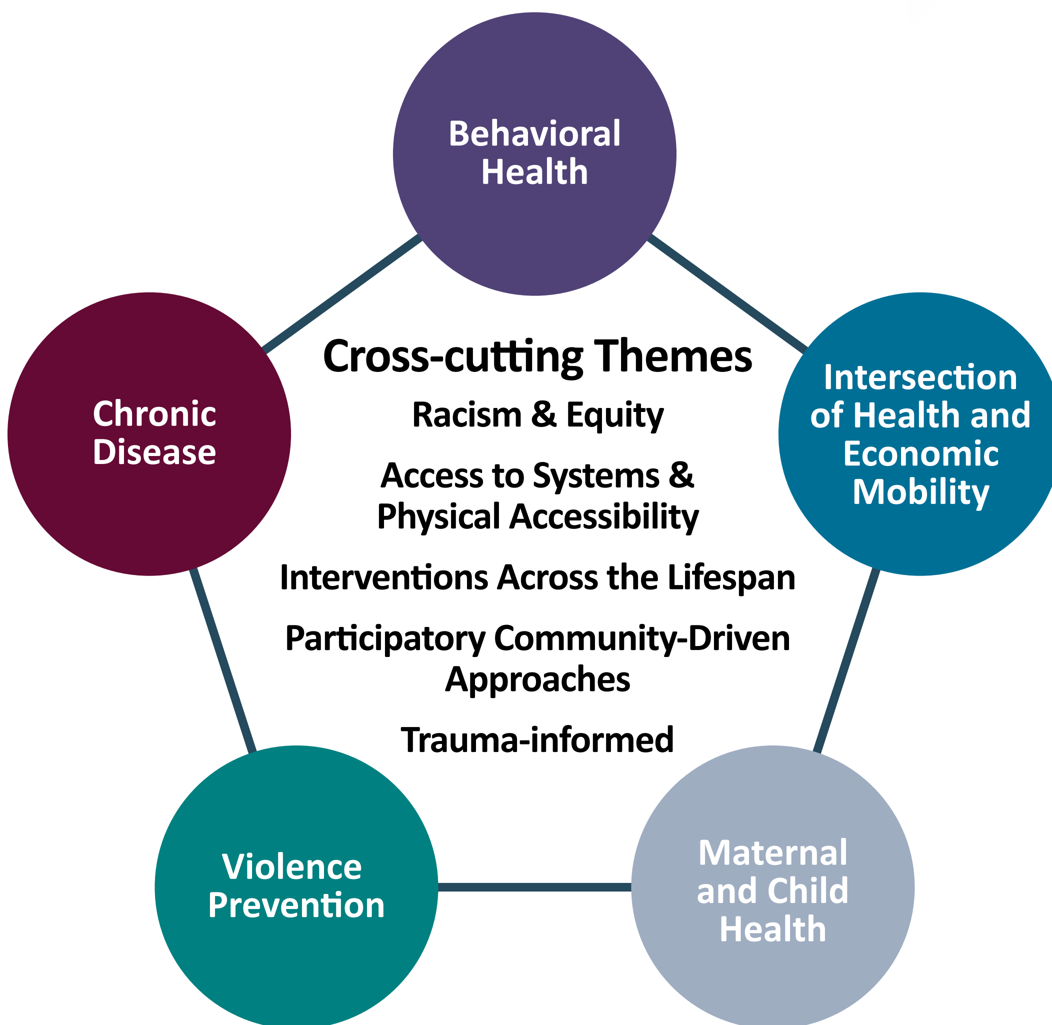
To select the priority areas for the 2023 – 2027 CHIP, the City of St. Louis and St. Louis County public health leadership utilized input from an Advisory Team, information gathered from the MAPP assessments, and regional data gathered in the CHA. The Advisory Team utilized the following prioritization criteria as part of the selection process.

**Table 3. Prioritization Criteria**

| |
|---|
| **Size:** How many people are impacted by this issue? |
| **Seriousness:** Does this issue result in hospitalization, disability, or death? |
| **Trends:** Is this issue improving or getting worse over time? |
| **Disparities:** Are there populations that are disproportionately impacted? |

A survey was then conducted to rank the identified priority topics based on the agreed prioritization criteria. From these results, priority areas were selected by the leadership team after considering all of the inputs, including data, assessments, and community input. The priority areas selected for the 2023 – 2027 CHIP are Behavioral Health, the Intersection of Health and Economic Mobility, Maternal and Child Health, Violence Prevention, and Chronic Disease. The following graphic displays the five priority areas and identified cross-cutting themes.

**Figure 9. CHIP Priorities**



# Community Health Improvement Plan (CHIP)

## Overview

The 2023 – 2027 CHIP builds on the knowledge, data, and priority areas from the CHA. This CHIP identifies goals, objectives, and strategies to improve health outcomes in each of the five priority areas. These priority areas are Behavioral Health, the Intersection of Health and Economic Mobility, Maternal and Child Health, Violence Prevention, and Chronic Disease, which will be the focus of the St. Louis Partnership for a Healthy Community for the next five years. While helping guide the future of health in the St. Louis region, this CHIP builds on the progress and lessons learned from the previous CHIP developed in 2019.

Broadly speaking, a regional CHIP is a strategic plan for the region to improve public health. The purpose of a CHIP is to define future goals for the health of the community through a cooperative process that addresses the strengths, weaknesses, challenges, and opportunities that exist within the community to improve the public health status of that community. The 2023-2027 St. Louis Regional CHIP outlines the final priority areas, provides contextual data for each, and sets forth goals, objectives, and activities to make actionable and measurable improvements in the health of all St. Louis residents.

**Figure 10. CHIP Priorities**

## Developing Goals and Objectives

The St. Louis Partnership for a Healthy Community Leadership team invited community stakeholders to participate in a call-to-action meeting on October 19, 2022. The purpose was to provide an overview of the five identified priority areas and the populations impacted most by each issue. Facilitated discussions identified assets, resources, and barriers for each priority. Then, the group explored how to engage current and new Action Team members to develop the action plans for each priority. Following the call-to-action meeting, a survey was provided to garner commitment to participate in upcoming Action Team planning meetings and stakeholders were charged with recruiting partner organizations identified in the meeting.

In October and November of 2022, two brainstorming meetings were conducted around each priority. This involved sharing data, exploring what is already happening in the region, identifying barriers to current efforts, and gathering recommendations and approaches from Health People 2030. In early 2023, Action Teams convened individually to determine how best to address priority areas, and they developed goals, objectives, activities, and ways to measure their progress. Throughout this process, additional partners were recruited as needed. The action plans were finalized and approved by Action Team members and the St. Louis Partnership for Healthy a Community in October 2023.

## Action Phase

The action cycle links the planning, implementation, and evaluation of the CHIP. Implementation will occur at the beginning of 2024. Team leaders are meeting throughout the end of 2023 to discuss overarching processes that will guide implementation and evaluation activities. The activities included in each of the five action plans will be monitored through a collaborative process between the Action Team members and the St. Louis Partnership for a Healthy Community leadership team. Data collection and monitoring will occur quarterly using updated metrics from all the activities across the priority areas to evaluate our selected health outcomes. A survey, created in Qualtrics, will be distributed to the Action Team members to fill in updated metrics and progress reports for activities under their jurisdiction. Once this data is collected, the leadership team will input it into an overarching monitoring system to analyze progress and create trend reports. The goal is to provide a rich summary of efforts, identify areas of success and improvement, and create a narrative on the progress of the CHIP goals.

## The Dynamic Nature of Priority Areas

The St. Louis Partnership for a Healthy Community plans ongoing assessments and community engagement to help ensure responsiveness to the changing landscape of health in the St. Louis region. We actively seek feedback from community members, stakeholders, and public health leaders to identify emerging health issues, gaps in services, and opportunities for improvement.

To maintain the "living" aspect of this document, CHIP Priority Action Teams are doing the following:

**Regular monitoring and evaluation:**

- We will periodically assess our priority areas and strategies to ensure their continued relevance based on input from community members, partners, and health professionals.

**Evidence-based decision-making:**

- In addition to the data included in the CHA, we will stay informed on additional health data and trends, using this information to inform our priority areas and to assess the impact of existing strategies.

**Community engagement:**

- We will actively engage community members to solicit their input, concerns, and suggestions.

**Collaborative partnerships:**

- We will continue collaborating with local organizations and community leaders to leverage resources and expertise, ensuring a coordinated and effective approach to addressing health disparities.

As a result, the CHIP is not a static document but rather a living, breathing roadmap for enhancing the well-being of our community. We recognize that the needs of our community evolve over time, and new community partners may join this effort. The CHIP priority areas and strategies will be modified to address these changes.

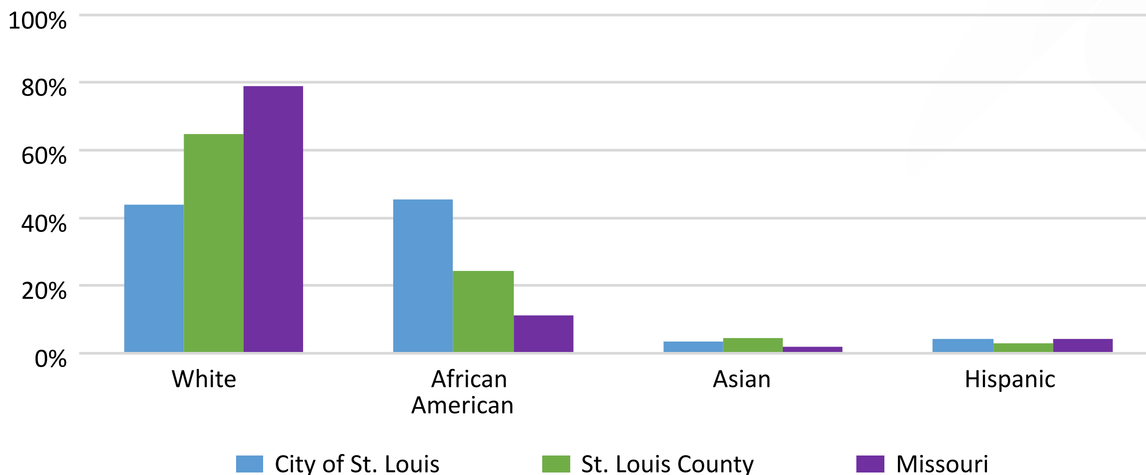
Population demographics and social and structural determinants of health play a key role in determining the type of health and social services needed most by communities. The next section aims to briefly describe the demographics of the City of St. Louis and St. Louis County and highlight selected upstream factors that affect population health in the St. Louis region. Additionally, data for each of the five priority areas are presented.

# St. Louis by the Numbers: Background and Demographics

## Population Demographics

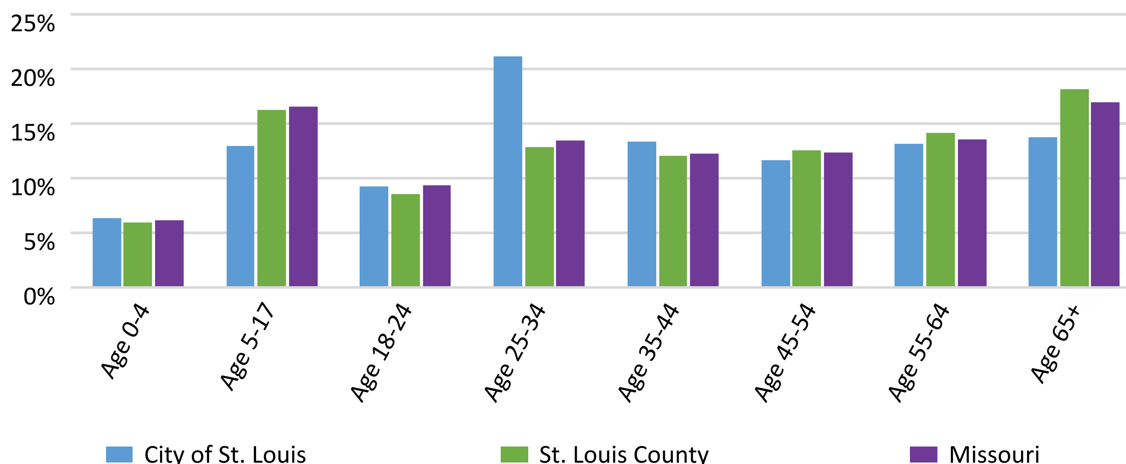
The City of St. Louis has 304,709 residents, and St. Louis County has 996,179 residents. The region's combined population is 1,300,888 within a 569.6 square mile area, giving a population density of 2,284 persons per square mile.[6] When disaggregated by sex, both the City of St. Louis and St. Louis County have a slightly higher proportion of women (52%) than men (48%).[6] White and Black residents make up the majority of the population in the region (Fig. 11), with a roughly even split in the City (45.8% White and 47.4% Black), while the County has a higher proportion of White residents (66.8% White and 24.9% Black).[6] The next largest racial category for both jurisdictions is Asian-American, at 3% in the City and 5% in the County. When disaggregated by age, the City's population skews younger than the County, with the highest population count in the 25 – 34 age group, while the County's largest age group population is in the 65+ group (Fig. 12).[6]

**Figure 11. Population by Race (2016 – 2020)**




Source: US Census Bureau, 2020 (ACS, 5-Year Estimate)

**Figure 12. Population by Age Group (2016 – 2020)**




Source: US Census Bureau, 2020 (ACS, 5-Year Estimate)

## Social Determinants of Health

Social determinants of health (SDOH) are non-medical factors which affect a person's overall health and health outcomes. These non-medical factors, such as education, income, housing, transportation, food, and the built environment, all greatly influence an individual's health. Table 6 shows an assortment of statistics related to these social determinants of health, including median household income, educational attainment, rates of disability, and access to health insurance. Household income may be the single greatest upstream determinant for health because financial stability can impact many aspects of a person's well-being. A family living in poverty may have limited access to safe housing, transportation, quality education, and healthy foods, which are all related to quality of life and life expectancy. The map in Figure 13 shows the percentage of families living in poverty by census tract across the St. Louis region. North City and County have the highest rates of poverty.

**Table 6. Metrics related to Social Determinants of Health**

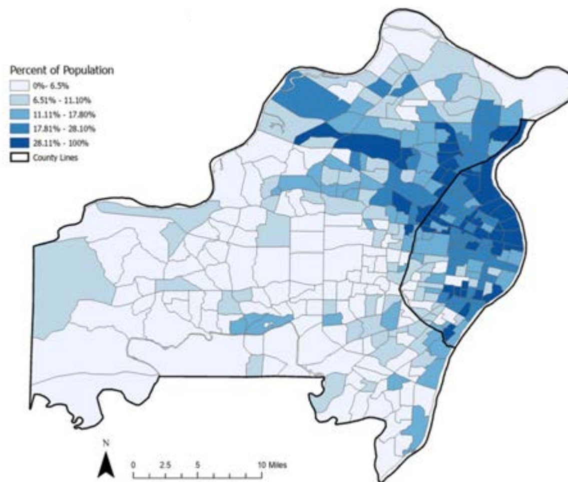
| Source: US Census Bureau, 2020 (ACS, 5-Year Estimate) | Median Household Income | Bachelor's Degree or Higher | Disability (any cause) | No Health Care Insurance |
|---|---|---|---|---|
| **St. Louis City** | $45,782 | 37.3% | 15.3% | 10.2% |
| **St. Louis County** | $68,661 | 44.5% | 11.7% | 6.1% |
| **St. Louis Region** | $92,870 | 42.8% | 12.6% | 7.0% |
| **Missouri** | $57,290 | 29.9% | 14.4% | 9.4% |

Source: US Census Bureau, 2020 (ACS, 5-Year Estimate)

## Access and Linkage to Care

Access to timely, quality health care is a key driver of health status and outcomes. Lack of health insurance is a primary barrier to health care access, including regular primary care, specialty care, and other health services. Historically, the U.S. population has experienced inconsistent access to care based on race, ethnicity, socio-economic status, age, sex, disability status, sexual orientation, gender identity, and residential location. The City has a higher rate of uninsured persons (10.2%) compared to the County (6.1%) and Missouri overall (9.4%).

**Figure 13. Percent of Population Whose Income in the Past 12 Months is Below the Poverty Level by Census Tract**



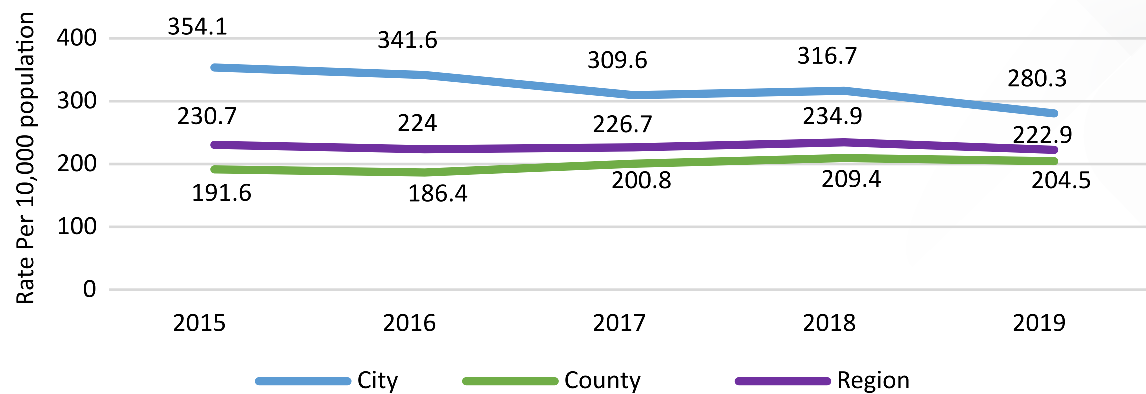

Source: US Census Bureau, 2020 (ACS, 5-Year Estimate)

Whether there are sufficient health care facilities and workers to meet a region's demand also influences health care access. Understanding the ratio of care providers to population is essential to understand the availability of various care providers. The ratio of population to primary care physicians in the City of St. Louis is 1 physician for every 1130 residents (1:1130), compared to St. Louis County's rate of 1:820 and a statewide rate of 1:1430.[7] Within the St. Louis region, one-fifth (20.05%) of residents live in an area where there is at least one health professional shortage.[8] Eighty percent of St. Louis County residents and 78.3% of City of St. Louis residents saw a primary care doctor in the past year. For dental care, 68.4% of St. Louis County and 56.4% of City of St. Louis residents saw a dentist within the past year.

While health insurance and physician availability help patients attain and afford health care, additional factors affect access to care. 18.7% of the City's population doesn't have access to a vehicle (compared to 6.2% in the County), making transportation more burdensome and time-consuming for patients seeking care. Furthermore, patients need to be able to communicate effectively about their needs.[6] About 3% of the St. Louis region's population speaks English less than "very well," and many more speak a language other than English as their primary language.[6] Language barriers create obstacles to health care access, communications, and health literacy/education. It is important to recognize and address social determinants like these when designing and implementing interventions to improve health outcomes and reduce health disparities.

## Behavioral Health

**Figure 14. Age-Adjusted ER Visits due to Mental Disorders, 2015 – 2019**




Source: Missouri Department of Health and Senior Services, 2015-2019

This section provides a brief background on the context of behavioral health in the St. Louis region. Two primary behavioral health issues emerged from the CHA: mental health and substance use. Of particular interest within these broad categories are depressive disorders, opioid addiction, and overdose. The following data provides context for the impact behavioral health issues have on residents of the St. Louis region, emphasizing noted disparities. Populations experiencing greater behavioral health disparities in the St. Louis region are Black men, Hispanic and multiracial residents, LGBT+ residents, seniors, and those with current or past substance misuse.

### Mental Health in the St. Louis Region

The City of St. Louis has the highest prevalence of mental health-related emergency room visits when compared to St. Louis County and Missouri. The rate of overall treatment services in the City of St. Louis was 26 per 1,000 population, compared to 7 per 1,000 for St. Louis County and 14 per 1,000 in Missouri.[9] In the City of St. Louis, the top three most prevalent mental disorders in 2020 were depressive disorders, schizophrenia, and bipolar mood disorders.[10] There are evident disparities seen in treatment related to race, education, sex, and location.

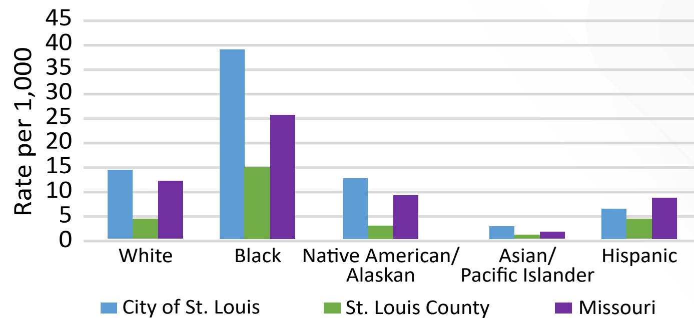
## Mental Health Disparities

Black and multiracial populations were admitted for clinical psychiatric services to treat a wide array of mental health disorders at the highest rates. In 2020, Black individuals in the City of St. Louis received services for mental illness at a rate of 39 per 1,000 compared to Whites with a rate of 14 per 1,000.[9]

There are higher rates of mental illness in North and Southeast City of St. Louis and North St. Louis County, with large Black populations and where poverty and chronic disease prevalence are also high.

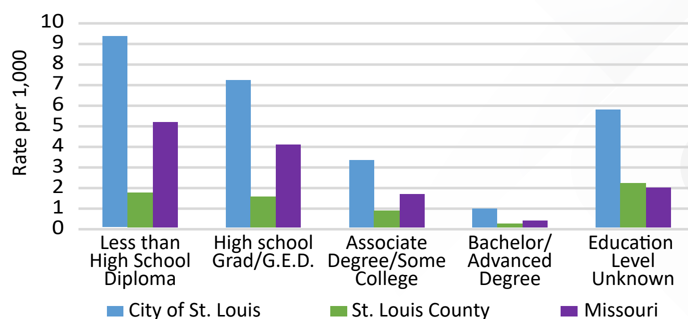
Women have an overall higher prevalence of mental illness, yet males receive treatment at a higher rate in the St. Louis region. Individuals with lower levels of educational attainment show higher rates of mental health service use.

**Figure 15. Mental Health Treatment Services by Race**




Source: Missouri Department of Mental Health, 2020

**Figure 16. Mental Health Treatment Services by Education**




Source: Missouri Department of Mental Health, 2020

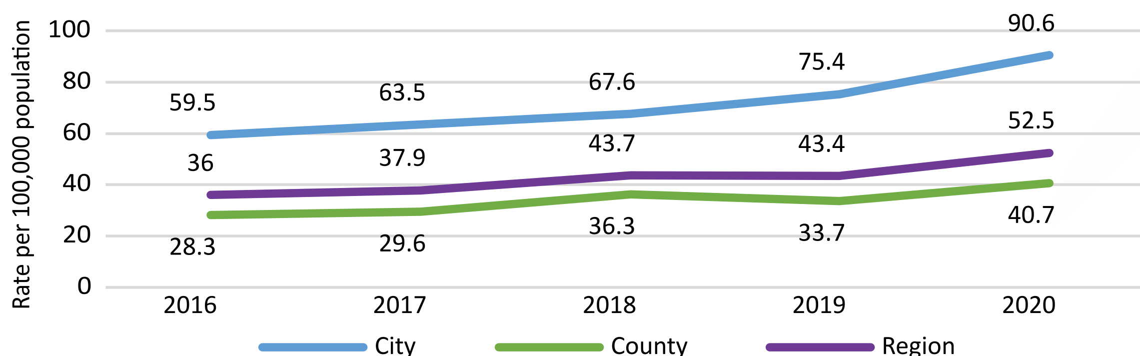
## Overdose Mortality in the Region

Overdose mortality accounts for deaths involving substances such as opioids, amphetamines, and benzodiazepines. This report does not account for alcohol-related mortality. Overdose mortality is one way to gauge the growing impacts of the overdose epidemic on the St. Louis region. Opioid overdoses, primarily involving illicitly manufactured fentanyl, are driving much of the growth in overdose deaths witnessed between 2016 and 2020.

In both the City of St. Louis and St. Louis County, the overdose mortality rate increased over the period between 2016 and 2020, with the highest mortality rate for each jurisdiction occurring in 2020. The region saw a 45.8% increase in overdose mortality from 2016 to 2020.[11] Opioid-related deaths account for the bulk of the overall overdose mortality in the St. Louis region.

**Figure 17. Age-adjusted Overdose Mortality, 2016 - 2020**

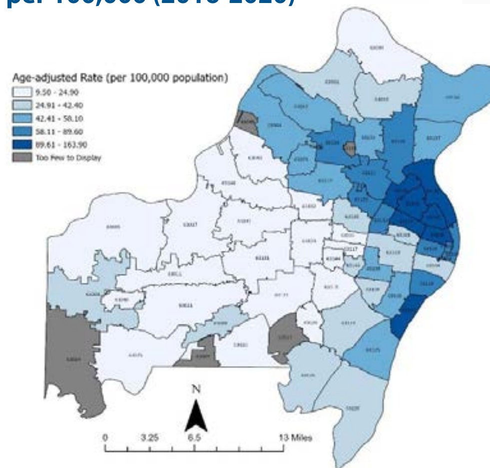
**Opioid Overdose Mortality in the Region**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

Between 2016 and 2020, 89.8% of overdose deaths in the region involved an opioid. The opioid-involved overdose mortality rate was nearly 50% higher in 2020 than in 2016, with a 48.2% increase in St. Louis County and a 50.4% increase in the City of St. Louis.[11]

**Figure 18. Regional Overdose Mortality Rate per 100,000 (2016-2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

### Substance Use Disparities in the Region

Figure 18 displays age-adjusted mortality rates for resident deaths caused by overdose in the St. Louis region by zip code from 2016 to 2020. Overdose mortality rates were highest for residents in select zip codes in north and southeastern parts of the City of St. Louis and St. Louis County.

Overdose mortality rates are twice as high for Black residents, at 70.6 deaths per 100,000, as they are for White residents, at 33.9 per 100,000.[11]

Men in the City of St. Louis and St. Louis County visited the emergency room for substance use at more than twice the rate of women. In the City of St. Louis, residents ages 35 – 44 had the highest rates of emergency room visits, but ages 25 – 34 had the highest rates in St. Louis County. The City of St. Louis showed the highest rates of overdose visits across all age groups in the region.[12]

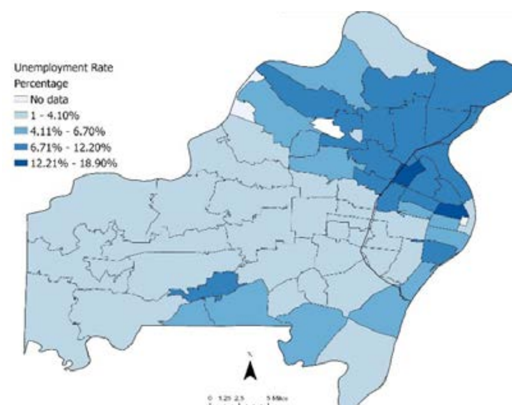
## Intersection of Health & Economic Mobility

This section provides a brief background on the context of the intersection of health and economic mobility in the St. Louis region. Specifically, five issues emerged from the CHA related to the Intersection of Health and Economic Mobility, including unemployment, home ownership, severe rent burden, business ownership, and the ability to improve income without impairing benefits. To better understand how economic mobility may impact the health of the residents in the St. Louis region, regional data on these issues are provided. This data will also highlight disparities in economic mobility that disproportionately affect Black residents, LGBT+, and youth and seniors living in Northern parts of the City of St. Louis and St. Louis County.

### Unemployment in the St. Louis Region

The economic and psychological costs of unemployment are significant. Jobs positively impact physical and mental health, resulting in less stress-related health conditions and reduced depression. Black residents are five times more likely to be unemployed than White residents in the City of St. Louis, while in St. Louis County, they are twice as likely to be unemployed.[13] Figure 19 shows the estimated unemployment rate for residents 16 years and older in the St. Louis region by zip code for 2020.[14] Residents living in select zip codes in north City and County and south City and County had the highest estimated unemployment rates.

**Figure 19. Unemployment Rates for Ages 16+ in St. Louis Region, 2020**

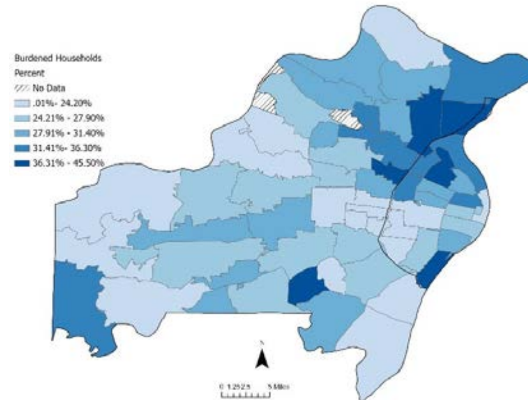



Source: US Census Bureau, 2020 (ACS, 5-Year Estimate)

## Rent Burden in the St. Louis Region

In 2018, 25.8% of all renters in the City of St. Louis experienced severe rent burden, meaning they spent more than 30% of their household income on rent. Rent-burdened households accounted for 31.3% of Black renter households and 14.7% of White renter households. In St. Louis County, only 11.8% of renters were rent-burdened, including 20% of Black renters and 9% of White renters.[15] Figure 20 shows an estimate of the cost-burdened rental households in the St. Louis region by ZIP code for 2020.[14] ZIP codes in North City and County have the highest percentage of cost-burdened households, while select ZIP codes in South City and County also have high percentages.

**Figure 20. Cost-burdened Households (>30% of Household Income Spent on Rent) in St. louis Region, 2020**




Source: US Census Bureau, 2020 (ACS, 5-Year Estimate)

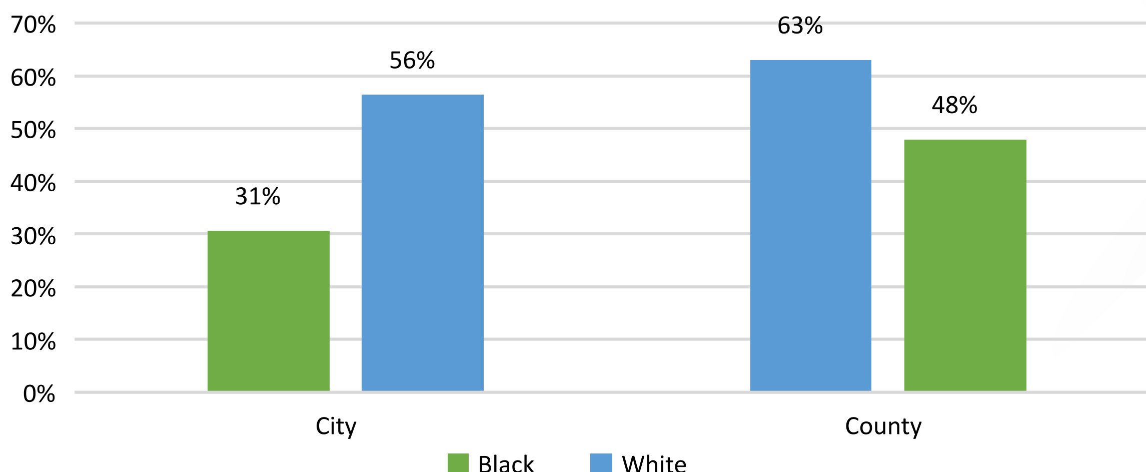
## Home Ownership and Home Loan Denial Rates in the St. Louis Region

Homeownership is frequently cited as the most critical indicator of wealth-building. This opportunity is not evenly available to the region's residents; 56.4% of White residents in the City of St. Louis own homes compared to 30.6% of Black residents, a rate 1.84 times higher. In St. Louis County, 63% of White residents own homes compared to 48% of Black residents, a rate 1.3 times higher.[15] The timing of entry into home ownership is critical given variable lending and home loan denial rates.

Black applicants in the City of St. Louis are **four times** as likely as White applicants to be denied a home loan.

A home loan denial rate measures the percentage of applications for home improvement and home purchase loans not approved by lenders for a specific reason. Black applicants in the City of St. Louis are four times as likely as White applicants to be denied a home loan. In St. Louis County, Black applicants are 1.7 times as likely as White applicants to be denied a home loan.[15] Common reasons cited for denial of a home loan are insufficient collateral, incomplete credit application, poor credit history, high debt-to-income ratio, employment history, or insufficient cash for down payment or closing.[16]

**Figure 21. Percentage of Home Ownership by Race, 2020**




Source US, Census Bureau, American Community Survey, 1-year PUMS, 2020

### Business Ownership in the St. Louis Region

Economists from the Federal Reserve Bank of Cleveland identified active small business ownership and minority business ownership as two major growth factors for regional economies. However, White residents in the City of St. Louis are 36% more likely to own a business than Black residents.[15] The Aspen Institute has identified business ownership as key to closing the racial wealth gap.

**Figure 22.**

Source: U.S. Censure Bureau, American Community Survey, 1-year PUMS, 2020

## Maternal and Child Health

The Maternal and Child Health (MCH) section of the CHIP report presents data on priority populations and indicators in the St. Louis region. Disparities in every facet of maternal and infant health are rooted in long-standing systemic inequities, often based on race. Women and birthing people of color are more likely to die from pregnancy-related causes than their White counterparts, and infants born to women and birthing people of color are more likely to die before they reach their first birthday than infants born to White women and birthing people.[11] Maternal and Child Health is an indicator of the community's overall health. Healthy parents and babies throughout the birthing process lay the foundation for improved health outcomes later in life.

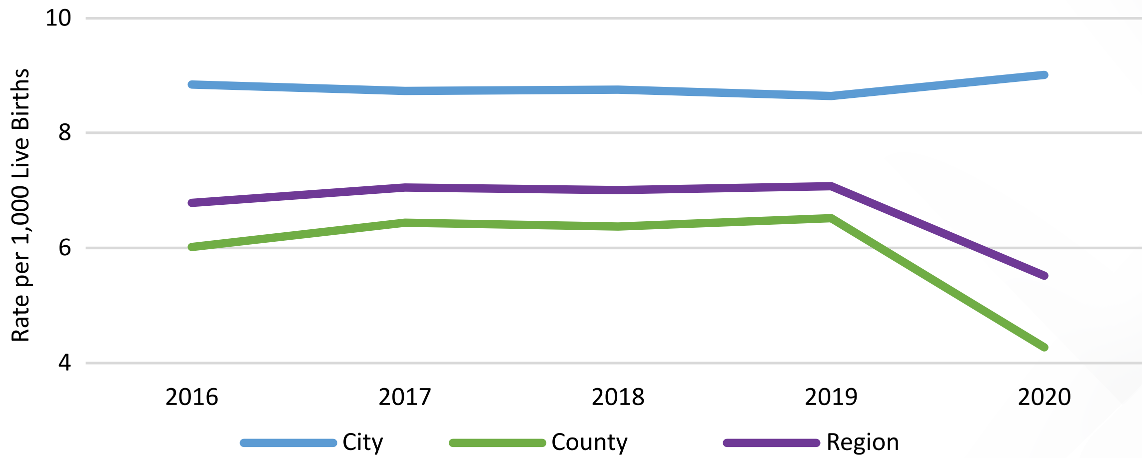
Data in this report can be used to better understand how maternal health care and outcomes can impact the health of the birthing parents and children in the St. Louis region and to identify factors that contribute to disparities in maternal and child health outcomes for Black residents. The priority populations identified in the CHSA included Black mothers and infants and mothers living in poverty. The priority data indicators identified in the CHSA were Black infant mortality, prenatal visits in the first trimester, and stigma perceived by Black parents during prenatal, natal, and postnatal periods.

### Infant Mortality

Infant mortality refers to the death of an infant before their first birthday. Common causes of death among infants include birth defects, preterm births and low birth weight, sudden infant death syndrome (SIDS), or other unexpected infant deaths, injuries, and complications from pregnancy. Healthy People 2030 set a target to reduce the number of infant deaths to less than 5 deaths per 1,000 live births.[13] In the City of St. Louis, infant mortality rates remained relatively stable from 2016 to 2020, while in St. Louis County, mortality rates decreased by 34.5%, while the City rate increased by 4.3%.[11]

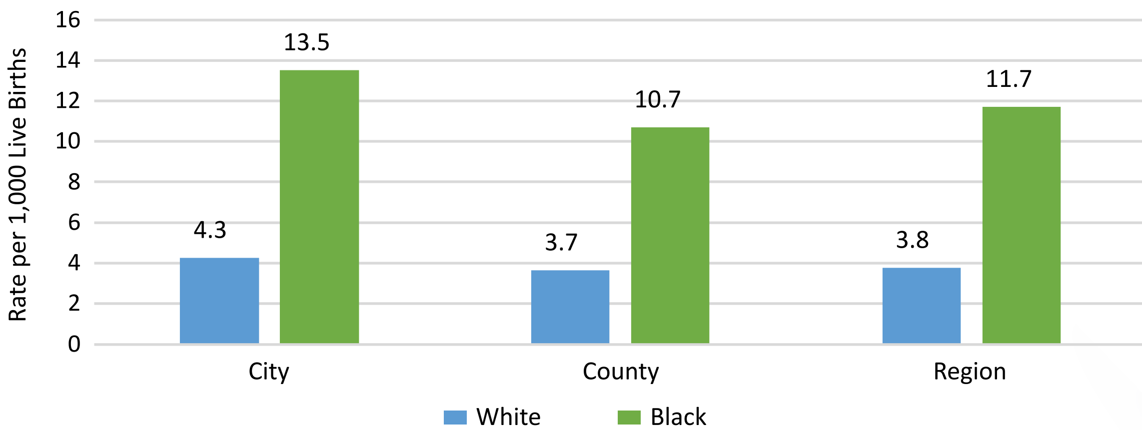
As with most other maternal, child, and family health indicators, there remains a large racial disparity in infant mortality. Black infants were about three times as likely to die during the first year than White infants in the City and County.[11]

**Figure 23. Infant Mortality Rates (2016 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

**Figure 24. Infant Mortality Rates by Race (2016 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

## Prenatal Care

The City of St. Louis, St. Louis County, and the St. Louis region have similar trends in the use of prenatal care services. They have all seen a slight decrease in the percentage of women and birthing people receiving prenatal care in the first trimester between 2019 and 2020.[11]

When disaggregated by race, White residents receive prenatal care at higher rates than Black residents in the City, County, and region overall. The disparity difference in the City shows a 49.2% decrease in prenatal care for Black women and birthing people, while the County and region show 41.6% and 47.1% decreases, respectively.[11] The race disparities between accessing prenatal care in the first trimester can have lasting effects on both mother and child, resulting in adverse health outcomes and co-morbidities.

The percentage of women and birthing people receiving prenatal care during the first trimester was highest in the west, central, and south regions of St. Louis County. Rates of prenatal care were lowest in North City and the Inner North region of St. Louis County. ZIP codes with the lowest percentage of residents receiving prenatal care in the first trimester were 63140, 63120, and 63115. ZIP codes with the highest rates of prenatal care were 63040, 63049, and 63144.[11]

## Stigma

CTSA focus group participants reported the need for culturally appropriate maternal health providers at the prenatal, natal, and postnatal periods. Qualitative findings also conveyed a lack of affordable health insurance, which is a barrier to accessing safe and de-stigmatized care. Adequate prenatal care and preventative services can help birthing parents take important steps to help reduce their risk of preterm birth and infant mortality. Another noted barrier to improved outcomes is lack of access to healthy food. By increasing access to healthy and affordable foods, comorbidities can be reduced in birthing parents to prevent or reduce negative maternal and child health outcomes.

**Figure 25. Percentage of Women Recieveing Prenatal Care in the 1st Trimester (2016 – 2020)**

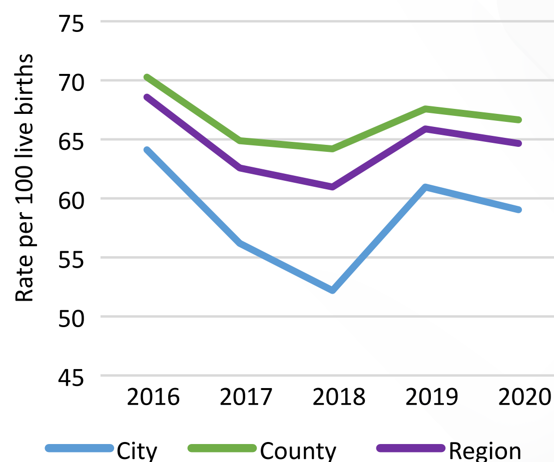



**Figure 26. Percentage of Women Receiving Prenatal Care in the 1st Trimester by Race (2016 – 2020)**

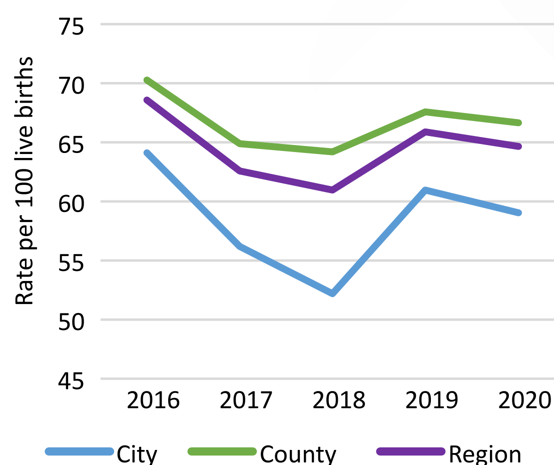
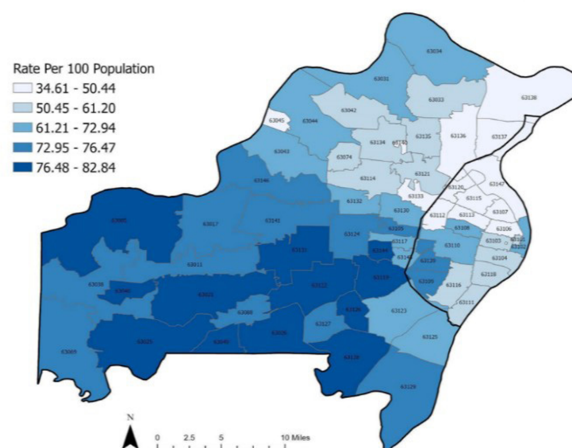



**Figure 27. Percentage of Women Receiving Prenatal Care in the First Trimester (2016 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

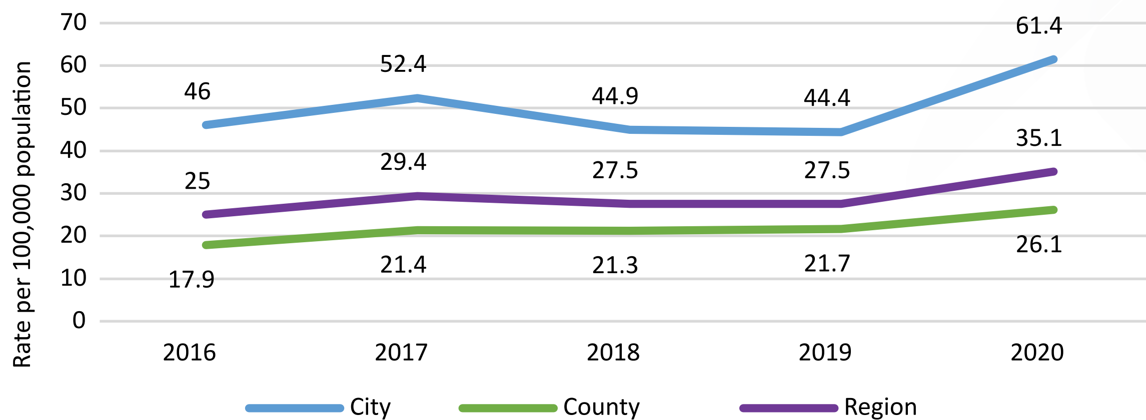
## Violence Prevention

This section provides a brief background on the context of violence in the St. Louis region. Specifically, two issues emerged from the CHA related to violence, namely gun safety and child mortality due to firearm-related accidents, homicide, or suicide. These issues are intertwined with firearm-related (gun) violence. Regional data on firearm-related mortality and child mortality show how gun violence impacts the health of the residents in the St. Louis region. The data also highlights disparities in violence that disproportionately affect Black children, youth, and adults, men, and residents living in the Northern areas of the City of St. Louis and St. Louis County.

### Firearm-related (Gun) Mortality in the St. Louis Region

Firearm-related mortality includes all deaths that involve a firearm, including suicides, accidents, unknown intent, and homicides. In 2020, the age-adjusted firearm-related mortality rate was 61.4 per 100,000 in the City of St. Louis and 26.1 per 100, 000 in St. Louis County. Since 2016, the City's firearm-related mortality rate has increased by 33.5%, and the County's mortality rate has increased by 45.8%.[11]

**Figure 28. Age-adjusted Firearm-related Mortality (2016 – 2020)**



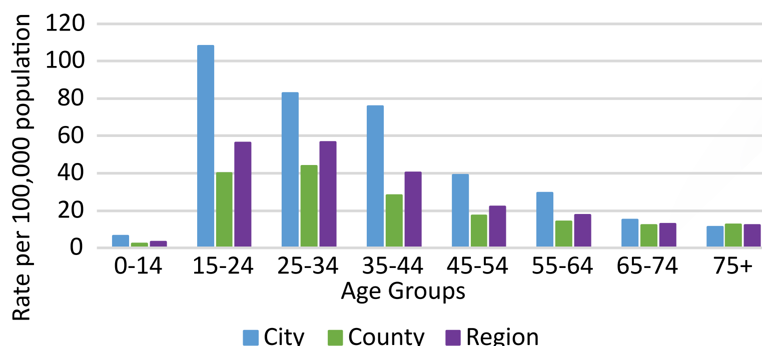

Source: MODHSS, Bureau of Vital Records Data, 2016-2020

Firearm-related mortality is not equally distributed by age, race, sex, and geographic location. The data below highlights the disparities that exist in the St. Louis region with regard to firearm-related morality.

### Firearm-related (Gun) Mortality by Age and Location

Firearm-related mortality is highest in the 15 – 24 age group in the City of St. Louis, followed by the 25 – 34 and 35 – 44 age groups. In St. Louis County, firearm-related mortality rates are highest in the 25 – 34 age group, followed closely by the 15 – 24 age group.[11] Firearm-related mortality is highest in ZIP codes in North City and North County.[11]

**Figure 29. Age-specific Firearm-related Mortality (2016 – 2020)**

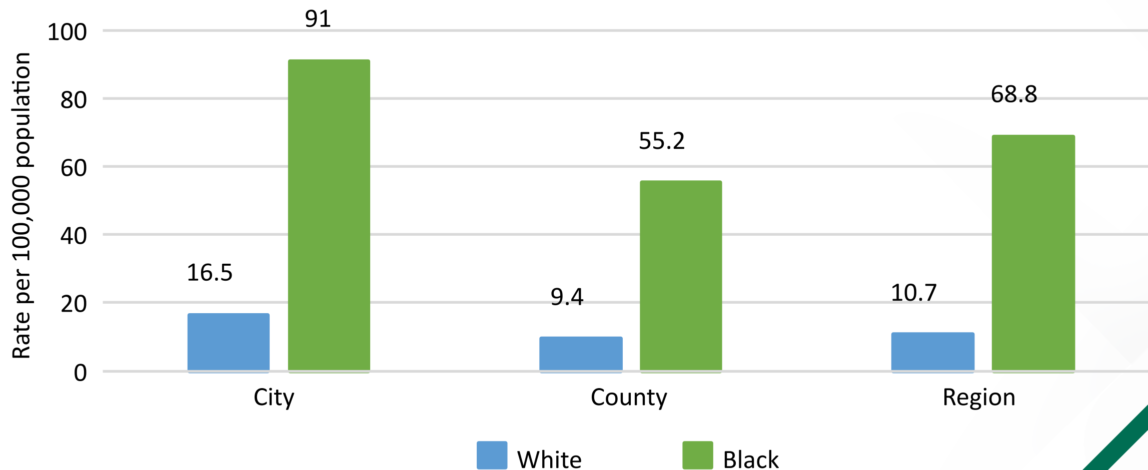



Source: MODHSS, Bureau of Vital Records Data, 2016-2020

### Firearm-related (Gun) Mortality by Race and Sex

In the City of St. Louis, from 2016 to 2020, the age-adjusted firearm-related mortality rate was 5.5 times higher for Black residents compared to White residents. In St. Louis County, Black residents experience a mortality rate 5.9 times higher than White residents.[11]

**Figure 30. Age-adjusted Firearm-related Mortality by Race (2016 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

Black residents across the region die by firearms at **6.4 times** the rate of White residents.

A similar disparity can be seen regarding firearm-related mortality by sex.

**Figure 31. Age-adjusted Firearm-related Mortality by Sex, St. Louis Region (2016 – 2020)**

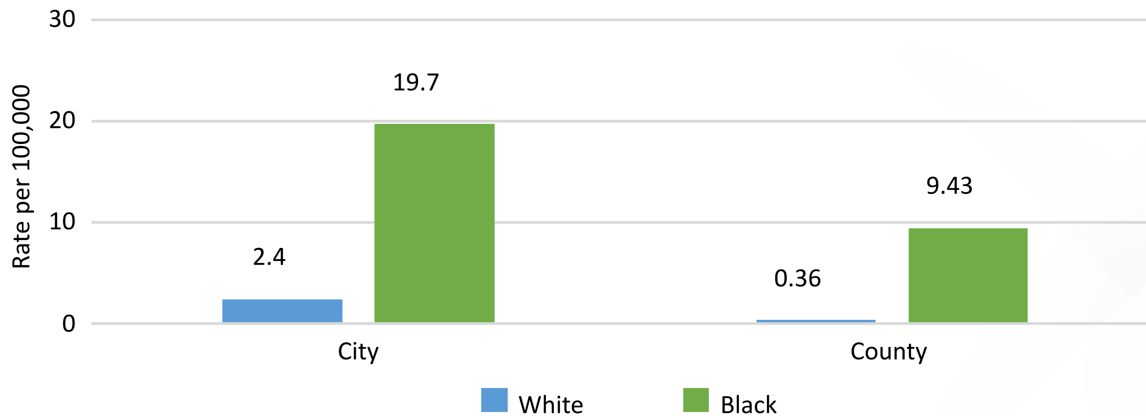
Male residents across the region die by firearm at **six times** the rate of female residents.

Source: MODHSS, Bureau of Vital Records Data, 2016-2020

## Child Mortality in the St. Louis Region

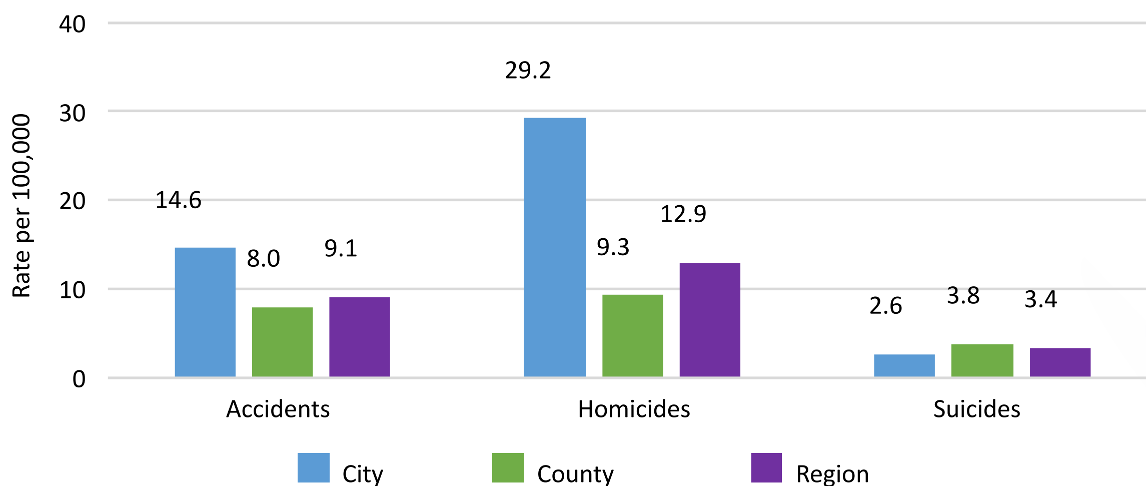
Approximately 48% of deaths in children aged 1 – 19 in 2020 in the City of St. Louis were attributed to accident, homicide, or suicide. Firearm-related homicides were the leading cause of death in the City for children ages 10 – 19 and the second leading cause of death for children ages 5 – 9. From 2011 – 2020, the homicide rate by firearm in the City was about eight times higher in Black children (19.7/100,000) when compared to White children (2.4/100,000).[11]

**Figure 32. Mortality Rate amoung Children Age<18 due to Homicide by Firearm (2011 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

**Figure 33. Mortality Rates by Type Children Aged 1 – 19 (2016 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

## Chronic Disease

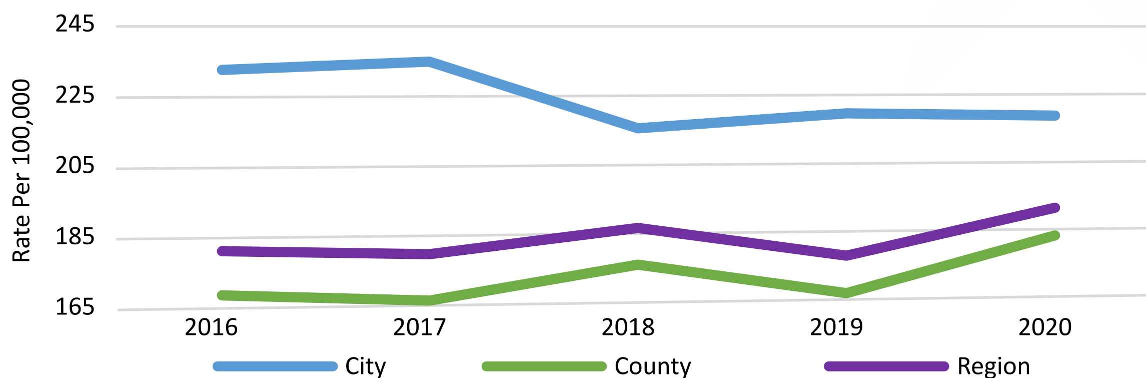
This section presents background on the context of chronic disease in the St. Louis region. Older low-income Black men are disproportionately impacted by chronic diseases when compared to other racial and socio-economic groups. The leading cause of early death due to chronic diseases among Black men is heart disease, and low-income, older Black men have a significantly higher risk of developing chronic diseases such as hypertension, diabetes, and stroke.

### Heart Disease and Diabetes Mortality Rate

Heart disease is one of the leading causes of death in the United States for men, as well as most racial and ethnic groups. For the St. Louis region, age-adjusted heart disease mortality was 219.9 per 100,000 in the City, 186.2 per 100,000 in the County, and 194 per 100,000 for the region in 2020.[11]

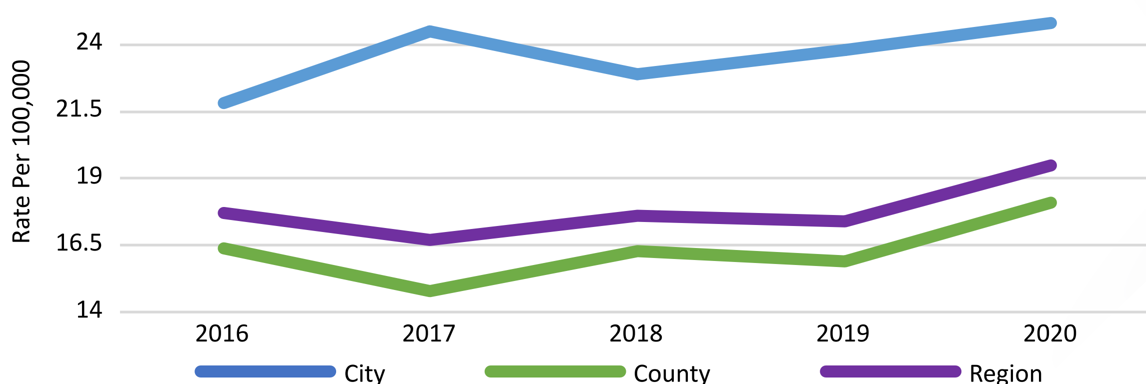
Diabetes is a serious medical condition that affects millions of people around the world. The 2020 age-adjusted diabetes mortality rate is 24.8 per 100,000 for the City, 18.1 per 100,000 for the County, and 19.5 per 100,000 for the region.[11] This highlights the need for greater research, improved access to treatments, and targeted public health initiatives to reduce the burden of these chronic diseases.

**Figure 34. Age-Adjusted Heart Disease Mortality (2016 – 2020)**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

**Figure 35. Age-Adjusted Diabetes Mortality (2016 – 2020)**



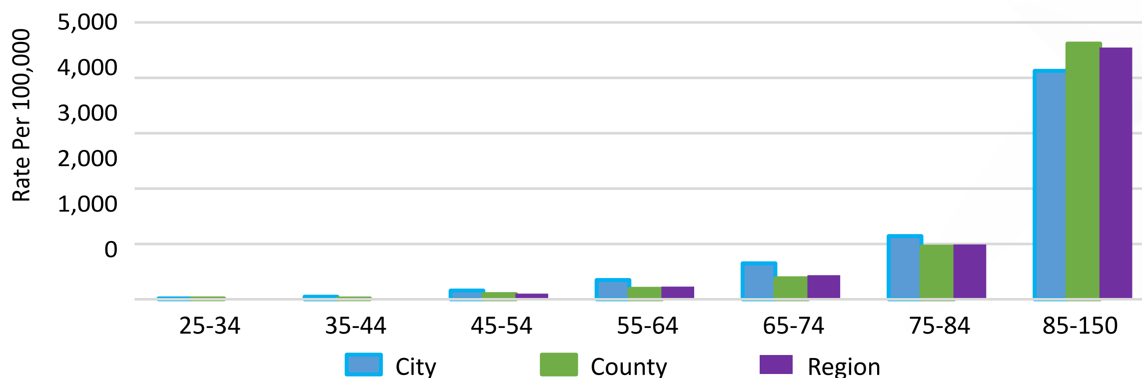

Source: MODHSS, Bureau of Vital Records Data, 2016-2020

## Heart Disease and Diabetes Mortality by Age

Heart disease mortality rates and risk factors, which include high blood pressure, high cholesterol, diabetes, and smoking, increase with age. These factors can accumulate over an individual's lifetime, leading to a reduction in cardiovascular health. For residents ages 85 and older, the age-adjusted heart disease mortality rate is 4,131 per 100,000 for the City, 4,630 per 100,000 for the County, and 4,547 per 100,000 for the region.[11]

There is a similar relationship between increasing age and diabetes mortality. Age-adjusted diabetes mortality rates are highest among residents ages 85 and older. The rate for this age group is 233.5 per 100,000 for the City, 246.6 per 100,000 for the County, and 244.5 per 100,000 for the region.[11]

**Figure 36. Age-Specific Heart Disease Mortality (2016 – 2020)**

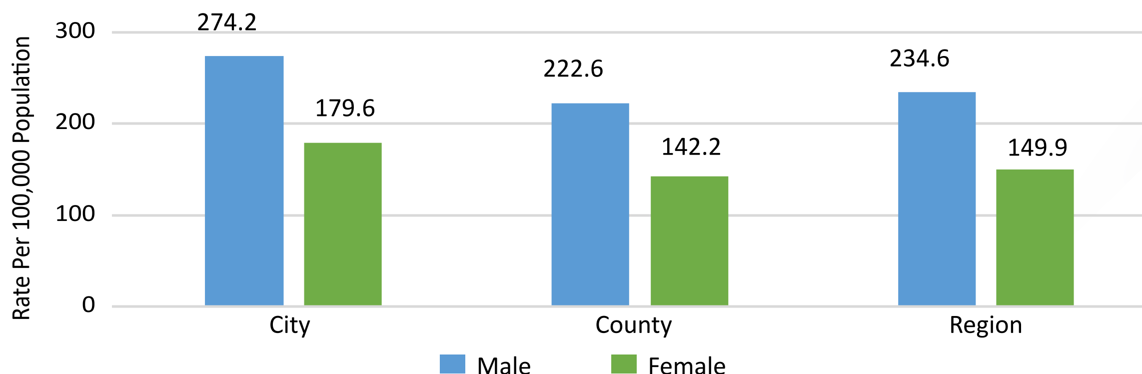



Source: MODHSS, Bureau of Vital Records Data, 2016-2020

## Heart Disease and Diabetes Mortality by Sex

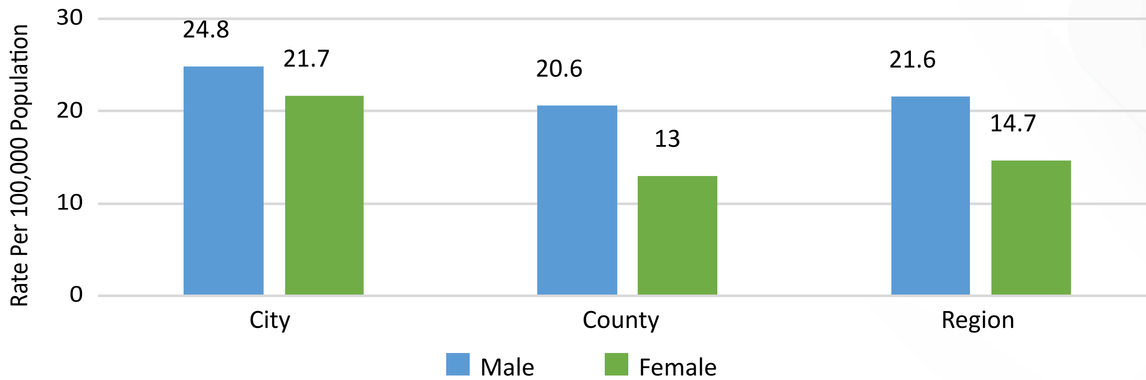
Data suggests that men are disproportionately impacted by heart disease when compared to females. For the St. Louis region, the age-adjusted heart disease mortality rate is 234.6 per 100,000 for men and 149.9 per 100,000 for women.[11] Lifestyle changes such as eating a balanced diet, avoiding smoking, engaging in regular physical activity, and managing stress can help reduce the likelihood of heart disease and premature death. Likewise, men are disproportionately impacted by diabetes when compared to females. For the St. Louis region, the age-adjusted diabetes death rate for men is 21.6 per 100,000 compared to 14.7 per 100,000 for women.[11]

**Figure 37. Age-Adjusted Heart Disease Mortality 2016 – 2020 by Sex**




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

Figure 38. Age-Adjusted Diabetes Mortality 2016 – 2020 by Sex

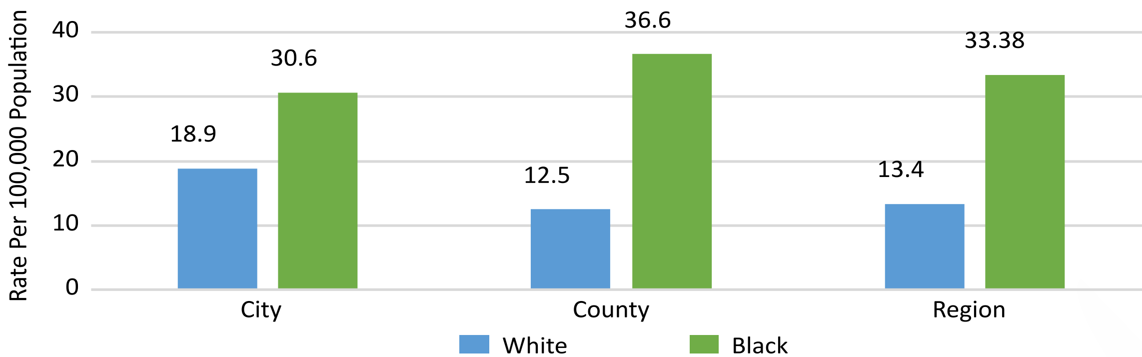



Source: MODHSS, Bureau of Vital Records Data, 2016-2020

## Heart Disease and Diabetes Mortality by Race

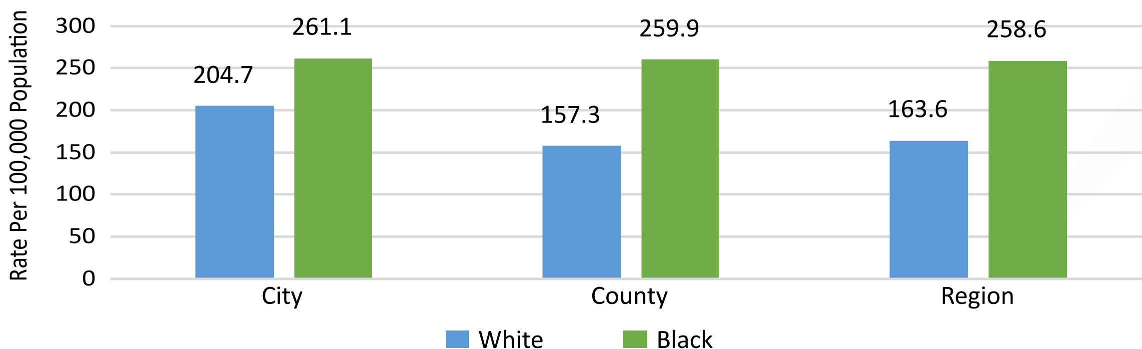
Black men are disproportionately affected by heart disease and diabetes compared to their White male counterparts. The rate of diabetes mortality by race is almost three times higher for Black residents than White residents in the region. The age-adjusted diabetes mortality rate for Black residents is 33.38 per 100,000, whereas the rate for White residents was 13.4 per 100,000.[11] Similarly, Black residents have higher rates of age-adjusted heart disease mortality at a rate of 258.6 per 100,000, compared to White residents with a rate of 163.6 per 100,000.[11]

Figure 39. Age-Adjusted Diabetes Mortality by Race 2016 – 2020




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

Figure 40. Age-Adjusted Heart Disease Mortality by Race 2016 – 2020




Source: MODHSS, Bureau of Vital Records Data, 2016-2020

# 2023 – 2027 St. Louis Regional CHIP

## Overview

| Priorities | Goals |
|---|---|
| Priority 1: Intersection of Health and Economic Mobility | 1. Build coalition infrastructure for the Intersection of Health and Economic Mobility.<br>2. By 2028, implement opportunities to increase overall wealth by reducing the cost of housing and improving housing-related resources.<br>3. By 2028, implement opportunities to increase overall income by increasing employment and education opportunities, improving wages, and reducing barriers as necessary. |
| Priority 2: Chronic Disease | 1. Increase healthy food availability, accessibility, and utilization as measured by:<br>a) More coordinated, unified, systemic nutrition security solutions.<br>b) Increased participation in food assistance programs (SNAP, WIC, School Meals, CACFP)<br>c) Food and nutrition prioritized in health care for prevention and management of chronic disease (food security screening and referral, healthy food prescription, etc.)<br>d) Nutrition valued as essential in hunger relief (food pantries, food banks) and food assistance programs (SNAP, WIC, School Meals, CACFP)<br>e) Reduced food desert footprint |
| Priority 3: Maternal and Child Health | 1. Address racial disparities to reduce morbidity and mortality and improve maternal and infant health. |
| Priority 4: Violence Prevention | 1. By 2028, reduce non-fatal shooting incidents by 25% through increased coordination of community-level response, implementation of prevention practices, and increased community engagement in a holistic approach to public safety. |
| Priority 5: Behavioral Health | 1. By 2027, improve behavioral health and wellness through the availability, accessibility, and affordability of integrated and consistent, coordinated, patient-centered care for our most affected populations in St. Louis County and City of St. Louis through policy changes.<br>2. By 2027, improve behavioral health and wellness among affected populations through education and community navigation.<br>3. By 2027, increase the availability and accessibility of behavioral health services by utilizing systems-level navigation and integrated, coordinated, patient-centered care in the St. Louis region. |

# Priority Area 1: Intersection of Health and Economic Mobility

| **Goal 1:** Build coalition infrastructure for the Intersection of Health and Economic Mobility. | |
|---|---|
| **Objective 1.1:** By 2025, launch a coalition of stakeholders representative of these focus areas and hold four multi-sectoral meetings: employment opportunities, homelessness and housing, health systems, utility companies, banks, financial institutions, rent advocacy, health and safety, transportation, environmental health, social services and community partner agencies, and health care economics. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.1.1** Identify target areas for agencies and organizations, with individuals (especially those with lived experience) to be part of the coalition. | CHIP Action Team |
| **1.1.2** Identify agencies in each target area for participation in the Action Team. | CHIP Action Team |
| **1.1.3** Gain participation agreement for the Action Team from at least one agency in each target area. | CHIP Action Team |
| **1.1.4** Hold one quarterly meeting with the Action Team representative of focus areas. | CHIP Action Team |
| **Objective 1.2:** By 7/15/2024, identify two funding opportunities to advance the strategic priority areas: housing, education/employment. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.2.1** Identify a list of possible funding sources to support goals 2 and 3. | CHIP Action Team |
| **1.2.2** Decide on funding sources that we will pursue. | CHIP Action Team |
| **1.2.3** Apply to funding opportunities. | CHIP Action Team |
| **GOAL 2: By 2028, implement opportunities to increase overall wealth by reducing the cost of housing and housing-related resources.** | |
| **OBJECTIVE 2.1:** By 2028, identify, advocate for, and pass five policies to increase the income eligibility (60% SMI/200% poverty) and reduce the eligibility barriers to regional housing and housing-related resources. | |
| **Activities:** | **Lead Person/Organizations:** |
| **2.1.1** Advocate for policies to increase minimum income eligibility for housing assistance. | City DOH, Tim McBride |
| **2.1.2** Reduce the eligibility barriers to regional housing (tax policies, land use controls, zoning ordinances, building codes). | St. Louis Housing Authority; Dept. of Human Services |
| **2.1.3** Reduce the eligibility barriers to utility resources (lack of awareness, language barriers, confusion about eligibility rules, complicated application procedures). | Heat Up St. Louis |
| **2.1.4** Increase the supply of available beds in the community to address increases in homelessness and the challenges of unsheltered persons. | City DOH and County DPH, St. Patrick's, Dept of Human Services, Almost Home, Beyond Housing |
| **2.1.5** Increase the availability of truly affordable, accessible, and safe housing stock which meets the needs of individuals and families. | Sal Valadez, Teka Childress (Gateway Housing First), Joe Yancey |
| **2.1.6** Provide wrap-around services especially focused on behavioral health challenges as barriers in obtaining or keeping housing. | GROW, City, County |
| **2.1.7** Increase the connection of homeless or transitioning housing clients to employment agencies for stabilizing income and housing situations. | SLATE, Employment Connection |

| GOAL 3: By 2028, implement opportunities to increase overall income by increasing employment and education opportunities, improving wages, and reducing barriers as necessary. | |
|---|---|
| **OBJECTIVE 3.1:** Launch 2-3 employment/education projects for increasing income or wages by 2028. | |
| **Activities:** | **Lead Person/Organizations:** |
| **3.1.1** Increase the number of apprenticeships and paid internships in the City and County where people can earn while they learn. | Federal Reserve Bank of St. Louis; unions; Greater St. Louis Inc.; SLATE; Sal Valdez |
| **3.1.2** Increase the number of Federal Bonding Program participants. | MO Dept. of Economic Dev; Office of Workforce Development |
| **3.1.3** Increase the number of Work Opportunity Tax Credit participants. | MO Dept. of Economic Dev; Office of Workforce Development |
| **3.1.4** Increase the number of labor union apprenticeships. | MO DOL; local labor unions; Sal Valdez |
| **3.1.5** Increase financial support for community colleges, trade schools, and programs providing high tech, in-demand job training with online accessibility. | DOL; Dept. of Education; Health Departments; MO Dept of Education; Workforce Development; Sal Valdez; Saint Louis Community College |
| **3.1.6** Incentivize employers to hire and retain local employees who have completed the above programs. | DOL; Dept. of Education; Health Departments; MO Dept of Education; Workforce Development; SLATE |
| **OBJECTIVE 3.2:** Pass policies to increase the income eligibility (60% SMI/200% poverty) and reduce the eligibility barriers to regional housing and utility resources. | |
| **Activities:** | **Lead Person/Organizations:** |
| **3.2.1** Pass an increase to the minimum wage in the City and County. | Federal Reserve Bank of St. Louis; unions; Greater St. Louis Inc.; Tim McBride |
| **3.2.2** Advocate policy at the state level to increase income eligibility and reduce eligibility barriers to regional housing. | Federal Reserve Bank of St. Louis; Unions; Greater St. Louis Inc.; MO Foundation for Health, City DOH and County DPH; Tim McBride; Board of Health |
| **3.2.3** Advocate policy at the state level to increase income eligibility and reduce eligibility barriers to utility resources. | Federal Reserve Bank of St. Louis; Unions; Greater St. Louis Inc.; MO Foundation for Health, City DOH and County DPH; Tim McBride; Community Action Agencies, Heat Up Cool Down St. Louis; Board of Health; Office of Public Counsel |
| **3.2.4** Advocate policy at the state level on legislation related to FMLA, family leave, disability, and childcare. | Federal Reserve Bank of St. Louis; Unions; Greater St. Louis Inc.; MO Foundation for Health, City DOH and County DPH; Tim McBride; Board of Health |

| | |
|---|---|
| **3.2.5** Advocate for MHDC/CDA policies and guidelines that are equitable for those individuals with the highest needs (disability, formerly homeless persons, individuals with mental illness, formerly incarcerated). | Federal Reserve Bank of St. Louis; Unions; Greater St. Louis Inc.; MO Foundation for Health, City DOH and County DPH; Tim McBride; Board of Health |
| **3.2.6** Empower individuals with lived experience and their stories in this advocacy for housing, education, and employment. | GROW STL, Gateway Housing First, other grassroots partners |
| **3.2.7** Attract and invite thought leaders in each one of the focus areas to provide detailed and insightful advocacy and policy in action. | Julie Gary, Tim McBride, Sal Valdez, Joe Yancey, Erise Williams |

| ALIGNMENT WITH STATE/NATIONAL PRIORITIES | |
|---|---|
| **Obj #** | **Healthy People 2030** |
| *1* | *Not directly related to this objective but will be indirectly related to the others* |

## Priority Area 2: Chronic Disease

**Goal 1:** Increase healthy food availability, accessibility, and utilization measured by:

- Increased coordinated, unified, systemic nutrition security solutions.
- Increased participation in food assistance programs (SNAP, WIC, School Meals, CACFP)
- Food and nutrition prioritized in health care for prevention and management of chronic disease (food security screening and referral, healthy food prescription, etc.)
- Nutrition is valued as essential in hunger relief (food pantries, food banks) and food assistance programs (SNAP, WIC, School Meals, CACFP)
- Reduced food desert footprint

**Objective 1.1:** By Dec. 31, 2024, develop a ten-year strategic plan to increase food security by 40% (capacity building)

| **Activities:** | **Lead Person/Organizations:** |
|---|---|
| **1.1.1** Meet with key stakeholders to identify existing nutrition security solutions being implemented in the region. | Action team, SLU/City DOH CDC project |
| **1.1.2** Engage in ongoing stakeholder organization needs and environmental assessments to identify gaps and opportunities. | Action Team |
| **1.1.3** Hold quarterly coalition/council/stakeholder meetings to create a shared space for collaboration, implementation, planning, and reporting. | Action Team chairs |
| **1.1.4** Create a St. Louis Nutrition Security toolkit of local resources for the specific needs of various target populations (e.g., children, seniors, and those living with chronic conditions). | American Heart Association, Action team |
| **1.1.5** Create a 10-year strategic plan. | Action Team |

| **Objective 1.2:** By Dec. 31, 2025, 100% of health care organizations in the St. Louis region will utilize a systemic screen and refer protocol for food insecurity. | |
|---|---|
| **Activities:** | **Lead Person/Organizations:** |
| **1.2.1** Catalog and create recommendations on validated food security screening tool or broader SDoH screener inclusive of food security. | American Heart Association, Action team, City DOH and County DPH |
| **1.2.2** Establish referral pathways to community resources and food assistance programs. | American Heart Association, Action team, Hospital groups – BJC/St. Luke's/Mercy/SSM |
| **1.2.3** Provide training to improve referral/intervention. | American Heart Association, Action Team |
| **1.2.4** Promote health care facilities and CBOs to implement food insecurity screening. | American Heart Association, Action Team |
| **1.2.5** Work with healthcare organizations to create a policy on the use of a validated food security screening tool or broader social determinants of health (SDoH) screener inclusive of food security. | American Heart Association, Action team, City DOH, and County DPH |
| **Objective 1.3:** By December 31, 2024, work with 25 community-based organizations to increase capacity to provide fresh or frozen produce or healthy prepared meals at food assistance facilities OR other community-based organizations serving population(s) with high rates of nutrition insecurity. (Systems, Environmental Change, lifting an existing community asset). | |
| **1.3.1** Assess the barriers that exist in food assistance facilities or CBOs that limit the capacity to provide fresh or frozen produce. | American Heart Association, City DOH, and County DPH |
| **1.3.2** Make connections in the community to overcome accessibility barriers faced by consumers and CBOs (education, infrastructure, refrigeration, shelving, staffing, business development). | American Heart Association, Action Team |
| **1.3.3** Support and/or seek funding for large-scale capacity building impact fund. | American Heart Association, Action Team |
| **Objective 1.4:** By June 1, 2026, support or establish ten new farmers markets, mobile markets, urban farms, pop-up markets, delivery services, and other sustainable access points to fruits and vegetables that meet SNAP eligibility requirements. (Systems, Environmental Change) | |
| **1.4.1** Explore funding opportunities to establish new food retail establishments or expand existing retail capacity to increase hours of operation, locations, etc. | American Heart Association, A Red Circle, BeWell Café, and Action Team for support |
| **1.4.2** Build a community awareness campaign plan to increase community awareness of new healthy food outlets. | American Heart Association, Action Team |
| **1.4.3** Connect new food retailers to technical assistance with applying for WIC and SNAP certification. | Action Team |
| **1.4.4** Provide information, linkages, and education to stores and communities about how they can promote healthier food purchasing, preparation, and consumption. | American Heart Association, Action team, City DOH, and County DPH |

| **Objective 1.5**: By June 1, 2026, establish a sustainable Double Up Food Bucks program (or other coupon/double bucks/added benefit program) via WIC, Senior Farmer Market, SNAP, etc., to increase access to locally grown fruit and vegetables in St. Louis region. | |
|---|---|
| **1.5.1** Apply for Nutrition Incentive/Capacity Building and Innovation Fund. | American Heart Association, SLU |
| **1.5.2** Complete an assessment/environmental scan on the region's opportunities to establish and sustain a coupon/double bucks/local F&V incentive program. | American Heart Association, SLU, Action Team, City DOH, and County DPH |
| **1.5.3** Research best practices and funding models. | American Heart Association, SLU, City DOH, and County DPH |
| **1.5.4** Create a target list of organizations or government agencies to fulfill a potential local match requirement (GusNIP). | American Heart Association, SLU, Action Team |
| **1.5.5** Build relationships and increase the number of organizations in the coalition to support the nutrition incentive program. | American Heart Association, SLU, Action Team, City DOH, and County DPH |
| **1.5.6** Create cooperative agreements with local organizations to implement nutrition incentive programs. | American Heart Association, Action Team |
| **1.5.7** Submit request for funding GusNIP – Nutrition Incentive Programs | American Heart Association |
| **1.5.8** Create a nutrition incentive program implementation plan (Jan. 1, 2025 – Dec. 31, 2026) | American Heart Association, SLU, Action Team |

| **ALIGNMENT WITH STATE/NATIONAL PRIORITIES** | |
|---|---|
| **Obj #** | **Healthy People 2030** |
| *1 – 6* | *Increase vegetable consumption by people aged two years and older.* |
| *2* | *Reduce household food insecurity and hunger.* |

## Priority Area 3: Maternal and Child Health

| **Goal 1:** Address racial disparities to reduce morbidity and mortality to improve maternal and infant health. | |
|---|---|
| **Objective 1.1:** By 2027, increase the percentage of Black and Brown pregnant people who receive early and adequate perinatal preventative care by 15%. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.1.1** Raise awareness for Medicaid coverage for one year postpartum. | Generate Health, March of Dimes, St. Louis Doula Project, City DOH |
| **1.1.2** Ensure Medicaid retention through increased re-enrollment by creating re-enrollment training manuals. | City DOH |
| **1.1.3** Increase clinic visits for pregnant people utilizing community health workers (CHWs), peer support, doulas, and patient navigators. | County DPH: Nurse Family Partnership (NFP) and Public Health Nursing (PHN). |
| **1.1.4** Advocate for Medicaid reimbursements for doulas as part of the care team. | Generate Health, March of Dimes, St. Louis Doula Project, IHN, BJC |

| | |
|---|---|
| **1.1.5** Create a consistent and efficient way to track current utilization for CHWs, peer support, doulas, and patient navigators at area clinics to better assess the work that needs to be done in individual organizations. | BJC, WASH U |
| **Objective 1.2:** By 2027, decrease racial and ethnic disparities in maternal mortality by 52.70% and infant mortality by 67.52% by improving the delivery of equitable, culturally congruent, people-facing services for pregnant people and their partners. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.2.1** Advocate for doulas to be recognized as part of the care team. | Generate Health, March of Dimes, St. Louis Doula Project, IHN – Dr. Jesse Davis |
| **1.2.2** Increase implementation and dispersion of evidence-based training modules for providers. | IHN, Generate Health, March of Dimes, SUD, County DPH, BJC |
| **1.2.3** Increase training, hiring, and retention of diverse nurses and other health care workers in women's health. | BJC |
| **Objective 1.3:** By 2027, Reduce rates of congenital syphilis by 90%. | |
| **1.3.1** Continue supporting operations of the Syphilis Review Board. | City DOH, Syphilis Review Board |
| **1.3.2** Advocate for state policy changes that require syphilis testing three times a pregnancy. | Syphilis Review Board |
| **1.3.3** Increase awareness of testing services and how to access them. | County DPH, City DOH, SSM MOMS line & St. Louis Doula Project |
| **1.3.4** Improving communication and cooperation between sexual partners and services through contact tracing and testing. | St. Louis Doula Project |
| **Objective 1.4:** By 2027, reduce pregnancy-related health disparities among Black and Brown pregnant people by 5% through health promotion and education programs. | |
| **1.4.1** Continued implementation of the Safe Sleep First Project to support safe sleep education access to resources for parents, caregivers, and other service providers. | St. Louis Doula Project, Generate Health, County DPH, March of Dimes, STL Diaper Bank |
| **1.4.2** Improving health literacy on nutrition and feeding practices for pregnant people and infants. | March of Dimes, County DPH, St. Louis Doula Project |
| **1.4.3** Connecting mothers to wellness resources in their community through support groups. | SSM MOMs Line partnership with Da Hood Connect |
| **1.4.4** Increase community awareness surrounding perinatal mood and anxiety disorders (PMAD). | BJC |
| **Objective 1.5**: By 2027, increase enrollment of organizations in the statewide CRIS system by ten. | |
| **1.5.1** Build provider capacity for those involved in the system**.** | Generate Health, Bloom Network, Perinatal Behavioral Health Initiative |
| **1.5.2** Market and promote the CRIS System to community members. | Generate Health, Bloom Network, Perinatal Behavioral Health Initiative |

| **Objective 1.6:** By 2027, create four opportunities for residents to engage in skill-building and community engagement training to advocate for maternal and child health. | |
|---|---|
| **1.6.1** Develop skill-building and training opportunities with community residents to empower leaders to advocate in the neighborhoods, with legislators, and in the media. | Generate Health, March of Dimes, St. Louis Doula Project |
| **1.6.2** Develop and spread models of community engagement and community-led decision-making in the region. | Generate Health, City DOH |

| **ALIGNMENT WITH STATE/NATIONAL PRIORITIES** | |
|---|---|
| **Obj #** | **Healthy People 2030** |
| *1* | *Increase the proportion of pregnant women who receive early and adequate prenatal care — MICH-08* |
| *2* | *Reduce congenital syphilis — STI-04* |
| *3* | *Reduce preterm births — MICH-07* |

## Priority Area 4: Violence Prevention

| **Goal 1:** By 2028, reduce non-fatal shooting incidents by 25% through increased coordination of community-level response, implementation of prevention practices, and increased community engagement in a holistic approach to public safety. | |
|---|---|
| **Objective 1.1:** Coordinate the community-level response to non-fatal shootings to increase the number of individuals affected by gun violence who access services by 40% by 2025. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.1.1** Conduct public education to increase awareness of services and how to access support. | VPC, Gun Violence Response Network Partners |
| **1.1.2** Maintain partnerships and incentivize participation by first responders in Handle with Care (HWC). | VPC, ASPEN, Missouri Juvenile Justice Association |
| **1.1.3** Establish statewide partnerships to explore the expansion of HWC across MO. | VPC, Missouri Juvenile Justice Association |
| **1.1.4** Partner with mental health professionals and healers to offer non-traditional and clinical supports to recruit and train community healers. | VPC, Gun Violence Response Network Partners |
| **1.1.5** Partner with community healers to help individuals and communities recover from violence/trauma. | VPC, Gun Violence Response Network Partners |
| **Objective 1.2:** Increase the number of evidence-based programs and trauma-informed violence prevention programs funded by the Violence Prevention Commission (VPC) and core funding partners that address root causes of violence by 10% by 2028. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.2.1** Identify and advocate for evidence-based strategies that address economic mobility, health (including behavioral health), and the built environment. | TBD |
| **1.2.2** Collaborate with the Economic Mobility CHIP Action Team to align violence prevention strategies. | VPC, Economic Mobility Action Team |
| **1.2.3** Increase access to drop-in centers/safe spaces that provide wrap-around services, culturally competent mental health services, etc., for youth/young adults at greatest risk. | City of St. Louis Office of Violence Prevention, VPC Youth Engagement and Safety Committee |
| **1.2.4** Establish guidance and best practices for organizations serving youth/young adults ages 15-25. | VPC |

| | |
|---|---|
| **1.2.5** Enhance the availability of quality mentoring programs designed to serve at-risk youth. | Youth Advocates Program |
| **1.2.6** Engage youth to promote leadership development and connections to youth-serving organizations. | VPC Youth Engagement and Safety Committee |
| **1.2.7** Strengthen technical assistance infrastructure to support grassroots organizations that provide direct services. | VPC |
| **1.2.8** Use the Cardiff Model to develop data-driven strategies for violence prevention and reduction for the Violence Prevention Commission (VPC) and other partners. | VPC, City DOH |
| **1.2.9** Engage municipal governments and residents in coordinated regional violence prevention efforts. | TBD |
| **Objective 1.3:** By 2025, work with regional stakeholders to advance at least one recommendation from a previous regional public safety plan. | |
| **1.3.1** Support alternatives to police contact to meet the needs of the community. | TBD |
| **1.3.2** Advocate for the implementation of plans that improve public safety and support systems partners in the process. | TBD |

| ALIGNMENT WITH STATE/NATIONAL PRIORITIES | |
|---|---|
| **Obj #** | **Healthy People 2030** |
| *1* | Reduce homicides — IVP-09<br>Reduce nonfatal physical assault injuries — IVP-10 Reduce firearm-related deaths — IVP-13<br>Reduce nonfatal firearm-related injuries — IVP-14 |
| *2* | Reduce the rate of minors and young adults committing violent crimes — AH-10<br>Reduce the rate of adolescent and young adult victimization from violent crimes — AH-R11 |
| *3* | Reduce homicides — IVP-09<br>Reduce nonfatal physical assault injuries — IVP-10 Reduce firearm-related deaths — IVP-13<br>Reduce nonfatal firearm-related injuries — IVP-14 |

## Priority Area 5: Behavioral Health

| **Goal 1:** By 2027, improve behavioral health and wellness through the availability, accessibility, and affordability of integrated and consistent, coordinated patient-centered care for our most vulnerable populations in St. Louis County and City through policy changes. | |
|---|---|
| **Objective 1.1:** By 2027, Identify ten policy, procedure, and guideline changes to implement and advocate to address those structural determinants of health that create barriers to positive behavioral health outcomes. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.1.1** Advocate for equity and accountability in service delivery; strategize around key systemic policies and procedures that have the largest impact in communities. | GROW STL, BHN, City DOH and County DPH, ECORN |
| **1.1.2** Advocate for research and legislative support for a key priority. | GROW STL, BHN, City DOH and County DPH , ECORN |
| **1.1.3** Provide opportunities to support resources and events that focus on people's ability to address emergent behavioral health needs - potential summit for limited English proficiency (LEP) individuals to share resources to address the need. | Behavioral Health Bureau – Julie Gary, ECORN-MO |
| **1.1.4** Create an education campaign for system-level decision-makers around historical policy issues that are creating disparities. | GROW STL, City DOH, BHB, Prevent Ed |

| | |
|---|---|
| **1.1.5** Establish a process to educate system-level leadership to address housing needs for individuals with behavioral health disorders. | BHN, Gateway Housing First, and DOH with support/ informed by community-level orgs, Wellston Loop, St. Patrick's Center, Haven, LIV |
| **1.1.6** Disaggregated data: race, gender, LEP. | ECORN-MO, City DOH and County DPH |
| **1.1.7** Broaden Medicaid expansion and retention as well as education/access. | Bilingual Assistant Services, RHC, MFH, Tim McBride, WASHU, City DOH and County DPH, Community Events |
| **1.1.8** Obtain broader insurance coverage for undocumented citizens. | Immigration Service Provider Network |
| **Objective 1.2:** By 2027, five partnerships will have implemented agreements for data-sharing, linkages, and consistency of care. | |
| **Activities:** | **Lead Person/Organizations:** |
| **1.2.1** Establish data sharing agreement to implement regional alerting in all three hospital systems for LINCS. | Anita Udaiyar- LINCS-BHN |
| **1.2.2** Leverage partnerships to improve referral, linkage, and screening processes for aging adults with behavioral health issues. | Britney Parson, BHN, STL mental health board |
| **GOAL 2:** By 2027, improve behavioral health and wellness among vulnerable populations through education and community navigation. | |
| **OBJECTIVE 2.1:** By 2027, increase the number of clients by 10% attending community-based training and utilizing behavioral health services through Navigators, Community Health Workers, and peer support. | |
| **Activities:** | **Lead Person/Organizations:** |
| **2.1.1** Using BCR Network offer- quarterly training for resources in the community. | Tamela Wright- Bridges to care and recovery- BHN |
| **2.1.2** Educate four community groups on resources for recovery. Engaging Patient in Coordinated Care (EPICC) Core. | Christy Ivory- EPICC- BHN |
| **2.1.3** Create awareness of the sobering center with potential referral sources. | Fred Evans/ Jean Sokora (BHN/PFH) |
| **2.1.4** Develop a literacy campaign around what behavioral health is and the importance of emotional well-being to reduce stigma - campaign to address stigma/ mental health in the opioid crisis among the Islamic community of St. Louis. | Places for People, STL County, GROW, RHC, ISPN ECORN-MO and Behavioral Health Bureau |
| **2.1.5** Market the 988 number / co-branding the regional crisis line with the 988 networks, targeting marketing in key areas of need. | BHR |

| **GOAL 3:** By 2027, increase the availability and accessibility of behavioral health services by utilizing *systems-level navigation* and integrated coordinated patient-centered care in the St. Louis region. | |
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| **OBJECTIVE 3.1:** By 2027, implement four best practice models to increase accessibility, awareness, and utilization of community-based resources through system-level methods. | |
| **Activities:** | **Lead Person/Organizations:** |
| **3.1.1** Expand the EPICC project to accept community referrals from high-risk areas. (EPICC CORE) | Christy Ivory, BHN |
| **3.1.2** Establish a new pilot model of care for medical respite (recuperative) care with community partners. | BHN |
| **3.1.3** Create community-level access points in partnership with treatment services providers. | Behavioral Health Bureau – DOH and ECORN-MO |
| **3.1.4** Ensure equitable language access through professional language access services or native language-speaking providers. | ISPN/RHC/ECORN/City DOH and County DPH |
| **3.1.5** Develop a publicly accessible, inclusive, racially and ethnically concordant resource community directory, maintained by the Behavioral Health Bureau. | Behavioral Health Bureau – DOH |
| **OBJECTIVE 3.2:** By Spring 2025, create a systems-level navigation that links 50% of limited English proficiency clients to culturally and linguistically appropriate services through their service provider. | |
| **Activities:** | **Lead Person/Organizations:** |
| **3.2.1** Create a cohort of navigators to engage neighborhood groups. | GROW STL with training from Bridges and Behavioral Health Bureau |
| **3.2.2** LINCS- Connect clients to Behavioral Health liaisons/CRC with navigators rounding hospitals. | BHN, IHN |
| **OBJECTIVE 3.3:** By 2027, establish effective wrap-around support services for people with Behavioral Health Disorders by increasing the number of organizations providing care and linkages to care by 25% and increased utilization of those services by 15%. | |
| 3.3.1 Develop fully inclusive concordant care referral services for providers. | Behavioral Health Bureau- DOH |
| 3.3.2 Establish an active workgroup to partner with the City/ County COC to address the need of individuals with behavioral health disorders (low-barrier housing opportunities in safe environments). | BHN and Gateway Housing First, GROW STL, Synergy with Economic Mobility action team |
| 3.3.3 Establish a plan for shelters and jails to better integrate and assist people with behavioral health disorders. | St Patrick's Center- Johnathan Belcher |

| ALIGNMENT WITH STATE/NATIONAL PRIORITIES | |
|---|---|
| **Obj #** | **Healthy People 2030** |
| *1* | *Increase the proportion of people with substance use and mental health disorders who get treatment for both — MHMD-07* |
| *2* | *Increase the proportion of homeless adults with mental health problems who get mental health services — MHMD-R01* |
| *3* | *Increase the proportion of adults with serious mental illness who get treatment — MHMD-04* |

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