

## Section 2.1

# THE DATABOOK

Released:  
Summer 2005

A Research Report  
Prepared for the  
St. Louis Regional  
Health Commission  
by Inneval LLC

## Community Health Infrastructure Assessment for St. Louis City and County

## Schools

This section has been extracted from a larger report called the Community Health Infrastructure Assessment for St. Louis City and County. For information about the context of the findings, research methods, focus areas and overall conclusions, please refer to the larger report or contact the authors.



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## BACKGROUND AND CONTEXT

“Clearly, no knowledge is more crucial than knowledge about health. Without it, no other life goal can be successfully achieved.”

— Boyer, E.L., The Carnegie Foundation  
for the Advancement of Teaching, 1983

### ***Balancing Immediate Educational Goals and Life-long Healthy Habits of Students***

It is difficult for children to learn if they are depressed, tired, being bullied, stressed, sick, using alcohol or other drugs, hungry or abused. School health efforts are generally focused on medical management of illness or the prevention of conditions that directly influence a child’s capacity to learn. Life-long health habits may become a secondary priority in many schools which are driven by specific learning objectives.

The school environment establishes social norms and health behaviors that children carry forward for a lifetime. Schools have the potential to make valuable contributions to lifelong healthy habits. One study reviewed the research on school-based interventions to prevent and treat obesity and showed positive, though modest, short-term results. The authors suggested that both primary and secondary obesity interventions have a role in schools and such interventions were suited for a school employing a comprehensive approach to health. While multi-faceted community-wide efforts are needed to address the growing problem of obesity, schools are in a unique position to play a pivotal role in promoting healthy lifestyles and helping to prevent diseases which may occur twenty or more years later. The assessment reviewed how schools are addressing the health needs of their students and the community at-large.

### ***Coordinated School Health Program is State-of-the-Art***

A state-of-the-art method of enhancing the role of schools in health is implementation of a coordinated school health program (CSHP). The CSHP model consists of eight interactive components. Schools cannot address the nation’s most serious health and social problems alone. Families, health care workers, the media, religious organizations, community organizations that serve youth and young people themselves also must be involved. However, schools could provide a critical facility in which many agencies might work together to maintain the well-being of young people.<sup>1</sup>

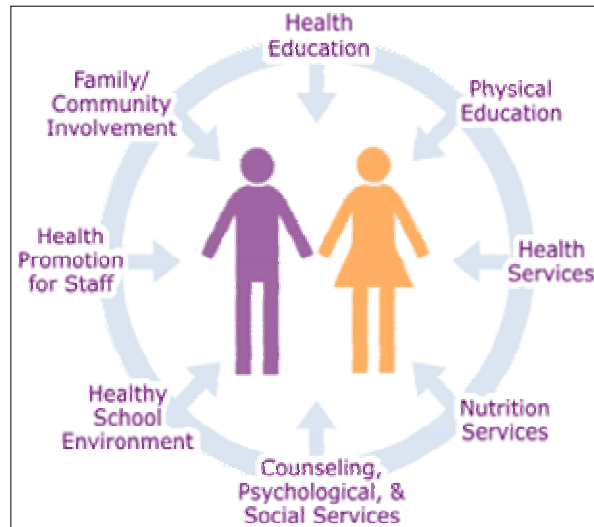
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<sup>1</sup>CDC, National Center for Chronic Disease Prevention & Health Promotion, Healthy Youth: Coordinated School Health Programs. <http://www.cdc.gov/healthyyouth/CSHP/>

The following are working descriptions of the eight components of a coordinated school health program.

**Health Education: A**

planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve health, prevent disease and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills and practices. The comprehensive health education curriculum includes a variety of topics such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease as well as substance use and abuse. Qualified, trained teachers provide health education.



**Physical Education:** A planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas such as basic movement skills; physical fitness; rhythms and dance; games; team, dual and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional and social development and should promote activities and sports that all students enjoy and can pursue throughout life. Qualified, trained teachers teach physical activity.

**Health Services:** Services provided for students to appraise, protect and promote health. These services are designed to ensure access and/or referral to primary health care services, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment and provide educational and counseling opportunities for promoting and maintaining individual, family and community health. Qualified professionals such as physicians, nurses, dentists, health educators and other allied health personnel provide these services.

**Nutrition Services:** Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.

**Health Promotion for Staff:** Opportunities for school staff to improve health status through activities such as health assessments, health education and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to improved health status, improved morale and a greater personal commitment to the school's overall coordinated health program. The personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism and reduced health insurance costs.

**Counseling and Psychological Services:** Services provided to improve students' mental, emotional and social health. These services include individual and group assessments, interventions and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute to the health of students and the school environment. Professionals such as certified school counselors, psychologists and social workers provide these services.

**Healthy School Environment:** The physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and surrounding area, any biological or chemical agents that are detrimental to health and physical conditions such as temperature, noise and lighting. The psychological environment includes the physical, emotional and social conditions that affect the well-being of students and staff.

**Parent/Community Involvement:** An integrated school, parent and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

## SURVEY METHOD

### *Schools in the High Need Zip Codes were Surveyed*

All primary and secondary schools in the zip codes of high need in St. Louis City and County were included in the sample surveyed. This included public, private/parochial and charter schools.

Two weeks after the survey completion due date, schools that had not responded were telephoned and when reached, surveys were completed over the telephone or re-sent via fax or mail. When available, messages were left on answering machines. The school nurse, if available, was the primary contact for collecting information.

## SURVEY RESULTS

### **56% Responded, Most were Elementary and Middle Schools**

Sixty-five of 117 (56%) schools completed and returned the survey. Twenty-six of the 65 schools served students in pre-Kindergarten, 41 served Kindergarten, 45 served some portion of grades one through five, 33 served some portion of grades six through eight and seven served grades nine through 12.

Enrollments ranged from 42 to 1,050, with an average student body of 388.

### **School Nurses are Common, but Health Advisory Committees are Rare**

Fifty-six of the 65 schools reported having a school nurse on staff; 14 of the 56 shared this nurse with another school. Of the 56 that reported having a school nurse, 44 were registered nurses (RN), two were licensed practical nurses (LPN) and 11 did not indicate the type of nurse employed. Also, 47 of the 56 nurses were full-time, five were part-time and four did not indicate full-time/part-time status.

The primary responsibilities of the school nurse (with most common responses appearing at the top of the list) were:

- Medical care needs, including first aid, assessments, monitoring and evaluation of treatment, dispensing medications, caring for sick and injured, emergency care and CPR
- Public health and safety issues, including maintaining safe environments, personal hygiene/hand washing, infection control, immunizations, compliance issues, screenings and implementing safety standards
- Serving as a health resource/liaison (education/teaching, coordinating prevention programs, providing information, communicating with parents)
- Clerical/paperwork responsibilities, including maintaining student health records, maintaining health resources and supplies and producing mandated reports
- Nineteen of the 65 schools reported having a health advisory committee.

### **Approximately One-third of Schools have Health Teachers**

Twenty-one of the 65 schools reported having a “health teacher” on staff and six of these 21 also serve as the school nurse. Fifteen of the 21 health teachers are full-time, one is part-time and the remaining five did not respond to the question. While only 21 of the schools reported having a health teacher, 36 of the 65 schools reported that having

a health education course; 10 of the 36 health education courses were taught by a certified health teacher. Forty-five of the 65 schools reported that health education is integrated into physical education, science or other classes. Of the 65 schools, 14 reported budgeting money to train teachers in health education, 19 reported required health education credits as part of student curriculum and 24 reported that the school evaluates the effectiveness of health education instruction.

**Still Unknown: “Has ‘No Child Left Behind’ Reduced Time Spent on Health Education?”**

Twenty-three of the 65 schools responded to the question inquiring about a reduction in time spent on health education in school as a result of the No Child Left Behind initiative. All 23 responded that there had not been a reduction.

**Asthma Leads List of Focus Areas Addressed by Schools**

Summarized in the table below are the responses provided by the 65 schools when asked about the existence of primary or secondary preventive services offered in the ten focus areas. Respondents were able to include preventive services offered to students, parents, staff and the wider community. Refer to Table 1.

**2.1 Table 1: Prevention Services by Focus Area**

Focus Area	Education (# of schools)	Screening (# of schools)	Mean number of individuals served*	Median number of individuals served*
Asthma	46	7	21	21
Breast Cancer	6	2	68	68
Prostate Cancer	3	2	68	68
Type 2 Diabetes	18	3	117	100
Cardiovascular Disease/ Hypertension	15	4	217	100
Lead Poisoning	19	11	116	62
HIV/AIDS/STDs	28	1	172	101
Maternal/Child Health	20	14	311	195
Tobacco	27	0	208	98
Obesity	27	2	184	100
“Other” (see below)	19	14	156	125

Examples of the types of education and screening services provided in each of the focus areas included:

### *Asthma*

#### Education

- Teach awareness for parents; teach students about disease process; invite speakers in from American Lung Association; smoking prevention workshops; inclusion of information at health fairs; education through teachers and school nurses; proper use of inhaler; “Open Airway” program

#### Screening

- Identify students with asthma; screenings at health fairs; Cardinal Glennon Children’s Hospital asthma screenings

### *Breast Cancer*

#### Education

- Breast cancer education for staff; keep printed resources available; information health fair; education about breast cancer in class; Hodassa Breast Cancer Prevention Program for schools

#### Screening

- No specific examples provided

### *Prostate Cancer*

#### Education

- Prostate cancer education at health fairs; education about prostate cancer in class

#### Screening

- No specific examples provided

*Cardiovascular Disease / Hypertension*

## Education

- Guest speakers; “Jump Rope for Heart” program from the American Heart Association; pamphlets provided to staff and students; month of February highlighted as “Heart Healthy Month”; disease process taught in class for higher grade levels; health fairs; information given about nutrition and risk factors in health classes; one-on-one education

## Screening

- Blood pressure screenings in school and at health fairs

*Type 2 Diabetes*

## Education

- Written information available through school nurse; students educated on disease process; in-services for staff and students offered by external resources; guest speakers; literature given out at health fairs; education for those diagnosed with diabetes

## Screening

- Screenings at health fairs; screenings provided by community clinics

*Lead Poisoning*

## Education

- Education for pregnant and parenting teens in collaboration with City Department of Health Lead Prevention Program; in-services for staff and students offered by external organizations; provide information to pre-kindergarten, kindergarten and 1<sup>st</sup> grade students’ parents about mandatory screenings; information provided at health fairs; annual survey

## Screening

- Referrals to St. Louis City Department of Health Lead Clinic for screening; lead screening requirement for school entrance; referrals for school entrance requirement; testing at schools; testing at primary care physician offices; screenings by mobile health unit; City Department of Health conducts required lead screenings in schools

*HIV/AIDS/STDs*

## Education

- Workshops given by school nurse or outside agencies; video presentations; included in information about “universal precautions”; St. Louis Effort for AIDS (EFA) speakers; counseling program with the St. Louis Archdiocese; staff and student in-services by external resources; Red Cross program; classes and discussions on abstinence; included in human sexuality class for 8<sup>th</sup> graders; review definitions, symptoms and treatment; the Abstinence by Choice program; programs provided by Area Resources for Community and Human Resources (ARCHS)

## Screening

- No examples given (Note: testing for HIV or other STDs was not indicated by any of the 65 schools)

*Maternal and Child Health*

## Education

- Educate kids about the importance of physical exams; St. Louis Children’s Hospital van outreach; vision and hearing screenings for kindergarten through 8<sup>th</sup> grades; immunization recommendations; one-on-one counseling for pregnant teens; nurse provides information; Abstinence by Choice program

## Screening

- Health screenings; referral to doctors; nurse provides screenings; community health agencies provide screenings

## Immunizations

- Referrals for immunizations; immunizations on-site; required immunizations for school attendance (updated at pre-kindergarten, kindergarten and 4<sup>th</sup> grades); Department of Health hosts “shot clinics”

*Obesity*

## Education

- Display literature on weight chart, food pyramid, nutritional value; a unit in “health class”; information sent to parents; one-on-one education; nutrition classes by school nurses and health teachers; nurse conducts workshop; offered in conjunction with St. Louis Children’s Hospital; health fairs; videos

## Screening

- Body Mass Index testing; daily activities monitored in the classroom; referrals for nutritional counseling and testing

*Tobacco Use*

## Education

- Videos and lectures (such as by the American Lung Association); taught in science class; in-services for student through external resources; no smoking policies; posters in halls; one-on-one counseling; speakers, workshops, etc. from St. Louis Children’s Hospital; health fairs; Abstinence by Choice program; D.A.R.E. program; Discover Skills class; integrated with the Abstinence by Choice program; individual teachers address the issue; literature provided to staff and students

## Screening

- No examples provided

*Other*

The other health focus areas cited by respondents, in descending order, were:

- Dental (8 responses)
- Substance Use/Drug Prevention (5 responses)
- Vision and Hearing (4 responses)
- Personal Hygiene (3 responses)
- Safety (2 responses)
- Self-esteem (1 response)
- Scoliosis (1 response)

### **Prevention Services Change as Children Grow Up**

The types of preventive health services emphasized across the 10 focus areas will shift as children mature in age and progress in school. To examine these differences, the 65 schools that responded to the survey were divided into three main groups: primary school (grades pre-kindergarten – 5), middle school (grades 6 - 8) and high school (grades 9 - 12). The data show that the type of primary and secondary preventive health services do vary across grades. Listed below are the top three focus areas (of the 10 emphasized in this report) for each of the grade categories, along with the number of schools that identified that focus area (in parentheses):

#### *Primary School (grades pre-kindergarten – 5)*

- Asthma (26)
- Lead (16)
- Obesity (14)

#### *Middle School (grades 6 – 8)*

- Asthma (12)
- Maternal and child health (10)
- HIV/AIDS/STDs (9)

#### *High School (grades 9 -12)*

- HIV/AIDS/STDs (5)
- Asthma, Breast Cancer, Diabetes, Obesity (tie, 3 each)

### **Schools Extend their Health Services into the Community**

Thirty-eight schools indicated that preventive health services extended into the surrounding community through organizations such as: the PTO; Parents as Teachers; collaborations with foundations, associations, local health agencies, hospitals and clinics; and through activities such as health fairs, community planning, food and blood drives, community fundraisers and community picnics.

### **Schools are a Significant Referral Source for Preventive Health Services**

Schools were also asked whether they referred students to other organizations for preventive health services. The following types of referrals (the numbers indicate a “yes” response for that type of referral organization) were reported:

- Community-based Health Centers (n = 55)
- City or County Health Department (n = 50)
- Private Physician (n = 49)
- Community Health Organizations (n = 48)
- Hospitals/Hospital Clinics (n = 41)
- National Associations (n = 34)
- Others (n = 4) (shelter; group home; professional counseling)

### **Partnerships Seem to Make Preventive Services Available in Schools**

Fifty-two of the 65 schools reported partnering with other organizations to provide preventive health services for students. When asked for explanations about these partnerships, they listed the organizations with which they have partnered in the past. The types of organizations included (most frequently mentioned types occur at the top of this list) were:

- Local hospitals/hospital systems (St. Louis Children’s Hospital, Cardinal Glennon Children’s Hospital, SLU, BJC, Forest Park, Christian Northeast)
- Local universities (St. Louis University, Washington University, Logan (get full name), Deaconess College of Nursing)
- Vision providers (Crown Optical, SLU vision, Lens Crafter, Bolin Vision)
- Dental providers (Health Care USA-Doc Bear Dental Care Program, Gateway Dental, Delta Dental, SMILE Team)
- Foundations (Asthma and Allergy Foundation of America – St. Louis Chapter, Epilepsy, women’s foundations)
- Associations (American Lung Association, American Heart Association)
- Community health centers (People’s Health Center, La Clinica)
- City and County Health Departments
- American Red Cross
- Private physicians, dentists and eye doctors
- Managed Care Organizations (MC+ plans)
- The School District and the Special School District
- Private Companies (Proctor and Gamble)

***Prevention is in the Future for Schools***

Finally, the list below indicates the frequency of health-related services schools are planning for the 2004-05 school year:

- Nutrition/exercise curriculums/programs and obesity prevention (6)
- Asthma education and services (several specific mentions of collaboration with the St. Louis Regional Asthma Consortium) (4)
- Health fairs (4)
- Diabetes programs (3)
- Hiring a health education teacher (2)
- Blood pressure screenings for parents (1)
- Speakers on various health topics (1)
- Pregnancy prevention (1)
- Engaging more parental assistance about health issues (1)
- Vision and hearing screenings (1)
- Lead program (1)
- Dental services (1)
- Immunizations on site (1)
- Medical exams (physicals) on site (1)
- Over-the-counter medications available on site (1)
- Food drive (1)

## OTHER CONSIDERATIONS

### *School Performance Scores Show Deficiencies for Health and Physical Education*

The Missouri Assessment Program administered by the Missouri Department of Elementary and Secondary Education reports school performance in many curriculum areas, including health and physical education. Since the majority of high need zip codes are located in St. Louis City, Missouri Assessment Program (MAP) scores for health and physical education for City students are shown alongside statewide scores in Table 2. At grade 5, 27% of City students are “proficient” or “advanced”, as compared to 54.5% of statewide students. At grade 9, City students at the “proficient” or “advanced” level declines to 4.4%; whereas, the statewide score drops to 23.8%.

**2.1 Table 2. Missouri Assessment Program for Health and Physical Education (PE), 2002**

Missouri Assessment Program (MAP), 2002		
Health P.E.	ST. LOUIS CITY	STATE
<i>5th Grade</i>		
Number of Students		
Accountable	3,550	71,679
Percent of Students		
Step 1 <sup>2</sup>	9.5	2
Progressing <sup>3</sup>	28.9	12
Nearing Proficient <sup>4</sup>	34.3	31.5
Proficient <sup>5</sup>	20	39.5
Advanced <sup>6</sup>	7	15
<i>9th Grade</i>		
Number of Students		
Accountable	2,627	70,140
Percent of Students		
Step 1	47.4	13.4
Progressing	29.6	21.6
Nearing Proficient	18.1	41.2
Proficient	4.4	21.5
Advanced	0	2.3

<sup>1</sup>*Step 1*: Students are substantially behind in terms of meeting the Show-Me Standards by demonstrating only a minimal understanding of fundamental concepts and little or no ability to apply that knowledge.

<sup>3</sup>*Progressing*: Students are beginning to use knowledge of simple concepts to solve basic problems, but still make numerous errors.

<sup>4</sup>*Nearing Proficient*: Students understand many key concepts, although application of that knowledge is limited.

<sup>5</sup>*Proficient*: This is the desired achievement level for all students. Students demonstrate the knowledge and skills called for by the Show-Me Standards.

## COMMUNITY RESPONSE

### *Community Commented on the Schools' Role in Changing Community Health*

At a forum organized by the RHC, community members provided responses to survey data and commented on the role of schools in the community health infrastructure. A summary of selected comments are provided below.

#### *General observations*

- The rates of asthma and incidences of acute symptoms do not align with what the schools indicate they are doing.
- Would be interesting to know the composition of health advisory committees as to whether they include parents and students.
- Need to have a better understanding of prevention programs in schools. Are they integrated into school policies and curriculum?
- Would be helpful to know frequency of physical education.
- What are the reasons why schools are not doing prevention education? (e.g., funding, resources, etc.)
- The fact that every school does not have a nurse was surprising.
- Looks like there is a lot going on in prevention education despite the perceived impact of No Child Left Behind.

#### *Recommendations and opportunities for schools*

- Place emphasis on nutrition and obesity in curriculum and programs.
- Encourage schools to track outcomes of programs.
- Create awareness among parents and teachers that primary prevention should be seen as a high priority in health curriculum.
- Increase coordination of health issues within the health curriculum.
- Highlight the issue of child health and wellbeing and the impact on learning.
- Disseminate programs into the community.

## OBSERVATIONS and CONCLUSIONS

A number of prominent findings emerged from the schools that completed the Community Health Assessment School Survey:

- While a minority of schools reported having a health advisory committee, a majority reported both having a school nurse on staff at least part-time and offering a health education course as a part of the curriculum (either as a stand-alone course or integrated into another course, most often physical education).
- A majority of survey respondents did not answer the question regarding the effect of the *No Child Left Behind* on health education.
- Asthma, HIV/AIDS/STD, tobacco and obesity prevention were reported as the educational services most often provided.
- With regard to health screening, maternal and child health (immunizations), lead poisoning and asthma were the most often reported services.
- Disease prevention and health education services that schools provided differed across grade levels:
- Asthma, lead and obesity prevention receive the greatest attention among schools serving Pre-K through grade 5 students
- Asthma, maternal and child health and HIV/AIDS/STD were most frequently provided among grades 6 through 8
- HIV/AIDS/STD was provided most often for grades 9 through 12
- The majority of schools reported providing services to students, staff, parents and the surrounding community.
- In addition to providing services, schools also reported referring students to community-based health centers, city/county health departments, private physicians, community health organizations, hospital clinics and national associations for disease prevention and health promotion services.
- Schools' plans for expansion of health-related services for the next academic year most often included nutrition/exercise programs and obesity prevention, asthma education and services, health fairs, diabetes programs and intentions to hire a health education teacher.

## Section 2.2

# THE DATABOOK

Released:  
Summer 2005

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## Community Health Infrastructure Assessment for St. Louis City and County

### Places of Worship

This section has been extracted from a larger report called the Community Health Infrastructure Assessment for St. Louis City and County. For information about the context of the findings, research methods, focus areas and overall conclusions, please refer to the larger report or contact the authors.



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## BACKGROUND AND CONTEXT

### *There are Signs of Convergence between Faith Communities and Community Health*

Community health and faith organizations share a common foundation. It has been observed that:

[B]oth public health and progressive religious structures were partners at the birth of a curiously optimistic social movement about a hundred years ago that saw the possibilities of community scale change, itself born of the crisis of urban industrialism. Both believe that there are social determinants to optimum health and wholeness... But both have also tended to give in to entrepreneurial pressures to develop services for paying citizens or members instead of focusing on core commitments to the social determinants of wholeness.<sup>1</sup>

An open letter by the Institute for Public Health Faith Collaboration<sup>2</sup> describes signs of convergence between faith and health and suggests the two build collaborations from diverse strengths. These signs of convergence are:

- **Research.** A stream of research now explores how spirituality affects individual health outcomes as a protective and coping factor. Even more promising research is emerging concerning the roles of faith structures and their capacity to contribute to community health.
- **Policy.** Changes in Federal policy are increasing the direct funding of religious-based projects involving key health issues, which in turn are increasing the attention to evaluation efforts.
- **Collaboration.** It is now common for health initiatives involving behavioral risks such as HIV, substance abuse and violence to work closely with community-based religious groups.
- **Training and education.** Nearly every national religious body has developed training and education units focused on health for its members and as ministries for others. Thousands of congregations now have staff and volunteers working in this area.
- **Role of religion.** The health sciences are increasingly interested in social determinants of health and community-based initiatives, which is opening a new era of examination into the complex role for religion and religious structures in society.

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<sup>1</sup><http://www.ihpnet.org>

<sup>2</sup>Gary Gunderson, Director of Interfaith Health Programs, The Carter Center

### *Places of Worship may be Well Suited for Health Promotion*

The role of places of worship within community health infrastructure has recently been explored. One report stated:

At the organizational level, the Black church has throughout the 20th century promoted education, business and political activism within the Black community. Furthermore, in addition to its contribution through organizational structures and social networks, the Black church has played an important cultural role for the Black community. One study found that both the Black church's collective ethos and its emphasis on God as active in earthly affairs support secular activities within the Black community. Given its historical and ongoing roles within the Black community, the church is an ideal setting in which to offer health promotion activities for African Americans”<sup>3</sup>

It has also been written that “[f]aith communities in general, and African-American churches in particular, are recognized as a largely untapped, but potent, resource to reduce the toll of substance abuse and other health issues.” It was concluded that given the historical and current role of the African-American Church it would stand to reason that African-American clergy could have an impact in helping the nation to meet Healthy People 2010 goals. In fact, “attention could be focused on the following leading health indicators: physical activity; overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, immunization, access to health care and HIV/AIDS.”<sup>4</sup>

There are several studies which have found that the church can be an important conduit through which to inform racial/ethnic minorities about preventive care and that the Black church, because of its ethic of service to others, is particularly well suited for health promotion.<sup>5</sup>

<sup>3</sup>Watson DW, et al. The Role of Small and Medium-Sized African American Churches in Promoting Health Life Styles. *Journal of Religion and Health*. 2003; 42 (3): 191-200.

<sup>4</sup>Markens S, et al. Role of Black Churches in Health Promotion Programs: Lessons From the Los Angeles Mammography Promotion in Churches Program. *Amer. J Public Health*. 2002; 92 (5); 805-810.

<sup>5</sup>*Selected references for the studies about health promotion and minority churches:*

Chatters LM, Levin JS, Ellison CG. Public health and health education in faith communities. *Health Educ Behav*. 1998;25:689-699.

Eng E, Hatch J, Callan A. Institutionalizing social support through the church and into the community. *Health Educ Q*. 1985;12:81-92.

Kong BW, Miller JM, Smoot RT. Churches as high blood pressure control centers. *J Natl Med Assoc*. 1982;74:920-923.

Lasater TM, Wells BL, Carleton RA, Elder JP. The role of churches in disease prevention research studies. *Public Health Rep*. 1986;101:125-131.

Levin JS. The role of the black church in community medicine. *J Natl Med Assoc*. 1984;76:477-483.

Churches as an Avenue to High Blood Pressure Control. Bethesda, Md: National Heart, Lung, and Blood Institute, National High Blood Pressure Education Program; 1987.

Olson LM, Reis J, Murphy L, Gehm JH. The religious community as a partner in health care. *J Community Health*. 1998;13:249-257.

The National Clearinghouse for Alcohol and Drug Information recommends that prevention practitioners look for partners among faith communities at the denominational, clergy and lay levels. Furthermore, the Institute of Medicine recommends that communities find ways to bring public and private health organizations together with schools, employers, churches, government agencies and others not traditionally associated with community efforts to improve health.

***Gaps Exist in Capacity of Places of Worship to be a Community Health Services Provider***

There are gaps in the capacity of places of worship to achieve their potential as community health services providers. One of the most significant gaps is the ability to provide accurate, credible information about complex health issues. The Carter Center Interfaith Health Program, a national research organization, has identified five gaps that keep faith groups from fulfilling their potential:

- Having the knowledge but not applying it
- What faith communities say about social justice and what they actually do
- Failing to make successful practices widely available for replication
- Faith communities operating in isolation from each other and health agencies
- Current needs/wants vs. future needs/wants

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<sup>5</sup>*Selected references for the studies about health promotion and minority churches continued:*

Saunders E, Kong BW. A role for churches in hypertension management. *Urban Health*. 1983;12(5):49-51, 55.

Smith ED. The role of black churches in supporting compliance with antihypertension regimens. *Public Health Nurs*. 1989;6:212-217.

Boehm S, Coleman-Burns P, Schlenk EA, Funnell MM, Parzuchowski J, Powell IJ. Prostate cancer in African American men: increasing knowledge and self-efficacy. *J Community Health Nurs*. 1995;12:161-169.

Davis, DT, Bustamante A, Brown, C.P. et al. The urban church and cancer control: a source of social influence in minority communities. *Public Health Rep*. 1994: 109: 500-506.

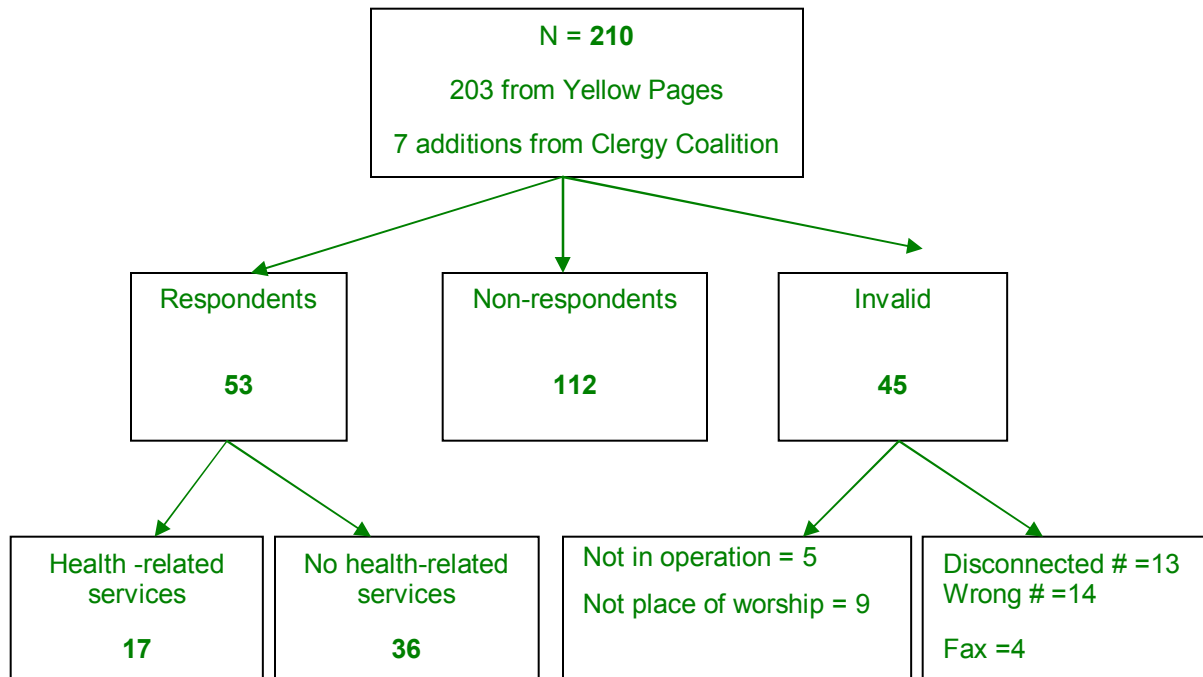
## SURVEY METHOD

### Places of Worship in the High Need Zip Codes were Surveyed

Places of worship, i.e., churches, temples and mosques, included in the assessment were those listed in 2004 St. Louis metropolitan yellow page telephone directory and were located in one of the high need zip codes. In addition, seven places of worship were identified by the St. Louis Metropolitan Clergy Coalition, providing an initial sample of 210. Table 1 (column 1) below displays the number of places of worship in each of the high needs zip codes that were invited to participate in the assessment.

Two weeks after the survey completion due date, congregations that had not responded were telephoned and when reached, surveys were completed over the telephone or re-sent via fax or mail. When available, messages were left on answering machines. Among the original sample of 209 organizations, 45 were found to be invalid, i.e., did not fit the criteria of places of worship or did not have a working telephone. Therefore, the valid sample size was 165. A total of 112 organizations did not respond to follow-up. With a response rate of approximately 32%, data analysis is restricted to the responses of 53 places of worship. Refer to Figure 1 for a description of the survey sample.

**2.2 Figure 1: Sample of places of worship**



*Description of respondents*

Table 1 lists the number of places of worship that responded to the survey by high need zip codes. Table 2 shows the denominations of the 53 responding places of worship. The size of congregations ranged from 30 to 2,000 individuals.

**2.2 Table 1: Number of responding places of worship by high need zip code**

Zip Code	Number of Surveys Distributed	Responses Received
63101	1	0
63103	4	3
63104	24	7
63106	13	2
63107	23	6
63110	6	1
63111	8	3
63112	15	4
63113	37	10
63115	26	5
63118	15	6
63120	4	0
63133	8	1
63136	14	3
63140	4	0
63147	8	2
TOTAL	210	53

**2.2 Table 2: Denominations of Responding Places of Worship**

Denomination	Count
Not reported	18
Catholic	16
Baptist	6
Non-denominational	5
Presbyterian	2
African Methodist Episcopal	1
Evangelical Free	1
Apostolic	1
Pentecostal	1
Methodist	1
United Church of Christ	1

## SURVEY RESULTS

### *One-third Offer Prevention Services for at least One Focus Area*

Places of worship were asked to indicate which, if any, of the 10 focus areas are addressed in any of the health services provided. Of the 53 organizations that responded to the survey, 36 (68%) reported not addressing any of the focus areas. Seventeen organizations (32%) reported that at least one focus area is addressed in the health services provided. Additionally, 11 organizations indicated other health areas that are addressed in the services provided. Substance abuse and mental health services were the most commonly reported of the other health areas. Table 3 ranks the frequency of the focus areas that are addressed in the health services provided by the responding places of worship.

**2.2 Table 3: Frequency of Focus Areas by Places of Worship**

Focus Area	Frequency
Diabetes	13
Heart disease	12
Breast cancer	9
HIV/AIDS/STD	6
Tobacco use	7
Obesity	7
Prostate cancer	5
Asthma	5
Lead poisoning	4
Maternal and child health	2
Other (e.g., mental health and substance abuse)	11

Among organizations that reported providing health services in at least one of the focus areas, the most frequent types of services provided were structured education classes (9; 57%) and screenings (9; 57%), followed by distribution of written materials (8; 50%) and health fairs (7; 44%). Only two of the organizations provided immunizations and one provided HIV/STD testing. Most places of worship had difficulty describing the reach of their health services in terms of number of people served. Ten of the 53 organizations provided estimates of the number of people served by various health services and ranged from as few as one up to 650 people per event.

### *Annual costs of health-related services*

The majority of respondents did not provide specific information about the amount of money that the place of worship spends on health-related services (don't know =8) or left it blank (n=39). Only three places of worship gave specific dollar amounts (\$500, \$2,000 and \$6,000). In some cases, respondents suggested that very little money is spent, as volunteers and donated services are frequently utilized.

### *Partnerships*

Twenty-five percent of respondents (n=13) indicated that they partner with other organizations to provide health services to congregation members, frequently in the form of referrals to other agencies. Hospitals and community-based organizations (e.g., American Heart Association, community centers) were the most frequently cited partners, followed by health departments, social service agencies, nursing schools or nursing-related organizations, community health centers and other places of worship. One respondent indicated a relationship with Interfaith Partnership.

### *Health committees*

Nineteen percent of organizations (n=10) reported having health committees within the congregations and all who have ministries also employ parish nurses. When asked to rate the role of the organization in the promotion of health of congregants, the average rating was extremely important, i.e., 5 on a scale of 1 to 5, with 5 being extremely important. However, only 16 out of the 53 places of worship responded to this question.

### *Planning for the future*

Many organizations indicated that they plan to continue current health-related activities. Several organizations indicated they plan to provide HIV/AIDS/STD prevention services and at least one organization is planning to develop an obesity prevention program. Additionally, organizations support the continuation of health fairs as a method of health service provision.

## OTHER CONSIDERATIONS

### ***The St. Louis Faith Community Embraces Community Health***

There are a number of faith- or religiously-based organizations in the metropolitan area that deserve mention in this section because of their commitment to community health issues. Since survey responses were limited to places of worship, organizations such as Interfaith Partnership of Metropolitan St. Louis, St. Louis Clergy Coalition and parish nurse groups are not directly represented here. They are, however, considered community health organizations and their responses are integrated in that section of the report.

#### *Interfaith Partnership of Metropolitan St. Louis*

Interfaith Partnership of Metropolitan St. Louis, an organization that promotes collaboration among the diverse religious groups in the area, offers focused programming in health promotion and disease prevention. One of its programs, Abraham's Children, works collaboratively with a number of community organizations to provide training, technical assistance and support for primary and secondary prevention activities to religious congregations, primarily in the north side of St. Louis. Abraham's Children has assisted 32 congregations in the development of health education projects that are designed to meet the specific needs of the community served by the congregations. Interfaith Partnership participated as a community health organization in this assessment.

#### *St. Louis Metropolitan Clergy Coalition*

The St. Louis Metropolitan Clergy Coalition is a voluntary inter-denominational organization of pastors focused on issues affecting the community in the areas of education, health, economics, civil rights and law and order. The Clergy Coalition, formed 15 years ago, consists of 80 members who represent St. Louis City, St. Louis County and Illinois denominations and congregations. Although the Clergy Coalition does not have a specific health focus, it has sponsored a series of trainings to help clergy understand the HIV/AIDS epidemic. The trainings enable clergy members to discuss HIV/AIDS with congregants within the context of their religious beliefs. Additionally, the Clergy Coalition is in the process of developing an obesity prevention program for children that will be implemented in member churches. It will be working with partner organizations involved in obesity prevention to provide this program.

### *Parish Nursing*

Parish nursing is a program provided by professionally trained nurses and “integrates current medical and behavioral knowledge with beliefs and practices within a faith community”.<sup>6</sup> Several Christian denominations have parish nurse programs, including Catholic, Baptist, Lutheran (ELCA and Missouri Synod), Presbyterian Church of the USA, United Church of Christ, Methodist and Seventh Day Christian. The responsibilities of parish nurses are unique to the community in which they serve and in general include health education, health counseling, advocacy, referrals and support, all within a spiritual context. Two examples of organizations that provide training and support to parish nurses include The Missouri Lutheran Parish Nurse Association and Deaconess Parish Nurse Ministries. Deaconess Parish Nurse Ministries became a separate entity of Deaconess Foundation in 2001 and has become a national model for parish nursing, offering the following services:

- Assists congregations to explore ways to become involved in health ministry
- Recruits parish nurse candidates
- Offers the parish nurse basic preparation course
- Arranges parish nurse continuing education and support
- Supplies parish nurses to congregations according to a covenantal agreement
- Grants financial assistance to help start parish nurse ministries
- Extends employee benefits to parish nurses
- Provides liability insurance for parish nurses and churches

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<sup>6</sup>American Nurses Association

*Archdiocese of St. Louis*

Historically, the Catholic church has directed a large effort toward improving the health of citizens. The Archbishop's Commission on Community Health, which ended in 2002, sought to "bring the healing ministry of Jesus into communities of need through social and health services".<sup>7</sup> Catholic Community Services, part of the Archbishop's Commission on Community Health, officially merged with Catholic Family Counseling to become Catholic Family Services in the summer of 2004. Currently, Catholic Family Services is focusing on a fee-for-service model. Therefore, an in-depth analysis of the Archdiocese systematic approach to the provision of health prevention services is not possible at this time.

*Inter-church Partnerships*

In addition to the work of the aforementioned organizations, it is important to note that some places of worship outside of the high need zip codes may provide health outreach and education by means of direct services or partnerships with churches operating in the high need zip codes.

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<sup>7</sup>[www.ccstl.org/ccs](http://www.ccstl.org/ccs)

## COMMUNITY RESPONSE

### *Community Provided Insight to Survey Findings and Expanded Understanding of the Faith-Health Partnership*

At a forum organized by the RHC, community members provided responses to survey data and commented on the role of places of worship in the community health infrastructure. A summary of selected comments are provided below.

#### *Limitations of the survey data*

- It is surprising that there is low importance placed on maternal and child health; however, it is likely to be a function of the age composition of many places of worship in the high need zip codes. Congregations surveyed are likely comprised of older adults and, therefore, focus on the typical health needs of older members, such as heart disease and diabetes.
- Some forum participants suggested that many congregants live outside the neighborhoods where their churches are located and may be “out of touch” with the neighborhood needs.
- Many places of worship have very limited staff and are typically limited to doing minimal programs, such as health fairs. They lack the resources to do more direct service programs or base programs in theory or evidence.
- Places of worship are involved in non-programmatic health activities, such as sermons, that could be ideal for encouraging action for disease prevention and health promotion.
- Community collaborations can affect congregations. *Healthy Mind, Body, Spirit*, a coalition created program, is an example of how advocates promote health in faith-based communities.
- Would like more detail about the specific types of education and nutrition programs that places of worship report conducting.

*Opportunities for places of worship*

- There is tremendous unrealized potential to reach beyond the “four walls of the church.” There may be great opportunity to follow long-term health outcomes through partnerships with churches since congregations tend to have stable memberships/populations.
- Forum participants were pleased to learn that places of worship are active in the areas of mental health and substance abuse.
- The individual health benefit of regular attendance at worship services and active membership in faith communities is supported by research studies.

*Recommendations for improving community health through places of worship*

- While there are many programs available, collaboration is necessary to bring a greater scale to the problems.
- There is a need for better communications networks and assistance with grant writing for places of worship.
- There is a need for more information about services available from community health organizations. Churches do not typically know what organizations to call for health fairs or other community health programs.
- The parish nursing program should be expanded.
- Active places of worship may be able to assist those that are not actively involved in community health because there is a potential for an “army of outreach.”
- Churches need resources that help them learn of and connect more effectively with services and community health resources.

## OBSERVATIONS and CONCLUSIONS

Of the places of worship that responded to the survey (32% of the valid sample), a number of prominent findings emerged:

- Approximately one-half of respondents were involved in any sort of health-related activity. Only one-third were involved in one or more of the assessment focus areas.
- With a few notable exceptions, places of worship generally utilize a non-systematic and reactive approach to health promotion and disease prevention services.
- Most places of worship do not appear to have the capacity to independently address the health care needs of their congregants, thereby underscoring the importance of being integrated with health care providers and public health professionals.
- Less than one-quarter of respondents indicated that they partner with other organizations to provide health services to congregation members. Partnership, when present, is frequently in the form of referrals to other agencies.
- Congregations that provide health services reported providing diabetes and heart disease related services most frequently. Many congregations reported providing services related to mental health and substance abuse, neither of which were focus areas for this report.
- Health education programs, screenings, written materials and health fairs are the most frequently used methods to provide health services.
- Since 25% of respondents believed they serve a very important role in the physical health of their congregants it is not surprising that only 20% have a health committee.
- The data provided by survey respondents does not provide an accurate estimation of money spent per year by congregations on health related activities. However, the types of activities conducted and the frequency indicate the amount of funding is likely to be very low.

## Section 2.3

# THE DATABOOK

Released:  
Summer 2005

A Research Report  
Prepared for the  
St. Louis Regional  
Health Commission  
by Inneval LLC

## Community Health Infrastructure Assessment for St. Louis City and County

Funders

This section has been extracted from a larger report called the Community Health Infrastructure Assessment for St. Louis City and County. For information about the context of the findings, research methods, focus areas and overall conclusions, please refer to the larger report or contact the authors.



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## BACKGROUND AND CONTEXT

### ***Health System Funding is Usually Directed Toward Medical Care and Biomedical Research***

At the dawn of the twenty-first century, Americans enjoyed better overall health than at any other time in the nation's history. Rapid advancements in medical technologies, breakthroughs in understanding some of the genetic underpinnings of health and ill health, improvements in the effectiveness and variety of pharmaceutical interventions, and other developments in biomedical research have helped to develop cures for many illnesses and to extend and improve the lives of those with chronic diseases. In support of these efforts, the vast majority of the nation's health research resources have been directed toward biomedical research endeavors. By itself, however, biomedical research cannot address the most significant challenges to improving the public's health in the new century. Approximately half of all causes of mortality in the United States are linked to social and behavioral factors such as smoking, diet, alcohol use, sedentary life-style, and accidents. Yet less than 5% of the approximately \$1 trillion spent annually on health care in the United States is devoted to reducing risks posed by these preventable conditions. Behavioral and social interventions therefore offer great promise to reduce disease morbidity and mortality, but as yet their potential to improve the public's health has been relatively poorly tapped.<sup>1</sup>

### ***Community Health Lacks Stable Financing***

Unlike medical care, community health services do not have a public financing system. There is no Medicare or Medicaid program for population-based prevention services. While some funding is provided by the Centers for Disease Control and Prevention and the State of Missouri Department of Health and Senior Services to government public health departments, community-based organizations are primarily reliant on private foundations to carry out disease prevention and health promotion activities. Thus, the community may experience periods of instability as funding priorities change.

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<sup>1</sup>Institute of Medicine (IOM) Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health

## SURVEY METHOD

### **Regional Agencies were Invited to Participate**

#### *Description of sample*

Thirteen funding agencies were identified for inclusion in the assessment. Six of the 13 are religious-affiliated foundations, one is a foundation resulting from the conversion of a non-profit insurance entity to a publicly-traded for-profit company, one is the local chapter of the United Way and the remaining five are non-religious affiliated, nonprofit community foundations.

## SURVEY RESULTS

### **Participating Agencies Provide Funding for Disease Prevention and Health Promotion**

#### *Description of respondents*

Ten of the 13 funding organizations completed and returned a survey. Of the ten respondents, one indicated no activity in the area of preventive health services; therefore, the data presented here represent nine funding agencies involved in preventive health services in the St. Louis region. Of these nine, eight indicated that they “provide funding to others for primary and/or secondary prevention,” five indicated that they “advocate for primary and/or secondary prevention” and three indicated that they are involved in “planning or coordinating primary/secondary prevention.” Note that these three activities are not mutually exclusive.

When asked about the *main* goal of the organization with regard to its funding priorities, the most common response was “to sustain infrastructure of organizations” (4 responses), with the second most common response being “to fund specific health initiatives” (3). Other responses included: “to create new programs” (2), “to fund health assessments/ needs assessments” (1), “to support agencies with programs in our focus area” (1), “to extend the healing ministry of Jesus Christ” (1) and “to fund kids health education programs” (1).

### **Only Three Respondents Exclusively Fund Health Programs and Activities**

Eight funding organizations reported a cumulative market value of approximately \$1.22 billion, with a mean of \$152 million, a median of \$29.2 million, and a range of \$281,000 to \$1 billion. One organization reported “not applicable” for market value of assets held. The largest of the funding organizations - the Missouri Foundation for Health, a conversion foundation with assets of \$1 billion - skews the mean significantly; the next largest organization reported a market value of \$84.7 million. When Missouri Foundation for Health is separated from the sample for analysis purposes, the cumulative market value of the remaining seven organizations is \$215 million, with a mean, median and range of market value of \$32.2 million, \$28 million and \$281,000 to \$84.7 million, respectively.

Three organizations indicated that 100% of grants are awarded in the area of health. For the remaining six organizations, awards for health as a percentage of total awards ranged from 11 to 90% (mean of 42.3%; median of 37.5%).

### *Funding Priorities and Methods Change*

Six organizations indicated that their funding strategy had changed during the past five years. The reasons given for a change in strategy included:

- “Moved focus areas to support activities among women, children and the poor”
- “Moved from funding specific programs or projects to funding capacity building needs for strengthening infrastructure”
- “Added a specific initiative to incorporate a spiritual component into new or existing programs”
- “Doing strategic planning to look for other sources of income and have targeted funding toward areas not funded by federal government”
- “Have shifted from general health and wellness to a greater focus on physical fitness and juvenile obesity”
- “More focused on kids living in inner city neighborhoods around the baseball (stadium) field”
- “Moving from recipient organizations setting expected outcomes to the foundation setting outcomes”

Although not asked for an explanation, two of the three organizations that indicated no change in funding strategy also provided additional remarks:

- “New organization — less than five years old”
- “No, but currently in a strategic planning cycle”

### ***A Few Focus Areas Receive Most of the Funding***

When asked about involvement in prevention along the ten focus areas addressed by this assessment, the nine funding organizations reported the following levels of involvement as shown in Table 1:

**2.3 Table 1. Number of Organizations Providing Funding by Focus Area**

Focus Area	Number of organizations providing funding
Maternal and Child Health	6
HIV/AIDS/STDs	6
Lead Poisoning	6
Asthma	5
Obesity	4
Type 2 Diabetes	3
Tobacco Use	3
Cardiovascular Disease/Hypertension	2
Breast Cancer	2
Prostate Cancer	2

Some of the organizations wrote in three additional focus areas not explicitly listed on the survey: “capacity building,” “mental health” and “elderly needs” (one response each).

When asked for specific dollar amounts directed to funding prevention in each of the ten focus areas, seven of the nine respondents provided the following results:

**2.3 Table 2. Funding by Focus Area, in Dollars, for Most Recently Completed Fiscal Year**

Focus Area	Number of Organizations Providing Funding	Average Annual Funding	Cumulative Annual Total*
Asthma	3	\$61,700	\$185,000
Breast Cancer	0	NA	
Prostate Cancer	1	NA	\$20,000
Cardiovascular Disease/ Hypertension	1	NA	\$4,400,000
Type 2 Diabetes	1	NA	\$10,000
HIV/AIDS/STDs	3	\$533,400	\$1,670,000
Lead Poisoning	2	\$17,500	\$35,000
Maternal and Child Health	4	\$1,628,000	\$6,512,000
Obesity	3	\$164,000	\$492,000
Tobacco Use	2	\$16,000	\$32,000
SUBTOTAL		\$2,420,600	\$13,356,000
United Way (not specified by Focus Area)			\$14,200,000
GRAND TOTAL			\$27,556,000

\* Most recently completed fiscal year

It should be noted that one of the organizations, the United Way of Greater St. Louis, invests donor dollars in organizations and not specific programs. Therefore, United Way funds to organizations working in all ten of the focus areas (totaling approximately \$14.2 million for 2003) are listed separately in Table 2.

**Funding for High Need Zip Codes is not Routinely Tracked**

The funding organizations were also asked to indicate which, if any, populations residing in high need zip codes are targeted by the programs funded in each of the 10 focus areas. Only one organization provided specific zip codes.

**Limited Funding for Advocacy and Planning is Available for Two Focus Areas: Maternal/Child Health and HIV/AIDS/STD**

Finally, the organizations were asked to estimate how prevention funds were being utilized for advocacy activities, planning activities or direct services across the ten focus areas. The responses indicated that in only two areas — maternal and child health and HIV/AIDS/STD — funds were used for anything other than direct services. While \$5.2 million was allocated for direct services for maternal and child health, \$422,000 and \$200,000 were directed toward its advocacy activities and planning activities, respectively. While over \$1.9 million was allocated toward direct services for HIV/AIDS/STD, \$40,000 was directed toward planning activities.

**Expected Outcomes and Evaluation Vary**

Four of the ten funders indicated that the organization receiving funds sets outcomes; however, one of these four indicated an intention to move toward a situation where the foundation would set expected outcomes for award recipients. The other five organizations reported that both the funding organization and the recipient are involved in setting outcomes.

## COMMUNITY RESPONSE

### *Community Commented on the Funders' Role in Changing Community Health*

At a forum organized by the RHC, community members provided responses to survey data and commented on the role of funders in the community health infrastructure. A summary of selected comments are provided below.

#### *Limitations of the survey data*

- Funds to and from federal, state and local government agencies are an important aspect of the community health infrastructure.
- Survey data does not explain why changes in funding methods occurred among local funders.
- Prevention is under-valued in our community; survey data confirms but does not show how social norms oppose it.
- “Evidence-based” is a buzzword that needs to be clarified and substantiated.
- Primary and secondary prevention is a “throw-in” that organizations add to strengthen proposals, but they are the first things thrown out when budget cuts are made by funders or agencies.
- Funder priorities may be limiting an organization’s ability to seek funding or may be causing organizations to create programs that do not fit the missions.
- Some forum participants believed that prevention is not “on the radar screen” of many funders.
- The connectedness among funders, communities, organizations and school districts is lacking.

#### *Recommendations for improving community health*

- While politicians want “fixes” before the next election, prevention activities rarely operate on such short timelines; therefore, assistance from private funders is especially necessary.
- Leadership from funders may be necessary to make a paradigm shift for prevention.
- Funders need to pay for the costs of collaborating among community-based organizations.
- Require grant recipients to demonstrate outcomes, specifically cost-saving measures.

- Highlight the importance of prevention services.
- Create a business model for organizations who want to be committed to prevention activities and enable them to provide long-term benefits to the region.

## OTHER CONSIDERATIONS

### *Survey non-responders and other sources private funding*

The RHC attempted to include all health funders in the assessment via surveys; however, the Susan G. Koman Foundation, the major funder of breast cancer prevention and early detection in the region, is not represented in Table 2. Research indicates that the Koman Foundation granted about \$1 million last year, of which approximately two-thirds is for hospital-based programs that combine education, screening and treatment referral and the remainder for community-based education awareness programs. These programs may cover areas in the region beyond St. Louis City and County.

### *Government funding not captured in the assessment*

The Centers for Disease Control and Prevention and State of Missouri provide significant grants and contracts to the health departments of St. Louis City and County. In some cases, funds are passed along to community organizations. Since this assessment was limited to the funding activities of private organizations, government funds were omitted.

## OBSERVATIONS and CONCLUSIONS

- The St. Louis region is fortunate to have a number of organizations that provide not only funding but leadership in advocacy and planning and coordination for preventive health services.
- The market value of assets held by the funding organizations that participated in this assessment is in excess of \$1.2 billion. The grants made by these organizations in the area of health for the most recent year totaled approximately \$27.6 million. Funding organizations support the organizational infrastructure of community-based organizations while also providing funding for specific health initiatives, newly created programs and assessments. Only a percentage of these funds appear to be for prevention-related activities.
- Approximately one-third of the nine funding organizations were totally focused on health issues. All of the organizations are either planning or have recently implemented changes to their funding strategies, demonstrating an awareness of the changing needs of agencies involved in disease prevention and health promotion activities.
- The three focus areas receiving the highest dollar amounts of funding were Maternal and Child Health, Cardiovascular Disease/Hypertension and HIV/AIDS/STD. These focus areas comprised 94% of all funding as reported by respondents.
- While there are recognized disparities in specific geographic regions of St. Louis City and County, only one funding organization provided funding by high-need zip codes.
- Finally, more than half of the funding organizations now have evaluation expectations for their grantees that are set at least in part by the foundation.

## Section 2.4

# THE DATABOOK

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A Research Report  
Prepared for the  
St. Louis Regional  
Health Commission  
by Inneval LLC

## Community Health Infrastructure Assessment for St. Louis City and County

## Hospitals

This section has been extracted from a larger report called the Community Health Infrastructure Assessment for St. Louis City and County. For information about the context of the findings, research methods, focus areas and overall conclusions, please refer to the larger report or contact the authors.



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## BACKGROUND AND CONTEXT

### *During the Twentieth Century Hospitals and Community Health were Distanced from One Another*

What is the role of hospitals in community health improvement? Are they simply providers of medical care, or can they make meaningful contributions in efforts to address the root causes of health problems? In the St. Louis region, most have a long history of supporting community health activities.

Research suggests “linkages between hospitals and the public health community can be traced back to the late 19th century, when high population density, poor housing and sanitation, and unsafe working conditions in large cities contributed to high rates of injury and disease.”<sup>1</sup> In fact, the impetus for coordination and cooperation to address the above led many public health agencies to maintain offices in local hospitals. The health department of both St. Louis City and County once operated hospitals. The connectedness between hospitals and public health decreased during the 20<sup>th</sup> century as technological specialization and market competition contributed to hospitals developing a more inward focus.

### *Community Health is not the Core Business of Acute Care Hospitals*

Hospitals are prominent institutions in St. Louis. Their brands are promoted everywhere as trustees of “health,” not just acute medical care providers. Many community members may view the hospital as an ideal partner, in some cases, the responsible party for community health activities. However, hospitals have been warned about broadening their involvement to include community health:

“It has become fashionable, even politically correct, to hear assertions that the acute care hospital should (and must) become virtually all things health to all people. Carried to its logical extreme, this view means that the acute care hospital will become the locus and focus of all broadly defined ‘health’ and ‘health-related’ activities in the community.”

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<sup>1</sup>Building Powerful Partnerships: The Role of Hospitals in Community-Based Public Health *Community Based Public Health Policy and Practice*. Issue #3, January 2002

Over the last decade there has been great pressure on hospitals to become more than acute care providers. Questions abound as to whether a hospital can satisfy the contemporary definitions of health that extend beyond the scope of traditional medical care to include behavioral and social influences. A two-dimensional concern exists for the role of hospitals in community health and suggests the role may belong more properly in some other organization:

The risk of distraction from their core business is the overarching concern, a concern that has two dimensions: (1) an overly broad definition of health and (2) nonacute and, especially, nonhealth-related services that are asserted to be the hospital's responsibility in an expanded role. Contemporary definitions of health include much more than somatic and psychological health--most call for primarily social measures... The second dimension is that nonacute and nonhealth-related services lie outside the traditional role and, arguably, the core competencies of acute care hospitals. As Johnson has noted, "It is in both the patient's and the primary care physician's best interests to keep the patient in good health. By contrast, the hospital's role is not wellness, but of providing a place for the treatment of disease." (Johnson 1995, 77).

## SURVEY METHOD

### Area Hospitals were Invited to Participate

#### *Description of sample*

To gather information about the delivery of prevention services, the following hospitals in St. Louis City and County were sent surveys:

- BJC Health Care
  - Barnes Jewish Hospital
  - St. Louis Children's Hospital
  - Christian Hospital Northeast
  - Christian Hospital Northwest
  - Missouri Baptist Medical Center
  - Barnes Jewish Hospital West County
- SSM Health Care
  - St. Mary's Hospital
  - St. Joseph's Hospital Kirkwood
  - DePaul Hospital
  - Cardinal Glennon Children's Hospital
- St. John's Medical Center
- St. Luke's Medical Center
- St. Anthony's Medical Center
- Tenet St. Louis
  - Des Peres Hospital
  - Forest Park Hospital
  - Saint Louis University Hospital
  - St. Alexius Hospital Broadway Campus
  - St. Alexius Hospital Jefferson Campus

## SURVEY RESULTS

### **Hospitals Serving the High Need Zip Codes Provided Information About Their Community Health Activities**

Eleven of the eighteen hospitals surveyed provided a response (61% response rate). All but three of the hospitals are religiously affiliated and all of the hospitals that responded are non-profit. Both of the children's hospitals in the St. Louis region are included among the respondents.

### **Five of Eleven Hospitals Spent \$5.4 Million for Primary and Secondary Prevention Services in Most Recent Fiscal Year**

All but one of the 11 respondents provided at least some of the financial information requested. Seven of the ten that did provide this information are on a January-December fiscal year, while the other three use a July-June fiscal year. For the five organizations that provided a budget amount for primary and secondary prevention services provided in the most recent fiscal year, the mean was \$1.085 Million, with a median of \$306,000 and a range of \$90,000 to \$3.076 Million. Total revenue was reported by four of the eleven hospitals, with a mean of \$115 Million, a median of \$86 Million and a range of \$28 to \$263 Million.

### **Funding for Prevention Comes from Hospital Revenue**

When asked about the sources of this funding, the five organizations that provided an answer responded that, on average, 98% of these resources are budgeted from their hospital revenue. Three hospitals reported funding from sources other than generated revenue; one reported that less than 1% came from federal grants, one reported that 5% came from local foundation grants, and one reported that 1% came from donations/fundraising.

Two of the 11 organizations provided financial data regarding *how* these prevention dollars were spent. The categories that garnered the largest amount of resources, on average, were outreach, health education and risk reduction, screening and early detection, and administration.

Three of the 11 participating hospitals provided information about where *geographically* their prevention dollars were spent during the most recent fiscal year. For two of the three, at least 80% was spent in St. Louis County with none being spent in St. Louis City (the remaining 10-20% was spent outside of the St. Louis region); for the third hospital, 75% was spent in St. Louis City, with the remaining 25% spent in St. Louis County.

### **Disease Prevention Programs are Coordinated by People**

#### *Paid staff*

Nine of the 11 participating hospitals were able to provide some level of information regarding the numbers of paid staff dedicated to primary and secondary prevention activities. For the five of the 11 which broke-out figures into focus areas (asthma, breast cancer, etc.), total paid staff for all prevention services are reported instead. The mean number of paid FTEs for prevention was 9.5, with a median of 8.0 and a range of 1.5 to 21 FTEs.

#### *Volunteers*

Two of the 11 participating hospitals provided data for the number of volunteers involved in delivering primary or secondary prevention services—five volunteers in one organization and two in the other.

### **Home Visit Outreach is not a Hospital-based Service**

Two hospitals were able to provide information regarding home visits by community health nurses. For four of the other nine, the information was missing; for the remaining five hospitals, they responded either that the question was not applicable to them or that home visits were done by another entity in their health care system. For the two hospitals that did provide information, one reported 80% of the home health visits were for patients of their health center and that the services provided included screening for blood pressure and asthma symptoms, for medication management, and for wound care, assessments, teaching on disease process and monitoring signs and symptoms; the other, one of the children's hospitals, reported that they do not use community health nurses or provide home visits.

### **Survey Captured the 'Big Picture'**

Each of the hospitals surveyed were provided with seven charts to complete; these charts focused on primary and secondary prevention services among the ten focus areas emphasized in this assessment. Similar to the Focus Area Surveys sent to community health organizations, the ten focus areas were collapsed into seven categories for the purposing of collecting this information. The hospitals were asked to describe the primary and secondary prevention activities conducted *outside* (in a community-based manner) their organizations, including the most common types of activities in each focus area, the amount of funds spent in 2003, and the *reach* (numbers, amounts, etc.) generally and to high-need populations. Unfortunately, information regarding amounts of money spent and “reach”—both generally and to high need populations—was missing among the majority of respondents and is therefore not reported here.

### *Needs of Hospital Patients Seem to be a Priority for Preventative Services*

#### *Type-2 diabetes, cardiovascular disease, and obesity*

All 11 of the hospitals reported some level of involvement in prevention of these related disease. Nine of the 11 participating hospitals reported distribution of written material, involvement in advertising/media campaigns, provision of nutrition classes, and offering smoking cessation classes—all activities designed to prevent type-2 diabetes, cardiovascular disease, and/or obesity. Nine of the 11 also reported providing blood pressure and cholesterol screening, while seven reported sponsoring support groups, offering weight loss classes and doing risk factor screening. Six reported providing exercise classes and five reported offering screening for overweight and obesity. Four of the hospitals also offer physical activity education and three provide an advice/help line.

#### *Breast cancer and prostate cancer*

Of the 11 hospitals, all but two indicated some involvement in activities designed to prevent breast and/or prostate cancer. That two, both children's hospitals, do not treat adults, so this part of the survey was "not applicable" for those organizations. Eight of the remaining nine hospitals reported distributing written materials about cancer prevention and promoting mammography specifically, the two most commonly reported activities for cancer prevention among this group of hospitals. Seven of the nine hospitals also promote self-breast exams, provide prostate cancer screening (including PSA blood tests), provide mammography screening, and participate in advertising/media campaigns designed to raise awareness for cancer prevention and screening. Additionally, six of the hospitals sponsor programs that promote nutrition for cancer prevention and four of them provide support groups. Finally, four hospitals conduct clinical breast exams and digital prostate exams, two emphasize risk factor/family history for cancer screening, and one hospital sponsors a help/advice line.

#### *Asthma*

This is one of several focus areas where the majority of hospitals report little or no activity. One of the 11 hospitals (Barnes-Jewish) reported this as "not applicable" given that asthma is done at a pediatric hospital. Of the ten remaining hospitals, six reported providing prevention services for asthma. Six hospitals reported involvement in distribution of written materials and sponsoring of an asthma self management program and participation in advertising/media campaigns, while five reported participation in advertising/media campaigns. Four provide support groups to asthmatics, conduct environmental con-

trol education trainings, and child symptom screening; three do adult screening. One of the hospitals reported having an advice/help line. Finally, one of the children's hospitals also reported involvement in school-based asthma programs.

#### *HIV/AIDS/STDs*

Along with lead poisoning prevention, this is the focus area with least the involvement among the 11 hospitals that responded to the survey. Four of the 11 hospitals indicated involvement in distributing written materials about HIV/AIDS/STDs, while three reported participating in advertising/media campaigns, providing educational classes to reduce the risk of HIV due to sexual behavior or drug use behavior, conducting behavioral risk screening/assessment for HIV/STDs, and doing HIV testing. Two hospitals reported doing HIV prevention case management and providing STD testing. One hospital reported each of the following types of activities: sponsoring support groups, bar/street outreach, and sponsoring peer programs. None of the hospitals have an advice/help line for HIV/AIDS/STDs.

#### *Maternal and child health*

Of the 11 hospitals, all but two indicated some level of activity in maternal and child health. Nine of the eleven participating hospitals indicate they distribute written materials containing information about maternal and child health and wellness and six of the hospitals offer child birth classes. Four of the 11 hospitals report providing parenting classes, immunization education for parents, participating in advertisement/media campaigns, offering the childhood immunization series, and doing injury prevention education. Three hospitals reported each of the following types of activities: prenatal health education and counseling, providing prenatal physical exams, doing well child visits, and providing genetic counseling. Two hospitals provide support groups. Only one hospital reported doing early periodic screening diagnosis and treatment (EPSDT).

#### *Tobacco use*

Most hospitals reported some activity in this focus area. Nine of the 11 participating hospitals indicate they distribute written materials designed to prevent tobacco use and eight hospitals sponsor tobacco education (smoking cessation) for adults. Six of the hospitals report participating in advertising/media campaigns designed to prevent tobacco use and five report involvement in tobacco education for elementary and secondary school children. Three of the hospitals sponsor support groups for tobacco cessation and two sponsor youth prevention classes incorporating refusal skills, etc. None of the hospitals reported providing an advice/help line for tobacco use.

### *Lead poisoning*

Along with HIV/AIDS/STDs, this is the focus area with the least involvement among the 11 hospitals that responded to the survey. While four of the hospitals provide tertiary prevention (case management, follow-up and monitoring of children exposed to lead) and conduct blood lead level screening, there are very few additional prevention activities among the group of 11. While the two children's hospitals in this sample do clearly focus on secondary prevention (childhood screening, pre-natal lead screening) and tertiary prevention (treatment for lead poisoning), they do not report much emphasis on primary prevention. Three hospitals reported distribution of written materials about lead poisoning prevention, while two hospitals reported each of the following types of activities: provision of training for lead abatement and, provision of training for home dust removal and lead remediation. One hospital reported participation in advertising/media campaigns.

### **Prevention Activity is Includes Advocacy and Planning**

#### *Advocacy*

Six of the nine hospitals that responded to questions regarding advocacy indicated that their organizations conduct advocacy activities. One of the organizations that indicated "no" also wrote in that advocacy is done at the "corporate/system" level. The following advocacy activities were reported:

- Lobbying (3 responses)
- Media interviews, development and distribution of press releases, community outreach programming (all 2 responses each)
- Providing information to legislatures, coalition building and participation in community groups (all 1 response each)

Factors considered in evaluating advocacy activities included policy changes (6 responses), specific recommendations that follow (1 response), response of policy makers (1 response) and process indicators such as number of press releases, media interviews, and lobbying activities (1 response). Four hospitals reported that internal staff conducts evaluations while two reported that both internal and external staff are engaged in these evaluations. The number of FTE staff devoted to advocacy activities ranged from 0 (advocacy staff at corporate level, not hospital level) to 2, with a median of 1.2 and a median of 1.5. Four of the six organizations reported that the hospital's advocacy activities are greatly related to achieving the mission, while two indicated it was somewhat related.

*Planning and coordination*

Nine of the 11 hospitals indicated that their organizations are represented within groups that plan and coordinate prevention services, such as coalitions and consortiums. On average, the hospitals reported being involved in more than seven of these kinds of community groups. Additionally, about half indicated some leadership position (board member or committee chair) within these kinds of groups.

Named coalitions, consortiums, associations, or other groups include:

- American Hospital Association
- American Lung Association
- Outreach and Enrollment Coalition (form MC+/Medicaid enrollment)
- American Cancer Society
- Healthy Mind Body Spirit
- Allergy and Asthma Foundation
- Tobacco Free Missouri
- American Diabetes Association
- Health Literacy Committee
- Missouri Coordinated School Health Coalition
- St. Louis Regional Asthma Consortium
- St. Louis Lead Prevention Coalition
- MO Child Fatality Review Panel
- Cystic Fibrosis Midwest Consortium

*Community needs and feedback*

Eight of nine hospitals responding to a question about conducting community needs assessments reported conducting an assessment in the past five years; two of the hospitals offered to share the results with the RHC. Three of the nine reported collecting feedback from the community regarding the services they provide during the past five years; none of the three agreed to share this information.

*Other findings*

Finally, one of the participating hospitals indicated a concern about the lack of evaluation of prevention activities. Given that many prevention programs are behavioral/health education interventions, the respondent felt that “longitudinal evaluation is greatly needed to determine the long-term and sustained impact of prevention services.”

## OTHER CONSIDERATIONS

### *Healthy Mind, Body and Spirit*

Healthy Mind, Body and Spirit is an example of a holistic community health program. BJC HealthCare, SSM Health Care, Tenet Health care, St. Luke's Hospitals, St. Anthony's Medical Center and St. John's Mercy Medical Center and Abraham's Children have all partnered to create a faith-based outreach program designed to improve the health of the medically underserved in the St. Louis region. This collaboration provides screenings, education and other health-related services through churches. Programs are designed to address the specific needs of the congregation and surrounding communities.

### *Missouri Hospital Association Survey*

The Missouri Hospital Association contributed aggregate data about community-health related services offered by 28 hospitals in St. Louis City and County as reported in the 2002 Annual Licensing Survey. Responses related to the ten focus areas are presented with general items in Table 1 (on the next page). The mission statements of most hospitals (86%) include a statement about community benefit and most hospitals (79%) have a long-term community health plan. Hospital-based prevention-related programs, such as weight management, are much more common in the County than City. Only one-third of respondents stated they have a formal linkage with public health, a key partner in the community health infrastructure. Hospitals participating in the 2002 Annual Licensing Survey:

#### County Hospitals

All Saints - Bridgeton MO  
 BJ W Cnty Hosp-St. Louis MO  
 Christian Hosp NE-NW - StL MO  
 Des Peres Hosp-St. Louis MO  
 Hawthorn Chldrn's Psych-STL MO  
 MO Baptist Med Ctr-Twn&Ctry MO  
 SSM DePaul HC-Bridgeton MO  
 SSM Rehab - St. Louis, MO  
 SSM St Joseph Hsp of Kirkwd MO  
 SSM St Mary's-Richmnd Hghts MO  
 Shriners Childrens Hosp-STL MO  
 St Anthony's Med Cntr-STL MO  
 St Johns Mercy MC-St Louis MO  
 St Luke's Hosp-Chesterfield MO

#### City Hospitals

Barnes-Jewish Hospital-STL MO  
 Forest Park Hospital-STL MO  
 Kindred Hospital St Louis - MO  
 Metro StL Psychiatric Ctr-MO  
 SSM Card Glennon Chldrn-STL MO  
 Saint Louis ConnectCare-MO  
 Saint Louis University Hosp-MO  
 Select Spclty Hosp-St Louis MO  
 St Alexius Hospital - STL MO  
 St Alexius-Jefferson-STL MO  
 St Louis Children's Hosp - MO  
 St Louis Psych Rehab Center  
 The Rehab Inst. of St Louis-MO  
 VA Med Center-St. Louis MO

**2.4 Table 1. 2002 Annual Hospital Licensing Survey Results  
Summary of Indicators Related to Community Health**

	City		County		Total	
Number of Hospitals	14		14		28	
<i>Screening Services</i>						
Perform Health Screenings at Hospital	9	64%	13	93%	22	79%
Breast Cancer Screening at the Hospital	7	50%	10	71%	17	61%
Breast Exam Program	4	29%	7	50%	11	39%
Mammography Discount-Community Participant	2	14%	4	29%	6	21%
PSA Screening Program	4	29%	7	50%	11	39%
Diabetes Screening Program	6	43%	5	36%	11	39%
Cholesterol Screen Program	6	43%	9	64%	15	54%
<i>Available Prevention Programs</i>						
Heart Health Ed. Program	5	36%	10	71%	15	54%
Fitness Exercise Program	1	7%	10	71%	11	39%
Fitness Center at the Hospital	1	7%	7	50%	8	29%
Weight Management Program	1	7%	7	50%	8	29%
Smoking Cessation Program	3	21%	6	43%	9	32%
Diabetes Education Program	7	50%	8	57%	15	54%
<i>Health Promotion, Education and Outreach</i>						
Community Outreach Hospital	8	57%	10	71%	18	64%
Health Fair at Hospital	7	50%	12	86%	19	68%
Patient Education Center at Hospital	10	71%	12	86%	22	79%
Health Information Center at Hospital	7	50%	7	50%	14	50%
Teen Outreach Services Hospital	3	21%	4	29%	7	25%
<i>Other</i>						
Hospital Has Formal Affiliation with Local Public Health	5	36%	5	36%	10	36%
Mission Have Community Benefit Statement	10	71%	14	100%	24	86%
Have A Long-Term Community Health Plan	9	64%	13	93%	22	79%

## OBSERVATIONS and CONCLUSIONS

- Eleven of 18 St. Louis hospitals completed a survey inquiring about the provision of primary and secondary prevention services across the ten focus areas.
- For the organizations that were able to report information for money spent on primary and secondary prevention services, the mean was approximately \$1 Million. Prevention funds were allocated from average revenue of \$115 Million, which is important given that the hospitals report that 98% of funds used to provide prevention services come from their own hospital-generated revenue.
- Although the data were limited, the hospitals that did indicate how these expenditures were spent reported outreach, health education and risk reduction, screening and early detection, and administrative costs as the major categories. Not surprisingly, hospitals tend to spend these prevention dollars among the populations and in the communities they directly serve in St. Louis City and/or County.
- On average, the hospitals employ 9.5 FTEs to focus on delivery of primary and secondary prevention services.
- The degree to which the 11 participating hospitals engaged in delivery of prevention services varied greatly across the seven surveyed areas. While the majority of hospitals reported at least some activity in Type-2 Diabetes/Cardiovascular Disease/Obesity, Breast and Prostate Cancer, Maternal and Child Wellness, and Tobacco Use, there was less reported activity for Asthma and much less reported activity for HIV/AIDS/STDs and Lead Poisoning.
- Within categories or types of activities, there were also clear themes. The majority of hospitals provide written materials about prevention for most if not all of the focus areas; and most report being involved in advertisement/media campaigns to raise awareness of these issues. However, less are involved in screening, detection and testing (secondary prevention) for these diseases—and even less report developing and implementing primary interventions directed at individuals or groups.
- One additional theme is the difference between the nine hospitals primarily serving adult populations and the two that focus solely on children. Not surprisingly, the two children's hospitals in the sample reported little or no activities around breast and prostate cancer or type-2 diabetes and cardiovascular disease while both having more involvement and specific sponsored programs for asthma, lead poisoning, and other health issues that account for high morbidity among St. Louis' children.
- For some of the hospitals in the sample, the other prevention-related activities—such as advocacy and planning and coordination are conducted at the hospital “system” level. However, a small majority did report engaging in advocacy activities such as

lobbying and media relations. The great majority of hospitals reported being involved in community groups that plan and coordinate prevention services—and on average, reported being involved with five of these groups. To a large extent, the majority of these named coalitions, consortiums or planning groups are either disease specific (tobacco, diabetes, etc.) or focused on a particular population (e.g., Medicaid enrollees).

- While less than one-third of the hospitals reported collecting feedback from the community regarding their services, all but one reported conducting a community needs assessment during the past five years.
- One hospital expressed specific concern about the lack of—and need for—longitudinal evaluation of prevention services.

## Section 2.5

# THE DATABOOK

Released:  
Summer 2005

A Research Report  
Prepared for the  
St. Louis Regional  
Health Commission  
by Inneval LLC

## Community Health Infrastructure Assessment for St. Louis City and County

### Community Health Organizations

This section has been extracted from a larger report called the Community Health Infrastructure Assessment for St. Louis City and County. For information about the context of the findings, research methods, focus areas and overall conclusions, please refer to the larger report or contact the authors.



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## OVERVIEW

Community health organizations (CHO) are an essential component of the community health infrastructure. There are many CHOs in St. Louis City and County and the approaches to disease prevention, health promotion and early detection vary considerably based on organizational characteristics and focus area attributes. The assessment engaged CHOs in two phases. In the first phase, the largest possible number of organizations were invited to provide basic information about their mission and prevention services. In the second phase, organizations meeting the criteria were asked to provide specific information about their structure, activities, financing, etc. Methods, results and conclusions of both phases are presented separately in this section. Details about activities in the specific focus areas can be found in the next sections.

## BACKGROUND AND CONTEXT

### *Community Health Organizations Take a Population Perspective*

A population-based approach to health identifies groups within the community that share common health needs. Programs and services are then designed to meet the specific needs of these groups. Prevention services can be delivered to specific individuals (e.g., immunizations); however, community health organizations (CHO) are generally focused on the distribution of prevention services across a population.

To identify the needs of different groups, CHOs look at social and economic factors called health determinants. These factors can increase or decrease a person's chance for good health. Factors such as age, income, language and education can make it difficult for some people to get to medical care providers, understand how the system works and/or afford special services.

Disease prevention and health promotion require a population perspective to be effective. In many cases, CHOs are trying to change social and cultural norms while addressing the needs of individuals. For example, improving an individual's nutrition by increasing fruit and vegetable consumption – a known health determinant of cancer, diabetes and heart disease – may include one-on-one education. Environmental factors such as availability of fresh produce and cultural factors such as food preferences are addressed by comprehensive community health approaches because these factors influence individual health behavior as well.

The ecological model focuses attention on both individual and social environmental factors as targets for health promotion intervention. It addresses the importance of interventions directed at changing interpersonal, organizational, community and public policy factors which support and maintain unhealthy behaviors. The model assumes that appropriate changes in the social environment will produce changes in individuals and that the support of individuals in the population is essential for implementing environmental changes. Whether named or not, the ecological model is a common theory adopted by many CHOs.

## SURVEY METHOD

### PHASE ONE

#### *When the Assessment Began, the Number of Community Health Organizations was Unknown*

At the onset of this assessment, the number of CHOs operating in St. Louis City and County was unknown. There is no coordinating organization for community health services; there is no credentialing body. In many cases, CHOs are departments, divisions or programs of community-based organizations. In order to determine what types of organizations, divisions or programs would be included, the following criteria were utilized:

#### *Definition of a community health organization*

CHOs are generally classified as community-based organizations. For the purposes of this assessment, CHOs are defined as health, medical, social service, educational or faith-based organizations that:

1. Provide direct primary and/or secondary preventive health services, and/or
2. Facilitate, coordinate, plan or advocate for primary and/or secondary preventive health services, and/or
3. Provide funding to organizations that provide primary or secondary preventive services.

For inclusion in the assessment, it was determined that a CHO must also:

1. Have a recognized tax status,
2. Explicitly state the provision of or advocacy for primary and/or secondary preventive health services within its mission statement,
3. Offer services in at least one of the ten focus areas or influence health outcomes in St. Louis City or County,
4. Not be a research institution,<sup>1</sup>
5. Not be considered an organization type included elsewhere in the assessment.<sup>2</sup>

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<sup>1</sup>Research institutions are not community health organizations because their primary interest lies in scientific research. In some cases, they contribute significantly to community health outcomes through disease prevention research efforts.

<sup>2</sup>Places of worship, schools, community health centers, MC+ plans, funders, hospitals and health systems, and government public health departments

*Origin of the sample*

CHOs were identified from lists obtained from partner organizations, such as area health funders, the United Way of Greater St. Louis and numerous community organizations. The lists were compiled to create a master listing of CHOs that contained over 4,000 entries. Organizations that did not fit the criteria listed above and duplicate entries were deleted from the master database. The final list consisted of 544 organizations. From that list, 73 organizations were found to be invalid, e.g., did not meet the criteria, out of business, etc., after initial surveys were mailed and 16 were added by referral. Therefore, the final valid sample consisted of 487 organizations.

## SURVEY RESULTS

### PHASE ONE

#### **342 Organizations Respond**

Three hundred forty-two (342) CHOs returned the phase one *Introductory Survey*, providing an overall response of 70%. The majority of the organizations that responded to this question (84%) listed the legal incorporation or tax status as non-profit 501(c) 3. Eight percent listed the agency as public. The remainder of the CHOs indicated that the agency was for profit (2%), private non-profit (3%) or other (3%). Approximately one-third (34%) of organizations indicated that the office is physically located in one of the high need zip codes defined in this report.

#### **CHOs are about More Than Prevention**

Organizations were asked to describe their missions and goals. As identified in the missions and goals of the responding organizations, the following list provides a summary of the services provided and the populations served:

- Prevention services – health education and screening
- Support services – social and health services for individuals diagnosed with a specific disease
- Treatment services
- Residential services – shelters and other living facilities for individuals with health problems
- Faith-based ministries that include health promotion services
- Referral services
- Advocacy services
- Services specific to children and teens
- Services specific to seniors

#### **Few CHO Missions are Truly Dedicated to the 10 Focus Areas**

Of the 247 respondents who provided information about the organizations' mission and goals, 31 (13%) either explicitly stated that their mission was to address one of the ten focus areas or implicitly suggested work related to the focus areas, e.g., nutrition and physical activity.

### ***Respondents Identify Themselves as Advocates and Primary Prevention Providers***

Prevention services include primary prevention (activities that promote optimal health and include increasing awareness and health education) and secondary prevention (activities intended to detect symptoms or early stages of disease and include screening, detection and early diagnosis). Also included in prevention services are planning and coordination of, advocacy and/or funding for primary and/or secondary prevention. Organizations were asked to indicate the types of prevention services provided. Table 1 lists the number and percentages of prevention services provided by responding organizations.

**2.5 Table 1. Types of Prevention Services Provided by Responding Organizations (n=342)**

Type of Service	Respondents that report providing service	
	(Count)	(Percentage)
Advocacy	129	38%
Primary prevention	125	37%
Plan or coordinate	107	31%
Secondary prevention	92	27%
Provide funding	19	6%
Any one of the above	173	51%

### ***Emphasis of Respondent Activity is Not on Focus Areas***

Twenty percent or less of the responding organizations indicated that they provide primary or secondary services and/or plan and coordinate, advocate and/or provide funding for primary and/or secondary services in any of the ten focus areas. The table below lists the frequencies and percentages of organizations that reported providing prevention services in any focus area, in order of frequency. Additionally, 49% of respondents provide prevention services in areas not addressed by this assessment, including mental health, violence prevention, substance abuse and developmental issues in children.

**2.5 Table 2. Prevention Services Provided by Responding Organizations by Focus Areas (n=342)**

Type of Service	Respondents that report providing service	
	(Count)	(Percentage)
Maternal and Child Health	68	20%
Type 2 Diabetes	57	17%
Cardiovascular Disease/ Hypertension	44	13%
Lead Poisoning	45	13%
Breast Cancer	41	12%
Asthma	41	12%
HIV/AIDS/STDs	38	11%
Tobacco Use	36	11%
Obesity	33	10%
Prostate Cancer	33	10%
Other	112	33%

## OBSERVATIONS and CONCLUSIONS

### PHASE ONE

- Most organizations (84%; 165 of 197) listed their legal incorporation or tax status as non-profit 501(c) 3.
- Responding organizations provide prevention services as well as treatment, support and residential services.
- Approximately 13% of responding organizations provide services that address at least one of the ten focus areas.
- Advocacy was the most frequently reported type of prevention service (39%; n=133), followed by primary prevention activities (37%; n=127).
- Maternal and Child Health (20%) and Type 2 Diabetes (17%) were cited most frequently as the focus areas in which organizations surveyed are providing prevention services.
- Most organizations offer primary and secondary prevention services for areas such as, mental health, violence prevention, substance abuse and child development issues.

## SURVEY METHODS

### PHASE TWO

#### **130 CHOs were Invited to Submit Information for PHASE TWO**

Following receipt of the phase one *Introductory Survey* 130 CHOs that met the criteria for inclusion were sent a *Follow-Up Survey*.

## SURVEY RESULTS

### PHASE TWO

#### **One-third of CHOs Provided Detailed Information about Organizations and Programs**

Of the 130 organizations that were sent a *Follow-Up Survey*, 47 (36%) were returned. Not all organizations answered each question; therefore, some items are based on responses from less than 47. A review of the non-responders showed that they were unlikely to have been, with notable exceptions, a significant source of prevention services.

#### **Most CHOs are Well-established**

The average time that the responding CHOs had been in existence was 29 years, with a median of 19 years and a range of 0 to 151 years (n=39). Twenty-six of 39 organizations (55%) reported being independent organizations (not an affiliate or chapter of a larger organization). The size of the governing boards of these agencies ranged from 0 to 400 members, with a mean of 29 and a median of 19 (n=37).

**Respondents were Large Organizations with Annual Funding of more than \$4 Million**

In 2003, the average revenue among respondents was \$4,358,729 (n=26), which is higher than the 1998 average of \$3,889,729 (n=22).

**Fundraising Contributes One-Third of a Balanced Revenue Stream; the United Way Contributes Another Third**

Sources of funding varied along the following percentages<sup>3</sup>:

**2.5 Table 3. Sources of Revenue for CHOs**

Category	Average Percentage of Revenue	Respondents
Donations//Fundraising Events	34%	30
Program Services Fees	25%	15
Government Grants (Federal)	29%	21
Government Grants (State)	22%	17
Local Foundation Grants	26%	21
National Foundation Grants	15%	8
Investment Income	1.5%	12
Other	30%	20

<sup>3</sup>Note percentages do not total 100% given that these are average percentages for the subset of organizations that reported revenue in a particular category; hence, the varying sample sizes as well.

The most common “other” response was the United Way; on average, 39% of revenue for 20 of the respondents came from the United Way. Other sources were local government grants/contracts, named foundations, membership dues, in-kind donations, individual and corporate donations, school districts and parent organizations (including churches).

**2.5 Table 4. Expenditures by Activity**

Category	Average Allocation	Respondents
Outreach	23%	26
Health Education & Risk Reduction	28%	24
Screening and Early Detection	10%	16
Advocacy	12%	13
Referrals	5%	11
Treatment Services	26%	11
Fundraising	6%	19
Administration	12%	28
Other	48%	13

Categories reported under “other” expenditures included supplies, community development, planning, research, conferences and the production and distribution of materials.

CHOs were asked to specify the percentage of 2003 total expenditures dedicated to primary and secondary prevention services provided in St. Louis City, St. Louis County and outside St. Louis City and County. For expenditures on prevention services within the City of St. Louis, 29 organizations reported a mean of 58.5%, a median of 62.5% and a range of zero to 100%. For expenditures within St. Louis County, 27 organizations reported a mean of 39.6%, a median of 30% and a range of one to 100% for primary and secondary prevention services. For expenditures made on prevention services outside St. Louis City and County, 18 organizations reported a mean of 15.7%, a median of 10% and a range of zero to 50%.

<sup>4</sup>Note: percentages are averages for subset of organizations reporting expenditures in a particular category.

### **Few Staff are Devoted to Primary and Secondary Prevention Services**

Among the respondents to the *Follow-Up Survey*, the mean number of full-time, paid staff was 33, with a median of 7 and a range of zero to 414 (n=42). The mean number of part-time, paid staff was 69, with a median of 2 and a range of 0 to 2,402 (n=40). Thirty-six organizations reported a mean of 5.7, with a median of 3 and a range of 0 to 30 (17%) FTEs are devoted to the provision of primary and secondary prevention services.

The average number of volunteers among 39 reporting organizations was 826, with a median of 100 and a range of 0 to 9,800. When asked about the level of dependence on volunteers to deliver primary and secondary prevention services, 25% responded that they were not dependent at all, 21% reported very little dependence on volunteers, 27% reported they were somewhat dependent on volunteer staff and 27% indicated that they were dependent on volunteers to a great extent.

### **Some CHOs Conduct Needs Assessments; Many More Collect Information to Review Organizational Performance**

Fourteen of the 42 organizations (33%) conducted a community needs assessment during the past five years; ten of these 14 consented to share this information with the RHC. A review of these needs assessments is outside the scope of the project.

Thirty-one of the 45 organizations (69%) solicited feedback on the services provided during the past five years; 16 of the 31 agreed to provide this information to the RHC. A review of these documents is outside the scope of this project.

### **CHOs Administer Multiple Programs that Include Prevention Activities**

On average, organizations that responded to the *Follow-Up Survey* reported having five to six total programs (n=32). About half of these programs included primary prevention and about one-third included secondary prevention. Table 4 outlines the *number of programs* within an agency that include primary or secondary prevention services for one of the ten focus areas of this assessment.

**2.5 Table 4. Number of Programs by Focus Area**

Focus Area	Mean Number of Programs	Median Number of Programs	Range of Number of Programs	Number of agencies responding
Asthma	1.5	1.5	0 – 5	13
Breast Cancer	.6	.5	0 – 2	9
Prostate Cancer	.3	0	0 – 1	7
Cardiovascular Disease/Hypertension	1.5	1	0 – 5	15
Type 2 Diabetes	1.5	1	0 – 7	18
HIV/AIDS/STDs	1.1	1	0 – 4	11
Lead Poisoning	1	1	0 – 2	12
Maternal and Child Health	3.2	2	0 – 20	11
Obesity	1.6	1	0 – 8	13
Tobacco Use	1.6	1	0 – 8	12
Other	2.3	1	0 – 8	14

The “other” category most often included programs providing either primary or secondary prevention services in the areas of substance abuse, mental health, violence, type 1 diabetes, vision, nutrition, child development, stroke and bone density screening.

## OBSERVATIONS and CONCLUSIONS

### PHASE TWO

- Survey data indicates that the responding organizations are committed to many other activities unrelated to primary and secondary prevention.
- Organizations that returned a completed Follow-Up Survey had a median age of 19 years.
- Responding CHOs were almost evenly divided between independent organizations and those with an affiliation.
- Average revenue for 2003 was approximately \$4.36 million, with the largest portions of revenue coming from the United Way, donations/fundraising, federal government grants, local foundation grants, program service fees and state government grants.
- CHOs reported spending 28% of annual expenditures on health education and risk reduction services.
- Organizations had a median of 7 full-time paid staff, 2 part-time paid staff and 100 volunteers. Organizations also had a median of three paid staff devoted specifically to the provision of primary and secondary prevention services. More than half of the organizations reported being either somewhat dependent or dependent to a great extent on volunteers to deliver primary and secondary prevention services.
- Approximately one-third of the organizations reported conducting a community needs assessment during the past five years and slightly more than two-thirds reported soliciting client feedback on their services during that time.
- About half of the programs provided by CHOs include primary prevention and about one-third include secondary prevention.
- The most common programs reported fell under the Maternal and Child Health category, where, on average, there were more than three programs per agency.

## Section 2.6

# THE DATABOOK

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A Research Report  
Prepared for the  
St. Louis Regional  
Health Commission  
by Inneval LLC

## Community Health Infrastructure Assessment for St. Louis City and County

## Health Centers

This section has been extracted from a larger report called the Community Health Infrastructure Assessment for St. Louis City and County. For information about the context of the findings, research methods, focus areas and overall conclusions, please refer to the larger report or contact the authors.



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## BACKGROUND AND CONTEXT

### **Community Health Centers Provide Clinical Preventive Services and Primary Care**

Community health centers are local, non-profit outpatient medical offices serving low income and medically underserved communities. In a previous study by RHC, it was reported that nearly 250,000 patients receive primary care annually at these health centers. This represents over 1 in every 6 individuals in St. Louis City and County. Community health centers were included in the assessment because they are a major provider of primary care in the high need zip codes, and as such, a significant source of prevention services.

## SURVEY METHOD and RESULTS

Nine health centers operating in St. Louis City and County were sent surveys. The invited health centers were CHIPS, Family Care Health Centers, Grace Hill Neighborhood Health Centers, Inc., Health Care for Kids, La Clinica, Myrtle Hilliard Davis Comprehensive Health Center, People's Health Centers, Saint Louis ConnectCare, and the Health Resource Center. Of these centers, three (3) responded to the survey completely. One other organization provided limited information requested in the survey.

### *Community Health Centers Fund Medical Care Services*

Of the four responding health centers, two were established in the late 1960's and two in the 1990's (1994 and 1997.) Other characteristics of the respondents varied substantially. With regard to paid employees, the responding health centers range from four part-time employees to 446 full-time and part-time employees. One organization is almost totally dependent on volunteers while another uses one such individual. Revenues vary widely from almost \$40 million to \$7.6 million in revenues with one center not reporting. Two of the four centers reported the majority of revenues come from program service fees (54 and 64%) followed by grant sources (41 and 36%). One center indicated the majority of revenues are from DSH (49%), followed by program service fees (36%). The remaining center reported its revenues are generated mainly from fundraising (80%). Although two of the organizations did not report, approximately 80 percent of the expenditures in the other two health centers were for treatment services. The centers were generally unable to describe the distribution of their expenditures for primary or secondary prevention services.

### *Needs Assessments are Conducted by Health Centers*

Two of the health centers indicated that they had conducted a community needs assessment in the last five years. These same centers reported that they also collected feedback from their clients with regard to the services they provide.

### *Staff are Dedicated to Primary and Secondary Prevention Activities*

Two of the centers estimated that 20 and 64 employees (FTEs) are dedicated to primary and secondary prevention activities. The other two organizations were unable to report this information. Organizations were asked to describe the types of prevention activities (e.g., written materials, advertising, help lines, support groups, education classes, screening, etc.) for each of the ten focus areas (diabetes, cardiovascular disease and obesity and breast and prostate cancer were grouped together). In addition, they

were asked to indicate the amount spent on each activity and the reach of each activity, i.e., number of materials distributed or number of individuals served. Only one of the four organizations provided information about the amount of money spent on and the reach of specific prevention activities.

### **Screening is a Priority Among Other Activities**

All of the responding organizations provide some types of prevention activities for type 2 diabetes, cardiovascular disease, obesity and HIV/AIDS/ STDs.

#### *Type 2 diabetes, cardiovascular disease, and obesity*

All responding organizations provide screening for diabetes, cardiovascular disease and obesity, followed by distribution of written materials and advertising or media campaigns (n=3), education classes and support groups (n=2), and help or advice lines (n=1.)

#### *HIV/AIDS/STDs*

With regard to activities for HIV/AIDS/STD prevention, all responding organizations reported HIV or STD testing, while three provide education activities to reduce the risk of HIV. Two organizations indicated that they distribute written materials, use the media, and conduct outreach activities to provide information related to HIV/AIDS/STD prevention. Only one of the four organizations conducts peer programs and prevention case management for HIV/AIDS/STDs.

#### *Breast and cervical cancer*

Three of the four respondents indicated the provision of various types of prevention activities for breast and prostate cancers and maternal and child health. Of these organizations, all distribute written materials and provide some type of promotion for screening behaviors. Two of the organizations actually provide screening (mammography, clinical breast exam and PSA tests.) Only one of the organizations uses the media to promote cancer prevention, provides a help or advice line or a support group.

#### *Maternal and child health*

With regard to maternal and child health, all three organizations provide immunizations, EPSDT and well child exams. One organization distributes written materials about maternal and child health, provides a help or advice line, and prenatal health education and physical exams, while another uses the media to inform

### *Lead poisoning*

Finally only two of the responding organizations reported the provision of lead, tobacco and asthma prevention activities. Lead prevention activities that organizations reported providing include blood lead level and prenatal lead screening. One organization uses the media to inform clients about lead related issues. The other distributes written materials and abatement/cleaning materials and provides a help or advice line, training for lead abatement, and case management, follow-up or monitoring of children.

### *Tobacco use*

Tobacco prevention activities include tobacco education for adults (n=2), distribution of written materials (n=1), billboards (n=1) and a help or advice line (n=1).

### *Asthma*

Asthma self-management, internal environmental control education, and screening among adults and children are conducted by the two organizations that provide asthma prevention activities. One of the organizations distributes written materials about asthma, and provides a help or advice line and school-based asthma programs. The other uses television and billboards to distribute information about asthma.

### **Events are Common Ways to Reach the Community**

All four organizations reported a variety of community events and/or health fairs in which they participated. The purposes of these events were primarily education and awareness, followed by screening. The costs of the events ranged from \$200 to \$10,000. The zip codes included in the events are: 63106, 63107, 63110, 63111, 63112, 63115, and 63147.

### **Advocacy and Planning/Coordination Involvement is Limited**

Survey respondents were asked to indicate the level of organizational activity related to advocacy and planning and coordination of primary and secondary prevention. Only one of the organizations reported involvement in advocacy activities through the development and distribution of press releases, media interviews, and grass roots efforts such as letter writing and phone calls. This organization devotes one FTE to advocacy and indicated that advocacy activities are very important to achieving the mission of the organization. Two organizations indicated involvement in planning and coordinating prevention activities by serving on boards, coalitions or consortiums, and/or committees.

## OTHER CONSIDERATIONS

Information about community health centers gathered outside the survey indicates that community health centers are major providers of prevention services. However, their prevention activities are limited to their patient populations and are generally restricted to direct services, such as lab tests, physical exams, etc. Most community health centers have reduced their community outreach and education activities in favor of focusing organizational efforts on the provision of services, such as operational efficiency, quality improvement, and disease management protocols. While an important part of a complete approach to prevention, population-based education is not emphasized by community health centers.

## OBSERVATIONS and CONCLUSIONS

- Program service fees are significant sources of revenues for the community health centers, ranging from 36-64% of revenues for three of the four responding organizations.
- The majority of expenditures (80%) are devoted to treatment services for two of the four responding health centers.
- Two of the four health centers reported that a large number of full time employees (20 and 64) are dedicated to the provision of primary and secondary prevention activities.
- All organizations provide prevention activities for diabetes, cardiovascular disease and obesity and HIV, AIDS, and STDs.
- Three health centers provide various types of prevention activities for breast and prostate cancers and maternal and child health.
- One health center devotes one full time employee to advocacy efforts.