

Community Health Needs Assessment

Mercy Hospital South
2025



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FY23-25 Impact

The 2022 community health needs assessment identified three priority health areas:



A community health improvement plan was developed and implemented to address these significant needs. Mercy Hospital South developed and implemented a variety of programs and initiatives to address the needs identified in the 2022 CHNA.



FY23-25 Impact

Access to Care for Those at High Risk

Community Health Worker (CHW) Program: CHW's have been serving at Mercy Hospital South since 2018. Our CHW's serve as liaisons/links between health care, community and social service agencies. They screen for needs related to social determinants of health and facilitate access to services and improving the quality and cultural competence of care. Our CHWs provided resources and assistance to over 6,700 patients over the last three years with over 12,300 encounters with special attention paid to assisting with enrollment into Mercy Financial Assistance and Medicaid.

Community Referral Coordinator (CRC) Program*: CRC's connect patients from the Emergency Department and/or inpatient units of the hospital with a primary care home for follow-up and preventative care. The program focuses on serving underinsured and uninsured patients; however, work with all patients in need of a medical home which can be a Federally Qualified Health Center (FQHC) or a Mercy provider. The Mercy South CRC had 1,265 encounters during FY23 and scheduled appointments with an average kept rate of 57%.

*The CRC contract ended December of 2023.

Impact Evaluation of Previous CHNA

Access to Care *(continued)*

Health Leads Program: Health Leads connects low-income patients in the clinics to the resources they need to be healthy. Staff at Mercy Clinics utilize a screening tool to identify social needs that are acting as barriers to patient's medical care. If a need is identified, patients are contacted by Health Leads staff to connect to community resources to address the need(s). Since the beginning of the CHIP cycle, over 270,000 patients have been screened. An average of 8% of those screened identified as having a social need. Over 3,400 needs were addressed and closed.

Hancock Clinic Partnership: Mercy South financially supports the Hancock school-based Community Clinic that serves all verified residents of the 63123 and 63125 zip-code at no out-of-pocket expense to the patients. Services provided include general services, women's health, basic labs and mental health to this high-need/high-risk population. Patients from these zip codes that present at Mercy Hospital South without a PCP are connected with care at the Hancock Clinic. For the past three years, the Hancock Clinic has served over 2,500 patients.

Impact Evaluation of Previous CHNA

Access to Care *(continued)*

Crisis Nursery Outreach Partnership: The Crisis Nursery Outreach Center at Mercy Hospital South assists area families with children birth through 12 years with crisis counseling, community referrals, home visitation, and parent education groups to prevent child abuse and neglect and promote healthy families. The program also provides community families in need with donations of food bags, diapers, cleaning supplies and other household items. In the past three years, the Crisis Nursery at Mercy Hospital South had 1,000 encounters to assist community members and connected them to over 1,800 basic needs items.

Dispensary of Hope (DOH)- The DOH program launched at Mercy Hospital South in October of 2021, providing uninsured Mercy patients living at or below 300% of the Federal Poverty Line with life saving medications free of cost for up to one year. During the last CHIP cycle, the DOH program was able to assist over 350 patients and dispensed over 700 prescriptions through our retail pharmacy and saved those patients over \$58,000 in prescription costs.



FY23-25 Impact

Behavioral Health

Emergency Room Enhancement (Youth and Adult ERE): The Behavioral Health Network's ERE project facilitates an integrated 24/7 region-wide approach that targets high utilizers of emergency rooms who present with behavioral health symptoms, with the primary goal of reducing preventable hospital readmissions. Patients identified through the ERE project are connected to a peer support specialist who provide assistance with linking to community resources and inpatient and outpatient services. The program provides after-hours/weekend scheduling, as well as telephonic and mobile outreach crisis services for consumers referred to the ERE project. Over the last CHIP cycle, over 500 referrals made into the Youth ERE program, over 400 appointments scheduled with a kept rate average of 78%. For the Adult ERE program, there were data tracking issues that occurred halfway through the CHNA cycle. The data tracked for the first half of the cycle showed 233 referrals were made, 179 appointments set with an average kept rate of 32%.

Impact Evaluation of Previous CHNA

Behavioral Health (*continued*)

Virtual Behavioral Health (vBH)- This is a Ministry-wide program that provides integrated support for patients with behavioral health needs in the outpatient and inpatient setting. vBH provides virtual and telephonic behavioral health assessments to establish patients' level of care, and facilitate referrals for inpatient, outpatient services, as well as for basic social needs in their home communities. Over 11,000 unique patients in the Mercy South service area have been connected to this service.

Concert Health Collaborative Care- This partnership commenced in 2022 to support Primary Care providers (PCP) in providing their patients with mental/behavioral health support. The program helps provide a behavioral health care manager who interacts directly with the patient, performs an assessment, as well as initiates treatment, all in collaboration with their PCP. This collaboration strives to enhance support to PCPs by providing comprehensive mental and behavioral healthcare to patients while allowing the patient to obtain care in the same setting. During the last CHIP cycle, over 1,700 patients were referred to the Concert Health Program in this service area.

Impact Evaluation of Previous CHNA

Behavioral Health (*continued*)

Hospital Community Linkages (HCL): The HCL Inpatient project utilizes a designated liaison to identify and refer potential behavioral health consumers; facilitate referral and ensure discharge documentation is transferred for continuity of care. The HCL program is part of an integrated 24/7 region-wide approach that targets high utilizers of inpatient settings, with the primary goal of reducing preventable hospital readmissions. There have been over 300 referrals into the program, over 233 appointments made, and an appointment kept rate average of 83% during the last CHIP cycle.

Engaging Patients in Care Coordination (EPICC): The EPICC program, in partnership with the Behavioral Health Network of Greater St. Louis (BHN) connects opioid overdose survivors treated in emergency rooms to recovery support and substance use treatment services, including Medication Assisted Treatment (MAT). Individuals must be over the age of 18 and meet diagnostic criteria for opioid dependence. Intensive referral and linkage services are provided by peer Recovery Coaches. There have been over 250 referrals into the program, 246 appointments scheduled with an average appointment kept rate of 87%.

Impact Evaluation of Previous CHNA

Behavioral Health (*continued*)

- ***Substance Use Recovery Program (SURP)***: The SURP program is an integrated, mission-driven, patient-centric approach to Opioid Use Disorder. SURP will ensure that any patient seeking care through Mercy will be connected to ongoing care for Opioid Use Disorder regardless of geography, clinical setting, or ability to pay. Over 3,000 referrals have been made to this program in our region.



FY23-25 Impact

Diabetes

St. Louis County Diabetes Collaborative Program*: Established as a result of the on-going St. Louis County CHNA hospital collaborative upon jointly prioritizing diabetes top health concern across the St. Louis community.

****Scope of Work and Limitations:*** COVID-19 hit the community and caused a year-long pause in our collaborative as team-members were pulled to address different community concerns. The team re-grouped in 2021 and to reassess resources, programming and goals to create a new strategy for FY 23. Mercy South had to pause efforts due to change in Community Health Leadership and medical leave.



Executive Summary

For more than 140 years, generations of St. Louisans have relied on the healing tradition of care provided by Mercy Hospital South. Mercy Hospital South exemplifies the legacy of the Sisters of Mercy, who set an amazing standard in caring for the community by providing compassionate care that was second to none. As trusted partners, our physicians and employees seek to improve the health and well-being of the residents in the communities we serve by providing the same compassionate care every day. While the CHNA demonstrates the legacy of the ‘walking Sisters’, engaging actively out in community to address urgent needs, it also fulfills a legal imperative of Mercy as a non-profit health care organization.

As part of the Patient Protection and Affordable Care Act (PPACA) passed in March 2010, non-profit hospitals were mandated to conduct a community-based health needs assessment every three years. As part of that process, each hospital is required to solicit input from those who represent the broad interests of the community served by the hospital as well as those who have special knowledge and expertise in the area of public health. For this year’s CHNA, we also gathered and analyzed health-related information and statistics from both St. Louis County, City and State and sought out more targeted secondary data as appropriate.

Executive Summary *(continued)*

Five overall identified health needs emerged during the CHNA process. The Community Health Council of Mercy Hospital South reviewed and prioritized four of the needs based on several criteria. The 2025 prioritized health needs are:

- Access to Care
- Behavioral Health
- Aging Services
- Nutrition & Food Insecurity

These Four health priorities will be the basis of the community health improvement plan (CHIP), which will guide the coordination and targeting of resources and the planning, implementation and evaluation of new and existing programs and services. This community health needs assessment, along with the resulting community health improvement plan, will provide the framework for Mercy Hospital South as it works in collaboration with community partners to advance the health and quality of life for the community members it serves. We will strive diligently to address these needs over the next three years.

Please visit <https://www.mercy.net/about/community-benefits> to learn more about the community benefit work being done at Mercy. As always, we seek to develop a rich and rewarding network of partnerships with our neighbors and I welcome any suggestions you have as we seek to achieve our goal of a healthier community.



Sean Hogan

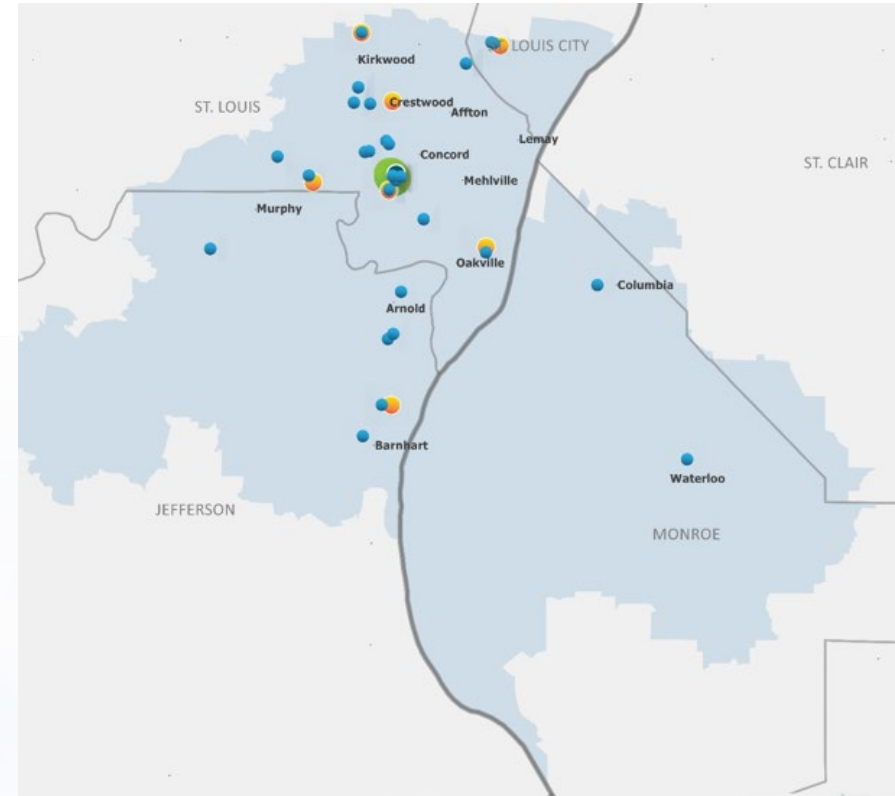
Sean Hogan
President
Mercy Hospital South

Community Profile

Defining the Community

Mercy Hospital South (MHS) is located in South St. Louis County and has a primary service area that consists of four counties (31 zip codes) across the Missouri-Illinois bi-state area. The service area spans rural, suburban, and urban settings.

For the purpose of this Community Health Needs Assessment (CHNA), MHS defines its primary community as the South St. Louis County, Northern Jefferson County, parts of South St. Louis City, and Monroe County. The next page shows a full listing of those zip codes.



Community Profile

Defining the Community *(continued)*

Zip Code	City
63010	Arnold
63012	Barnhart
63016	Cedar Hill
63019	Crystal City
63020	DeSoto
63026	Fenton
63028	Festus
63047	Hematite
63048	Herculaneum
63049	High Ridge
63050	Hillsboro

Zip Code	City
63051	House Springs
63052	Imperial
63053	Kimmswick
63057	Liguori
63070	Pevely
63109	Francis Park
63111	Carondelet
63116	Bevo
63118	Gravois Park
63119	Webster Groves

Zip Code	City
63122	Kirkwood
63123	Afton
63125	Lemay
63126	Crestwood
63127	Sunset Hills
63128	Concord
63129	Oakville
62236	Columbia, IL
62295	Valmeyer, IL
62298	Waterloo, IL

Community Profile

Demographics

Age and Racial Distribution	St. Louis County	Jefferson County	St. Louis City	Monroe County
Population size (number of persons)	1,004,125	226,739	301,578	34,962
Age distribution				
Under 18 years	22.10%	22.80%	18.60%	22.01%
18 to 44 years	33.80%	33.50%	42.80%	31.19%
45-64 years	25.40%	27.60%	23.70%	28.00%
65 years and over	18.70%	16.10%	14.90%	18.80%
Race distribution				
White	66.80%	96.82%	46.71%	98.35%
Black or African American	26.05%	1.11%	45.84%	0.36%
American Indian and Alaska Native	0.25%	0.33%	0.33%	0.20%
Asian	5.15%	0.88%	4.34%	0.56%
Native Hawaiian and Other Pacific Islander	0.03%	0.03%	0.03%	<0.01%
Other (2+ Races, Some Other Race)	1.71%	0.83%	2.74%	0.52%
Ethnicity distribution				
Hispanic or Latino (of any race)	3.93%	2.62%	5.44%	1.93%

Source: US Census Bureau



Median Age for Mercy Hospital South Service Area

Community Profile

Education

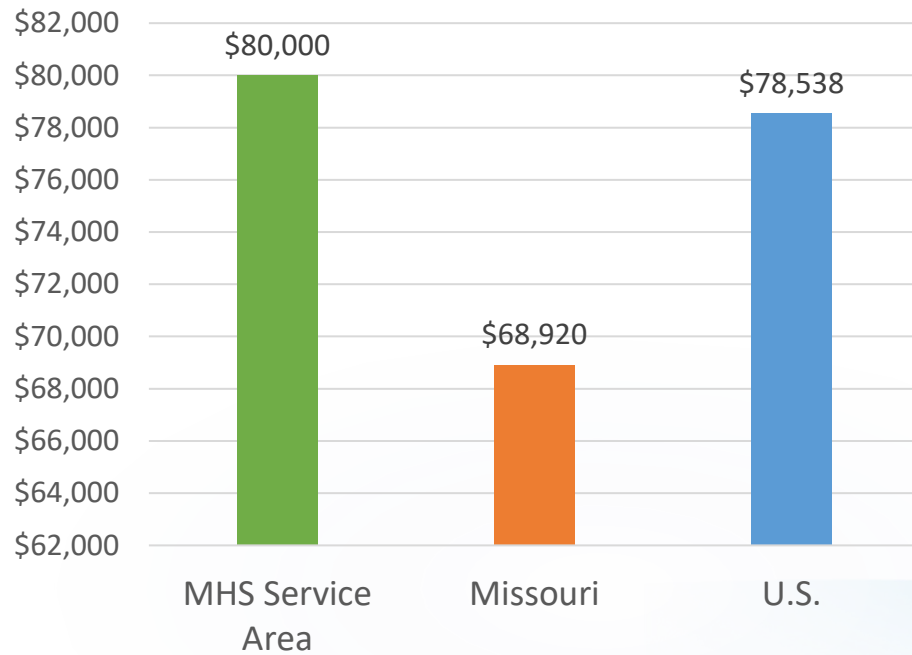
Level	St. Louis County	Jefferson	St. Louis City	Monroe	Missouri
No High School Diploma	5.8%	8.8%	10%	4.3%	8.7%
High School Diploma	20.8%	32.2%	24.7%	24.7%	30.5%
Some College	19.5%	23.7%	20.3%	22.2%	21.4%
Associate's Degree	7.8%	12.6%	6.4%	10.9%	8.2%
Bachelor's Degree or Greater	26.2%	15.3%	21.5%	23.9%	19.2%
Graduate or Professional Degree	19.9%	7.5%	17.1%	13.9%	12%

Source: SparkMap.org



Community Profile

Median Household Income



Sources: Advisory Board Demographic Estimates, 2023-2028
and sparkmap.org



Community Profile

Insurance Status

Mercy South Primary Service Area Payor Mix

Medicare – 22.2%

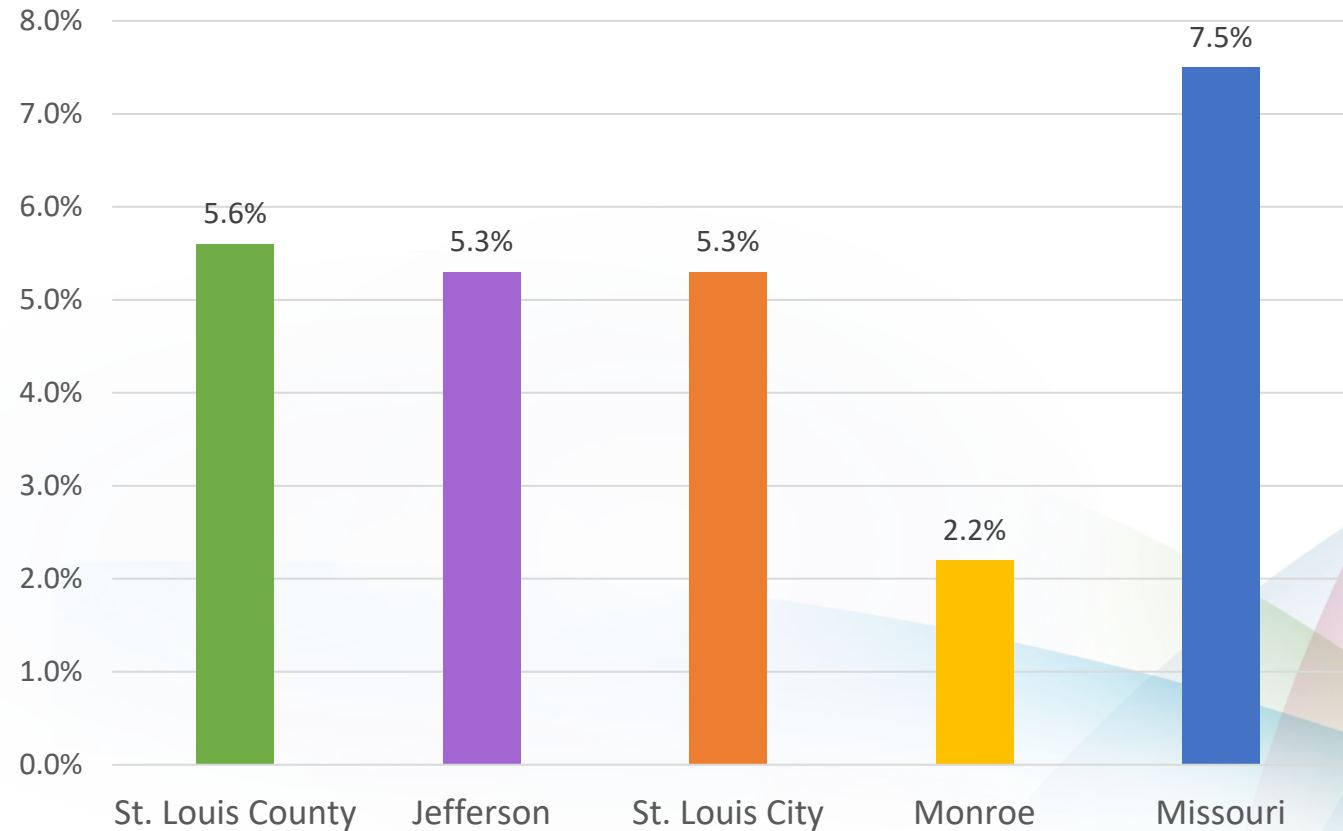
Medicaid – 16.5%

Commercial – 54.1%

Uninsured – 7.1%

Source: EDAO/Market Intelligence/Clarivate

Percent Uninsured by County



Source: US Census Bureau

Community Profile

Access to Care

	St. Louis	Jefferson	St. Louis City	Monroe	Missouri
Primary Care Physicians	820:1	3,930:1	1,030:1	2,500:1	1,420:1
Dentists	1,120:1	2,360:1	1,210:1	1,210:1	1,600:1
Mental Health Providers	280:1	960:1	270:1	610:1	410:1

Source: County Health Rankings, 2024.

Our Assessment Process

Data Collection

To capture relevant data and community voices for this Community Health Needs Assessment, MHS collected and analyzed a significant quantity of primary and secondary data during 2024. Primary data was collected by means of the community health surveys for community members, jointly sponsored by the St. Louis Regional Hospital Collaborative. A copy of the survey can be found in Appendix A.

Community input was also solicited through stakeholder focus groups and community conversations also sponsored by our regional collaborative (Appendix C & D). Stakeholder input was included from Jefferson County Community Partners and that summary can be found in Appendix E. The commitment to centering community voice was central to the health needs assessment process. Input from people representing broad interests of the community were solicited through the survey process.

Secondary data from publicly available sources was utilized to offer additional insights to the communities served by Mercy Hospital South and are listed later in this assessment.

Our Assessment Process

St. Louis Regional Hospital Collaborative

The St. Louis Regional Hospital Collaborative consists of BJC Health, Mercy, SSM Health, and St. Luke's Hospital. These systems have worked together in past CHNA cycles which has resulted in deeper efforts to work together. This collaborative ensures that the health systems are working to align priorities that will result in collective impact in partnership with the community.

These systems work together to solicit input from those who represent a broad interest of communities served by the hospitals, those who have knowledge and expertise in the field of public health and underserved populations, as well as community members who are marginalized and underserved. The health systems are committed to equity-focused collaboration.

The hospital collaborative partnered with Key Strategic Group (KSG) for collective CHNA work. KSG convened Community Health from the health systems to plan, implement, and evaluate stakeholder and community conversations. They also provided direction for future collaboration through a framework playbook.



Our Assessment Process

Community Health Needs Survey

From March through June of 2024, the St. Louis Regional Collaborative shared one community survey across the region. This was distributed in both English and Spanish, primarily digital but paper copies were made available in some settings. Direct outreach was made to over 3500 stakeholders and community organizations to share within the communities they serve, as well as used on social media and news outlets.

Over 6,800 community surveys were answered for the region. Mercy Hospital South's primary service area included 2,619 of those respondents. Below are survey responses.

Top health concerns for adults:	Top health concerns for children:	Barriers to health care access:	Least available resources:
<ul style="list-style-type: none">- Mental Health- Obesity and maintaining a healthy weight- Heart conditions- Age-related illnesses- Substance use	<ul style="list-style-type: none">- Mental Health- Obesity and maintaining a healthy weight- Substance use- Intellectual/developmental disabilities- Abuse and neglect	<ul style="list-style-type: none">- Costs associated with getting health care- No health insurance- Transportation- Scheduling problems- Not enough health care services or providers	<ul style="list-style-type: none">- Public transportation- Affordable housing- Mental health and substance use services- Aging services- Good paying jobs

Community Health Survey Data Summary for Mercy Hospital South located in Appendix B

Our Assessment Process

Community Stakeholder Conversations

Between July 9 and July 25, 2024, the St. Louis Regional Hospital Collaborative (the Collaborative), supported by Key Strategic Group (KSG), facilitated six stakeholder conversations across the St. Louis region. This included 5 conversations in the defined regional markets and 1 with a focus on children and youth across the region. The goal was to gather insights into the region's most pressing health concerns from stakeholders representing diverse sectors, including healthcare providers, public health professionals, community-based organizations, and social service agencies.

Discussions covered mental health, access to care, social determinants of health (SDOH), and systemic trust, focusing on identifying gaps and challenges while proposing actionable solutions. Each conversation was 90 minutes long and allowed those participants to engage in small group discussions surrounding community survey data. Participants committed to continued conversations between CHNA cycles.

Our Assessment Process

Community Stakeholder Conversations *(continued)*

Below is the summary of response from the community stakeholder conversation for the South Market held on July 9th, 2024. Community stakeholder conversation summary is located in Appendix C.

Primary Health Concerns:

- Mental Health
- Substance use
- Food Insecurity

Barriers to Achieving Optimal Health Outcomes:

- Transportation
- Education (nutrition, health, and healthcare)
- Access to culturally competent care



Photo taken July 9th meeting at SSM St. Clare Hospital - Fenton

Our Assessment Process

Jefferson Stakeholder Conversations

The inclusion of stakeholder input from Jefferson County is necessary, as it serves as a large portion of the Mercy Hospital South primary service area. The Jefferson Collaborative- which includes Mercy, Compass Health, Jefferson Franklin Community Action, the Jefferson County Health Department, Jefferson County Community Partnership- hosted a community partner collaboration day.

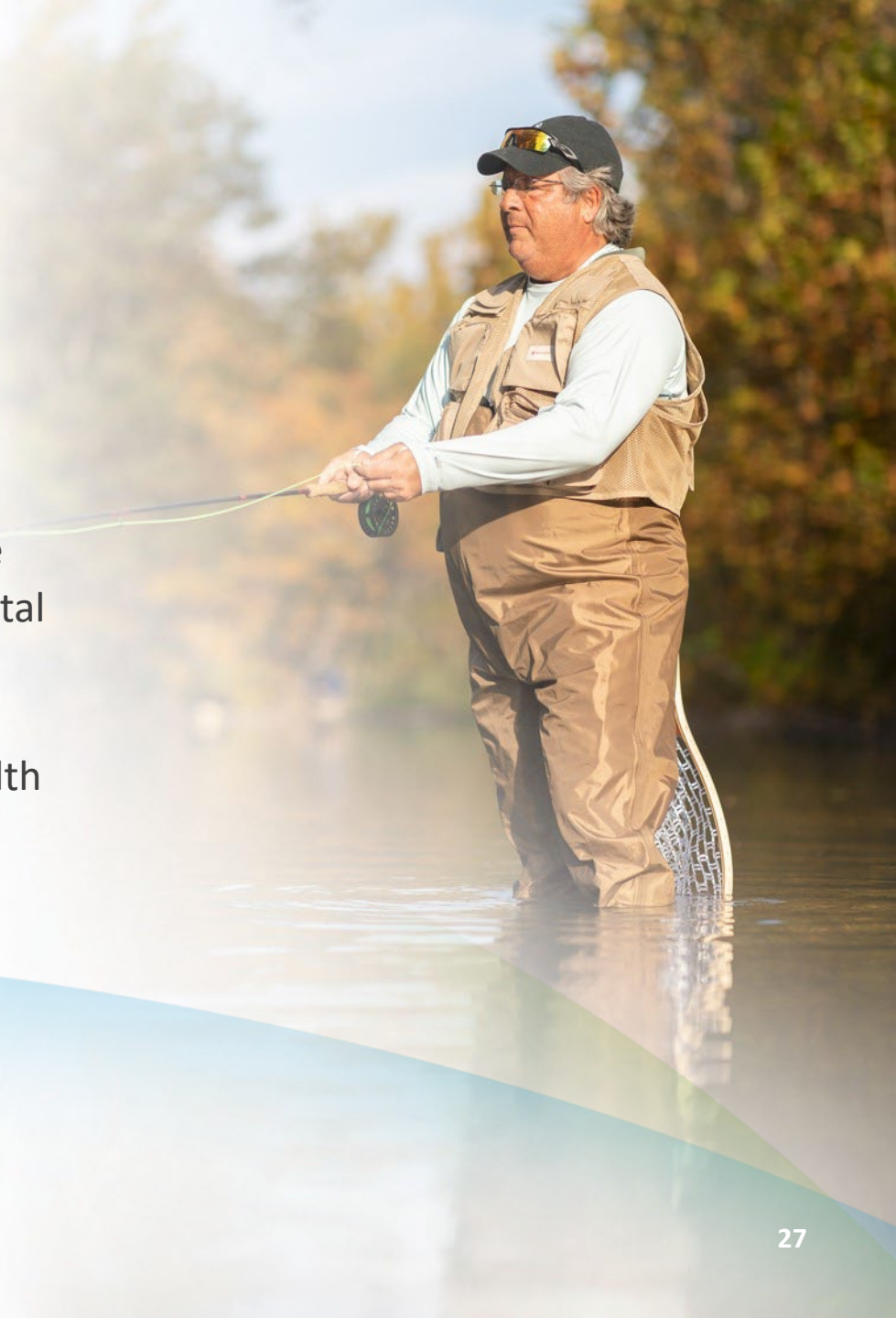
During this event, 50 participants from 29 organizations gathered to engage a review of community data and share insights into the community. Sectors represented included public health, education, public safety, and various community-based organizations. The discussions helped to identify existing assets and areas of opportunity to improve the overall health and well-being of residents. The day was structured with large group discussions, as well as small table discussions with areas of focus on mental health, substance use, physical health, childhood challenges, and barriers to accessing care.

Our Assessment Process

Jefferson Stakeholder Conversations *(continued)*

Twelve areas of need were identified as priority:

- Access to Care
- Financial Literacy
- Substance Use
- Behavioral Health
- Affordable Housing
- Transportation
- Age Related Illnesses
- Obesity/Healthy Lifestyle
- Intellectual/Developmental Disabilities
- Cancers
- Maternal and Infant Health



Our Assessment Process

Community Conversations

The St. Louis Regional Health Collaborative recognizes that achieving health equity requires understanding the lived experiences and perspectives of the communities it serves. The Collaborative and trusted partner organizations conducted 6 community conversations to that end. In this vital dialogue, these organizations connected with diverse groups, amplifying the voices of youth, older adults, immigrant communities, and individuals experiencing housing instability. Voices from these conversations included 60 participants at these partner organizations:

- St. Patrick's Center
- International Institute
- Oasis
- Beyond Housing/24:1
- Vision for Children at Risk
- Boys and Girls Club of Greater St. Charles

The Collaborative is committed to on-going conversations with community partners beyond the CHNA process.

Our Assessment Process

Community Conversations *(continued)*

Findings: Themes & Insights

- Barriers to Healthcare Access
- Mental Health as a Priority
- Culturally Competent Care
- Community Strengths and Assets

Call to Action

1. Prioritize equity-driven initiatives that reflect the lived experiences of diverse populations.
2. Invest in community-centered solutions such as mobile clinics, peer networks, and culturally tailored programs.
3. Establish accountability frameworks to monitor progress and ensure sustainable impact.

Resources

The following external sources of published data were used as part of the collection of secondary data during the assessment process:

- Advisory Board Demographic Estimates, 2023-2028. [Projected Population Growth 2023-2028 in the US – Overview](#)
- Clarivate- EDAO/Market Intelligence/Clarivate. <https://ir.clarivate.com/default.aspx>
- SparkMap, 2019-2023. <https://sparkmap.org/report/>
- U.S. Census Bureau. “Selected Characteristics of Health Insurance Coverage in the United States.” American Community Survey, 2023. <https://data.census.gov/table/ACSST1Y2023.S0101?g=050XX00US29189>
- U.S. Census Bureau. “Age and Sex.” American Community Survey, 2023. <https://data.census.gov/table/ACSST1Y2023.S2701?g=050XX00US29189>
- County Health Rankings and Roadmaps, 2025. <https://www.countyhealthrankings.org/health-data>

Prioritized Needs

Prioritizing Identified Health Needs

Thirteen identified health needs emerged during the process of analyzing primary and secondary data for the CHNA. Needs were identified if they were ranked highly as a need by survey respondents (Appendix B), identified as a health disparity by public health data, or were prioritized in a prior CHNA.

The Community Health Needs Advisory Committee of Mercy Hospital South met in March 2025 to prioritize the thirteen identified health needs. The committee reviewed the primary and secondary data collected during the CHNA process, evaluated the strengths and resources of the community, and considered the hospital's strategic plan. The committee narrowed the list of identified health needs by using a strategy grid. Criteria used to prioritize the needs using the strategy grid were Severity of the Need and Availability of Resources to address the need. The identified health needs were Access to Care, Aging Services, Behavioral Health, Cultural Competency, Nutrition/Food Insecurity.



Prioritized Needs

Prioritizing Identified Health Needs *(continued)*

A nominal group technique was then used to rank the five finalized priority health needs. Each committee member ranked each of the four needs using five criteria: 1) Magnitude of Need, 2) Feasibility to Change, 3) Alignment with Mission/Strategic Goals, 4) Resources Available, and 5) Importance to Community. Scores were totaled for all participants. Results of the strategy grid and nominal group technique are included in the nominal grouping results table.

Based on the results of the 2025 CHNA, MHS has prioritized four health needs: Access to Care, Behavioral Health, Aging Services, and Nutrition/Food Insecurity. The first two of which will be carried over from the 2019 CHNA, and two are newly identified needs. MHS will maintain current strategies which have been implemented and have been shown to be making positive impacts in these priority areas and will continue to seek out programs, interventions, and community partnerships to meet all the prioritized health needs.

Prioritized Needs

Prioritizing Identified Health Needs *(continued)*

Strategy Grid Results

		Magnitude of Need	
		High	Low
Resources Available	High	Access to Care Behavioral Health Substance Use Disorder	
	Medium	Nutrition/Food Insecurity Maternal and Infant Health Culturally Competent Care Cancers	Developmental Disabilities Heart Conditions
	Low	Affordable Housing Transportation	Crime Financial Literacy

Nominal Group Ranking Results

Identified Health Need	Total Score	Chosen as Priority Need
Access to Care	117	Yes
Behavioral Health	140	Yes
Aging Services	107	Yes
Culturally Competent Care	82	No
Nutrition/Food Insecurity	92	Yes

Prioritized Needs



Access to Care



Behavioral Health



Nutrition/Food
Insecurity



Aging Services

Prioritized Needs

Access to Care

Access to health care refers to comprehensive, timely, and quality health care services that result in the best health outcomes. Vulnerable populations suffer from limited access due to a variety of structural and individual factors. Such barriers include the high cost of care, lack of health insurance coverage or inadequate insurance coverage, limited availability of services, and transportation barriers. Those without care are not as able to obtain treatment for acute or chronic diseases, resulting in further exacerbation of their health conditions, increased cost of care, and, at times reduction in quality of life and premature death.

Another barrier to access to care is adequate numbers of primary care physicians (PCPs) for the population. Jefferson County, especially experiencing a shortage of primary care physicians. The rate of 1 PCPs per 3,930 of the population in Jefferson County is particularly low, and lower than the Missouri rate of 1 to 1,420.

Mercy Hospital South plans to continue much of the current programming focused on access to care, while exploring opportunities to increase the positive impact.



Prioritized Needs

Behavioral Health



Mental health is very closely linked to physical health and vice versa. Mental health and substance use many times can co-occur and are very closely related, as they fall under the behavioral health umbrella. Secondary data on overall behavioral health is challenging to obtain at the county level. As a nation, however, the data is clear that mental health is a very significant health issue. Opioid overdose deaths saw a 500% increase from 1999 to 2022 and over 20 million U.S. adults do have a co-occurring disorder [1].

Respondents to the Community Health Survey indicated that mental health and substance use were among the most important health issues or problems to them and the people in their households. Stakeholders in both St. Louis and Jefferson County as well as participants at the community conversations ranked mental health and substance use as top concerns for the health of their communities.

Mercy Hospital South intends to continue the efforts on mental health programming, as well as substance use under the behavioral health umbrella. For the overall health of an individual, behavioral health is a key component. The collaborative care approach Mercy South has engaged in to address this need to care for the whole person is paramount in affecting improved health outcomes for our community.

[1] <https://www.cdc.gov/mental-health/about/about-behavioral-health.html>

Prioritized Needs

Nutrition/Food Insecurity



A theme began to emerge from the stakeholder conversations when discussing health issues and barriers to care. The theme was centered around food and nutrition, healthy lifestyles, and food insecurity. These root causes for health conditions such as heart disease, diabetes, and other chronic diseases. It was also noted that by improving food and nutrition security, the direct health of the community would be positively impacted.

Food insecurity is a lack of consistent access to enough food for an active healthy lifestyle. Access to quality food that is also affordable, is important to health. According to the St. Louis Area Foodbank, 1 in 7 are food insecure and 1 in 6 children are food insecure in our region. Of those that the St. Louis Area Foodbank serves, 40% had to choose between food and medical care [2]. This statistic can and does lead to negative impacts. Feeding America notes that half of all households they serve have at least one person living with high blood pressure and more than one-third have one person living with diabetes [3].

Pursuing initiatives and programming on nutrition and food insecurity, with emphasis on food as medicine will be necessary to aid in a nutritionally secure community.

[2] <https://stlfoodbank.org/hunger-facts/>

[3] <https://www.feedingamerica.org/hunger-in-america/impact-of-hunger/hunger-and-nutrition>

Prioritized Needs

Aging Services

It is estimated that by 2030, the older adult population will outnumber minors. There are nearly 270,000 adults aged 65 and over living in the 4 counties that make up the Mercy Hospital South primary service area. Of those older adults living in the Missouri counties, 9% fall below the poverty level [4].

Due to both the rapid growth of the older adult population and the high rates of poverty, paired with the results of this assessment, a focus on aging services was determined a prioritized need. The efforts to do so will require a focus of traditional health care, as well as collaborative care that will address whole-person health.

[4] <https://health.mo.gov/seniors/masterplanaging/>



Resources

The following external sources of published data were used as part of the collection of secondary data during the prioritized need process:

1. About Behavioral Health, 2024. <https://www.cdc.gov/mental-health/about/about-behavioral-health.html>
2. Hunger Facts & Stats, 2025. <https://stlfoodbank.org/hunger-facts/>
3. Importance of Nutrition on Health in America, 2025. <https://www.feedingamerica.org/hunger-in-america/impact-of-hunger/hunger-and-nutrition>
4. Missouri Aging Profiles, 2025. <https://health.mo.gov/seniors/masterplanaging/>

IX Appendices*

- Appendix A: Community Health Survey
- Appendix B: Community Survey Data for MHS PSA Zip Codes
- Appendix C: Stakeholder Conversation Summary - South County
- Appendix D: St. Louis Regional Hospital Collaborative Community Conversation Summary Report
- Appendix E: Jefferson Primary Data

*Appendices are available as separate, supplemental pdf documents to this Community Health Needs Assessment Report.



Your life is our life's work.



St. Louis Community Health Needs Assessment

Your community is where you live, learn, work, worship, and play. You have an important perspective on the needs in your community, and we would like to learn from you. The hospital systems in the St. Louis region are working together to learn from community members and identify the top health concerns and health related needs. **Your input is very important and will be used to help identify priorities and develop solutions.**

The survey will take about 5 minutes. **All responses are confidential and anonymous.** You will not be asked for your name, and we will only share combined results. Once you complete the survey, please return it to the survey distributor. You can also take the survey online at <https://bit.ly/2024HealthNeedsSurvey> or using the QR code in the top right corner of this page. Share the link with your family, friends, and neighbors!

Tell Us About Your Community

1. What is your home ZIP code?

Enter the five-digit ZIP code of the address where you live:

The next question asks about the resources that help you and your neighbors be healthy.

2. Thinking about the community where you live, how available are the following resources?

For each resource below, choose a number from 1 to 5, where 1 means *Never available*, and 5 means *Always available*. If you do not know, choose *Not sure*.

	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always	Not sure
Safe childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affordable healthy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health and substance use services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Places to be physically active, such as community parks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that support people as they age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clean outdoor environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good paying jobs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions ask about the health needs in your community.

3. Thinking about adults in the community where you live, what are the top three health problems?

Choose **three** items from the list that are a concern for **adults** in your community.

- | | |
|--|--|
| <input type="checkbox"/> Age-related illnesses (such as memory issues, movement issues, and falls) | <input type="checkbox"/> Mental health (such as anxiety, depression, loneliness, and suicide) |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> Motor vehicle accidents and injuries |
| <input type="checkbox"/> Chronic pain and pain management | <input type="checkbox"/> Obesity and maintaining healthy weight |
| <input type="checkbox"/> Diabetes and high blood sugar | <input type="checkbox"/> Oral (mouth) and dental health |
| <input type="checkbox"/> Heart conditions (such as heart diseases, high blood pressure, and stroke) | <input type="checkbox"/> Reproductive and sexual health , including sexually transmitted infections (STIs and STDs) |
| <input type="checkbox"/> Infectious diseases (such as Covid-19, Influenza, pneumonia, and measles) | <input type="checkbox"/> Respiratory and lung diseases (such as allergies, asthma, and COPD) |
| <input type="checkbox"/> Maternal and infant health (such as preterm births and adequate care for birthing people and their babies) | <input type="checkbox"/> Substance use (such as alcohol, drug, and tobacco use) |
| <input type="checkbox"/> Not listed here or prefer to describe: _____ | <input type="checkbox"/> Violence (such as assaults, domestic violence, and gun violence) |
| <input type="checkbox"/> Not sure | |

4. Thinking about children in the community where you live, what are the top three health problems?

Choose **three** items from the list that are a concern for **children** in your community.

- | | |
|---|---|
| <input type="checkbox"/> Abuse and neglect | <input type="checkbox"/> Mental health (such as anxiety, depression, loneliness, suicide, and bullying) |
| <input type="checkbox"/> Blood diseases (such as lead poisoning, anemia, and sickle cell) | <input type="checkbox"/> Obesity and maintaining healthy weight |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> Oral (mouth) and dental health |
| <input type="checkbox"/> Diabetes and high blood sugar | <input type="checkbox"/> Reproductive and sexual health , including teen pregnancy and sexually transmitted infections (STIs and STDs) |
| <input type="checkbox"/> Infectious diseases (such as Covid-19, RSV, Influenza, pneumonia, and measles) | <input type="checkbox"/> Respiratory diseases (such as allergies and asthma) |
| <input type="checkbox"/> Injuries (such as motor vehicle accidents and injuries, poisonings, drownings, and burns) | <input type="checkbox"/> Substance use (such as alcohol, drug, and tobacco use) |
| <input type="checkbox"/> Intellectual / developmental disabilities (such as autism, Down Syndrome, ADHD) | <input type="checkbox"/> Violence (such as assaults, domestic violence, gun violence, and school shootings) |
| <input type="checkbox"/> Infant / baby health (such as low birth weight, health problems, and death before the age of one) | |
| <input type="checkbox"/> Not listed here or prefer to describe: _____ | |
| <input type="checkbox"/> Not sure | |

5. Thinking about the community where you live, which barriers prevent access to health care?

Select all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Cultural / religious beliefs | <input type="checkbox"/> Health insurance is not accepted |
| <input type="checkbox"/> Language barriers | <input type="checkbox"/> Transportation (getting to and from doctor's visits and appointments) |
| <input type="checkbox"/> Fear (such as fear of doctors or not ready to discuss a health problem) | <input type="checkbox"/> Don't know how to find healthcare services or providers |
| <input type="checkbox"/> Don't feel welcome or respected | <input type="checkbox"/> Not enough health care services or providers |
| <input type="checkbox"/> No health insurance | <input type="checkbox"/> Scheduling problems (such as health services not open when available) |
| <input type="checkbox"/> Costs associated with getting healthcare | |
| <input type="checkbox"/> Not listed here or prefer to describe: _____ | |
| <input type="checkbox"/> None | |

For many communities, mental health and substance use needs are at a crisis level. The following questions ask about specific needs in your community.

6. Thinking about adults in the community where you live, what are the top three mental health and substance use problems?

Choose **three** items from the list that are a concern for **adults** in your community.

- | | |
|---|---|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder) |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Not listed here or prefer to describe: _____ | |
| <input type="checkbox"/> Not sure | |

7. Thinking about children in the community where you live, what are the top three mental health and substance use problems?

Choose **three** items from the list that are a concern for **children** in your community.

- | | |
|---|---|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Post Traumatic Stress Disorder (PTSD) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder) |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Not listed here or prefer to describe: _____ | |
| <input type="checkbox"/> Not sure | |

Tell Us About You

We strive to create programs and services that represent the full diversity of our community. We ask the following questions about you to ensure that we meet this goal. You may skip any questions that you prefer not to answer. All responses are confidential and anonymous.

8. What is your age group?

Choose one answer.

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75+
- Prefer not to disclose

9. Which of the following best describes you?

Choose all that apply.

- Woman
- Man
- Genderqueer
- Transgender/Trans woman
- Transgender/Trans man
- Non-binary
- Other or prefer to self-describe: _____
- Prefer not to disclose

10. Which of the following best describes you?

Listed in alphabetical order. Choose all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Middle Eastern or North African
- Native Hawaiian or Other Pacific Islander
- White
- Other or prefer to self-describe: _____
- Prefer not to disclose

11. Which of the following best describes you?

Choose one answer.

- Hispanic
- Non-Hispanic
- Prefer not to disclose

12. What is the highest level of education you have completed?

Choose one answer.

- Less than high school
- High school diploma/GED
- Some college credit, no degree
- 2-year college / Vocational training
- 4-year college / Bachelor's degree
- Master's, Professional, or Doctorate degree
- Other or prefer to self-describe: _____
- Prefer not to disclose

13. Which languages do you speak at home?

Choose all that apply.

- English
- Albanian
- Arabic
- Bosnian
- Farsi/Dari (Persian)
- French
- Hindi
- Korean
- Nepali
- Pashto
- Mandarin
- Sign Language (ASL)
- Spanish
- Swahili
- Vietnamese
- Other or prefer to self-describe: _____
- Prefer not to disclose

14. What best describes your employment status?

Choose one answer.

- Full-time
- Disabled
- Not Employed
- On Active Military Duty
- Part-time
- Retired
- Self Employed
- Student Full-time
- Student Part-time
- Other or prefer to self-describe: _____
- Prefer not to disclose

15. What is your total household income for the year?

Choose one answer.

- Less than \$10,000
- \$10,000 to \$24,999
- \$25,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 to \$199,999
- \$200,000 or more
- Prefer not to disclose

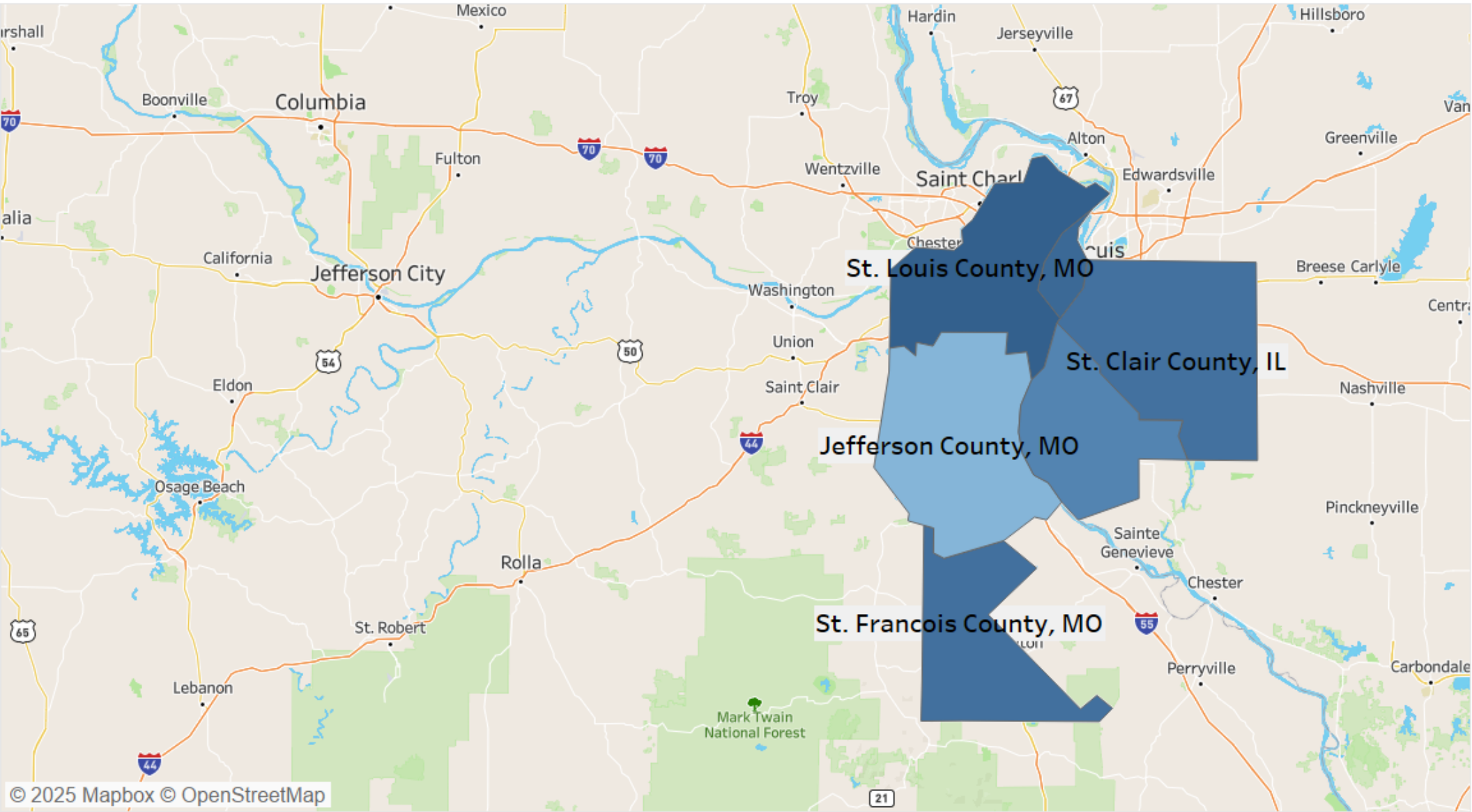
You have answered the final question of the survey. Please return the survey to the survey distributor.

Thank you for your time and input!

CHNA 2024 Survey Mercy South PSA

File created on: 1/16/2025 3:11:12 PM

STL MSA by County



- County Name (STL MSA)**
- Jefferson County, MO
 - Monroe County, IL
 - St. Clair County, IL
 - St. Francois County, MO
 - St. Louis city, MO
 - St. Louis County, MO

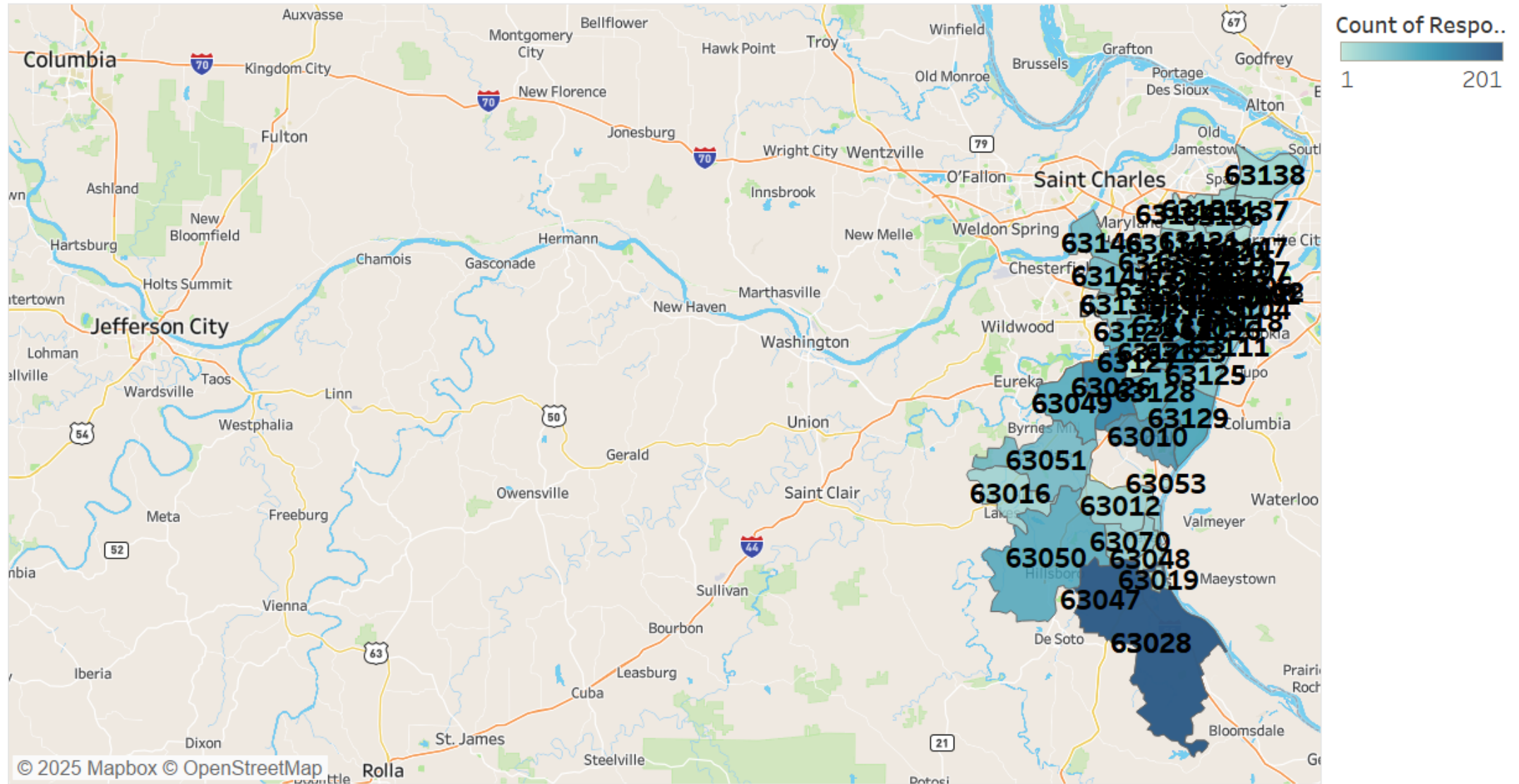
Map based on Longitude (generated) and Latitude (generated). Color shows details about County Name (STL MSA). The marks are labeled by County Name (STL MSA). Details are shown for County Code (STL MSA) and County Name (STL MSA). The data is filtered on Zip (Stl Msa), which keeps 31 of 363 members. The view is filtered on County Name (STL MSA), which keeps 21 of 21 members.

Total
Count
Total
surveys
meeting user
criteria

2,619

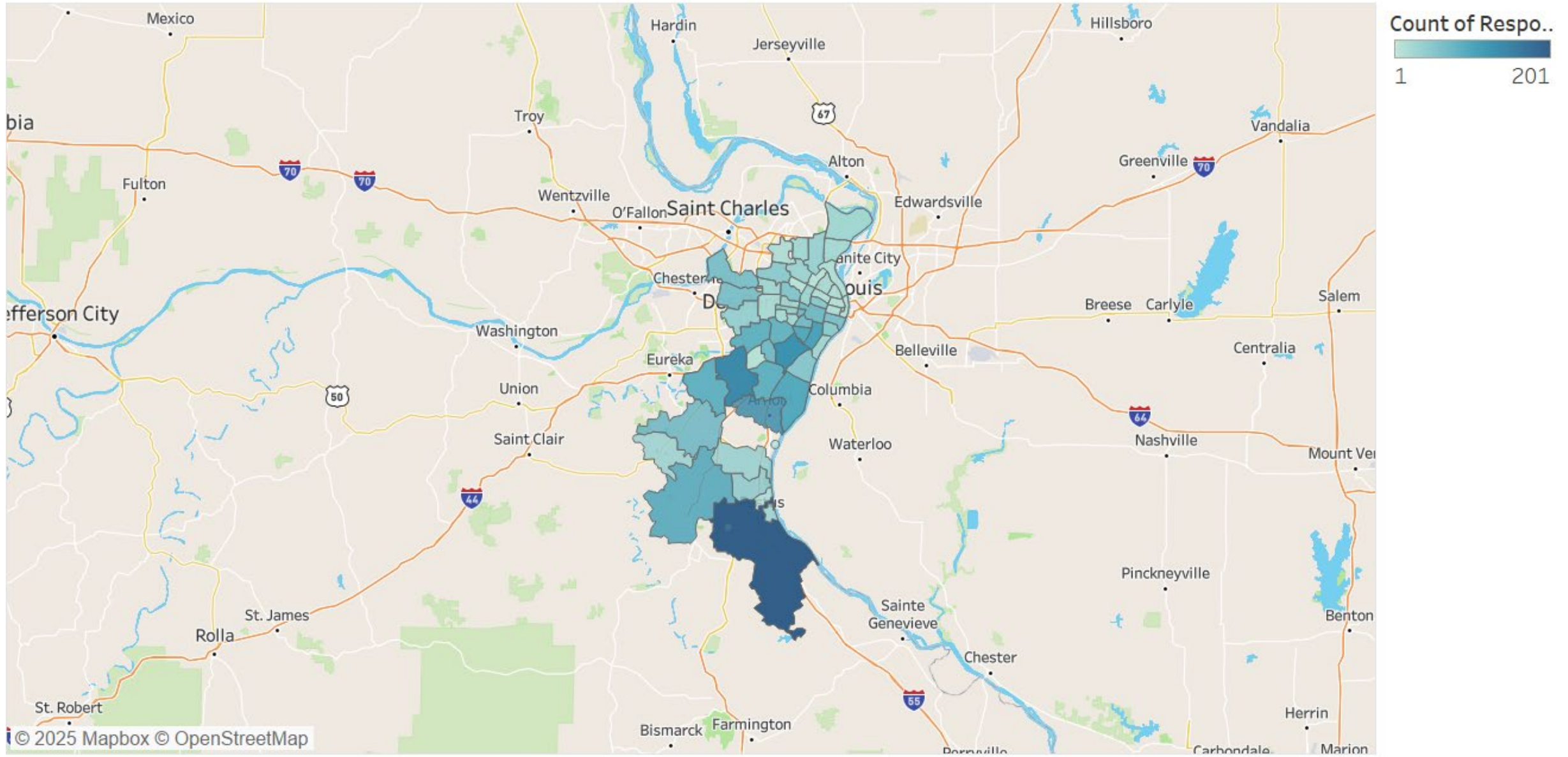
Count
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Zip
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MSA)
filter
keeps
22 of
22
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The
Zip
(Stl
Msa)
filter
keeps
31 of
364
mem-
bers.

Count



Map based on Longitude (generated) and Latitude (generated). Color shows count of Zip1. The marks are labeled by Zip (CHNA!data!Availability). Details are shown for County Name (STL MSA). The data is filtered on Zip (Stl Msa), which keeps 31 of 364 members. The view is filtered on County Name (STL MSA) and Exclusions (County Name (STL MSA), Zip (CHNA!data!Availability)). The County Name (STL MSA) filter keeps 22 of 22 members. The Exclusions (County Name (STL MSA), Zip (CHNA!data!Availability)) filter keeps 527 members.

Count



Map based on Longitude (generated) and Latitude (generated). Color shows count of Zip1. Details are shown for various dimensions. The data is filtered on Zip (Stl Msa), which keeps 31 of 364 members. The view is filtered on County Name (STL MSA), which keeps 22 of 22 members.

Demographics

County Name (STL MSA)

All

Age Group		Gender		Race		Ethnicity	
Under 18	4	Woman	1,649	White	1,644	Hispanic	42
18-24	44	Man	353	Black or African Amer..	244	Non-Hispanic	1,637
25-34	272	Genderqueer	13	Asian	37	Prefer not to disclose	82
35-44	471	Transgender/T..	3	Other or prefer to self..	23	Did not respond	858
45-54	409	Non-binary	9	American Indian or Al..	24		
55-64	427	Other or prefer..	6	Middle Eastern or No..	2		
65-74	326	Prefer not to di..	50	Prefer not to disclose	92		
75+	97	Did not respond	536	Did not respond	553		
Prefer not to ..	33						
Did not respo..	536						
Grand Total	2,619						

STL Region


Multiple values

Zip (Stl Msa)

Multiple values

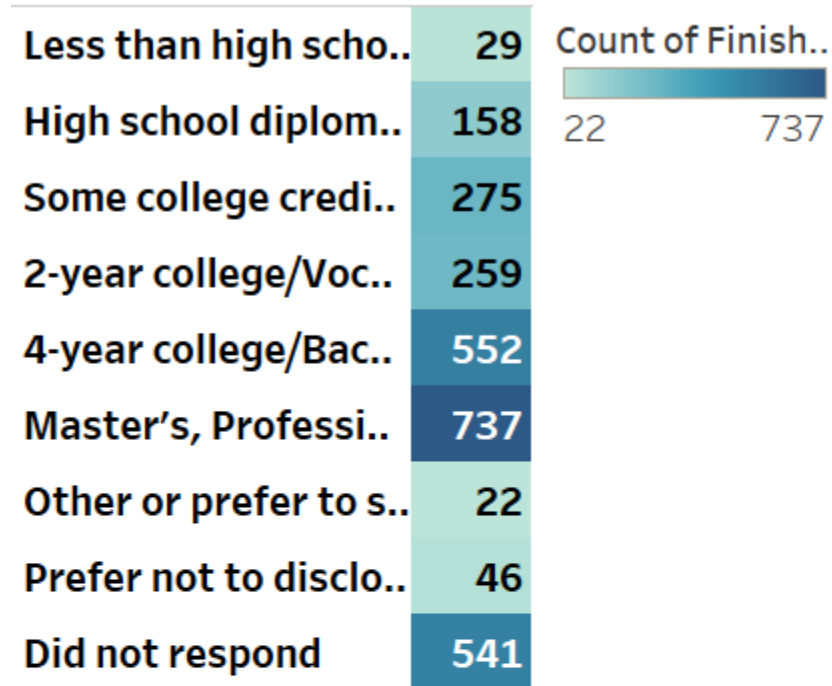
Language		Education		Employment		Income	
Bosnian	1	Less than high scho..	29	Full-time	1,310	Less than \$10,..	75
English	2,037	High school diplom..	158	Part-time	145	\$10,000 to \$2..	144
Hindi	1	Some college credi..	275	Disabled	111	\$25,000 to \$4..	291
Mandarin	1	2-year college/Voc..	259	Retired	306	\$50,000 to \$7..	298
Spanish	2	4-year college/Bac..	552	Self Employed	43	\$75,000 to \$9..	214
Other or prefer to self-describe	9	Master's, Professi..	737	Student Full-time	9	\$100,000 to \$..	345
Prefer not to disclose	24	Other or prefer to s..	22	Student Part-time	4	\$150,000 to \$..	222
Did not respond	544	Prefer not to disclo..	46	Not Employed	57	\$200,000 or m..	199
		Did not respond	541	Other or prefer to s..	40	Prefer not to di..	268
				Prefer not to disclose	39	Did not respond	563
				Did not respond	555		

Employment

		Count of Finish..
Full-time	1,310	
Part-time	145	4
Disabled	111	1,310
Retired	306	
Self Employed	43	
Student Full-time	9	
Student Part-time	4	
Not Employed	57	
Other or prefer to s..	40	
Prefer not to disclose	39	
Did not respond	555	

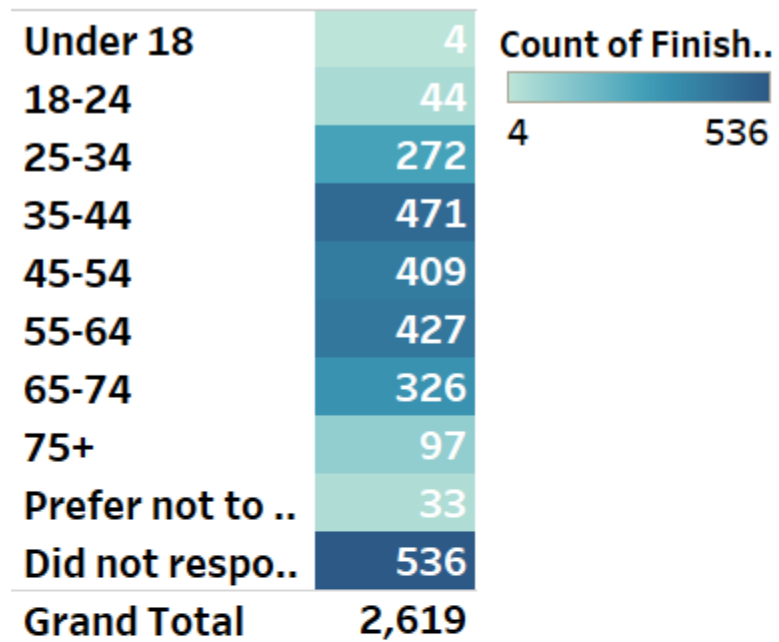
Count of Finished1 broken down by Employment1. Color shows count of Finished1. The marks are labeled by count of Finished1. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members.

Education



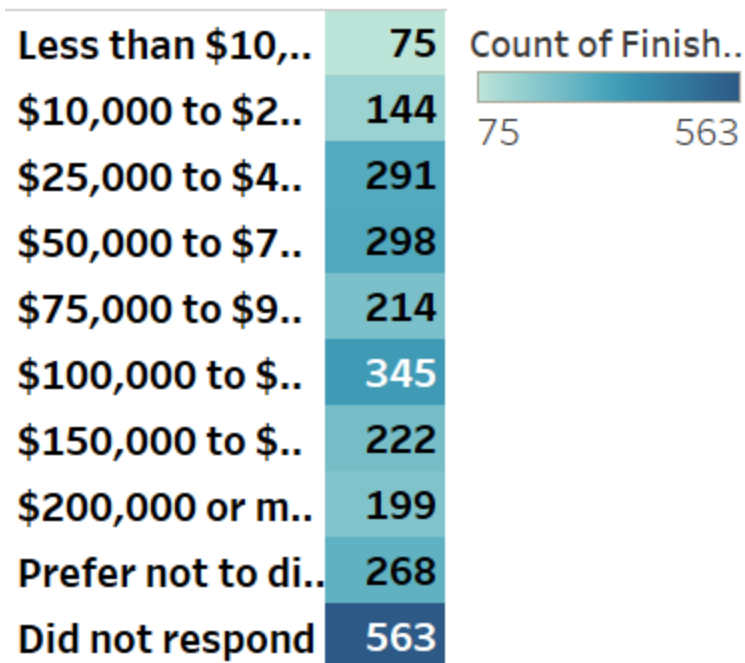
Count of Finished1 broken down by Education1. Color shows count of Finished1. The marks are labeled by count of Finished1. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members.

Age Group



Count of Finished1 broken down by Age group1. Color shows count of Finished1. The marks are labeled by count of Finished1. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members.

Income



Count of Finished1
broken down by Income1.
Color shows count of
Finished1. The marks are
labeled by count of
Finished1. The data is
filtered on County Name
(STL MSA) and Zip (Stl
Msa). The County Name
(STL MSA) filter keeps 22
of 22 members. The Zip
(Stl Msa) filter keeps 31
of 364 members.

Gender

	Count of Finish..
Woman	1,649
Man	353
Genderqueer	13
Transgender/T..	3
Non-binary	9
Other or prefer..	6
Prefer not to di..	50
Did not respond	536

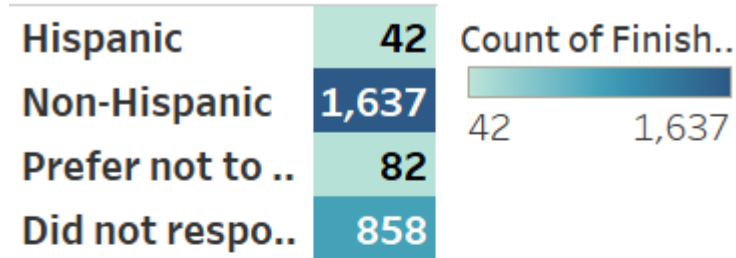
Count of Finished1 broken down by Gender1. Color shows count of Finished1. The marks are labeled by count of Finished1. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members.

Race

	Count of Finish..
White	1,644
Black or African Amer..	244
Asian	37
Other or prefer to self..	23
American Indian or Al..	24
Middle Eastern or No..	2
Prefer not to disclose	92
Did not respond	553

Count of Finished1 broken down by Race1. Color shows count of Finished1. The marks are labeled by count of Finished1. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members.

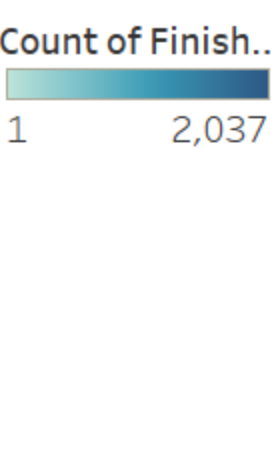
Ethnicity



Count of Finished1
broken down by
Ethnicity1. Color shows
count of Finished1. The
marks are labeled by
count of Finished1. The
data is filtered on
County Name (STL MSA)
and Zip (Stl Msa). The
County Name (STL MSA)
filter keeps 22 of 22
members. The Zip (Stl
Msa) filter keeps 31 of
364 members.

Language

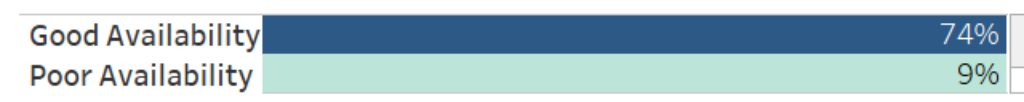
Language	Count of Finished1
Bosnian	1
English	2,037
Hindi	1
Mandarin	1
Spanish	2
Other or prefer..	9
Prefer not to di..	24
Did not respond	544



Count of Finished1 broken down by Language1. Color shows count of Finished1. The marks are labeled by count of Finished1. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members.

Resource Availability

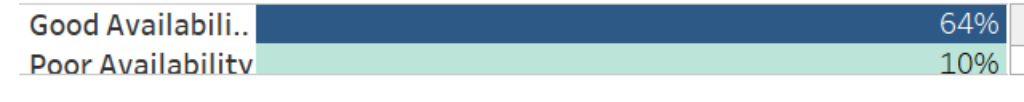
Places to be Physically Active



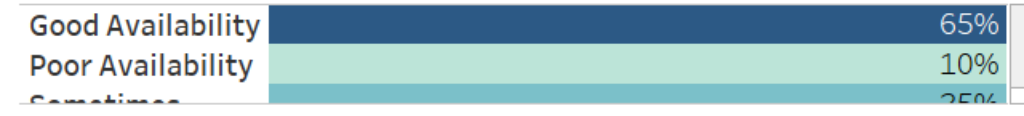
Good Schools



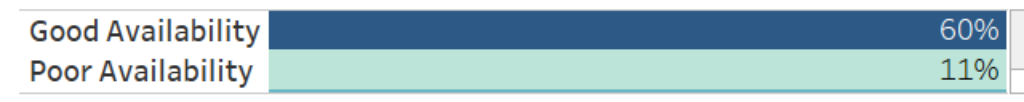
Clean Outdoor Environment



Health Care Services



Safe Community



Safe Childcare



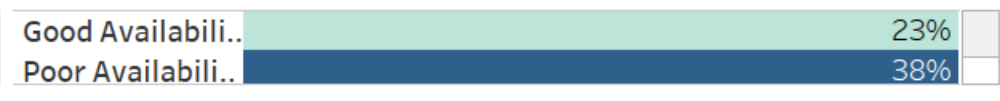
Affordable Food



Public Transportation



Affordable Housing



Mental Health and Substance Use Services



Good Paying Jobs



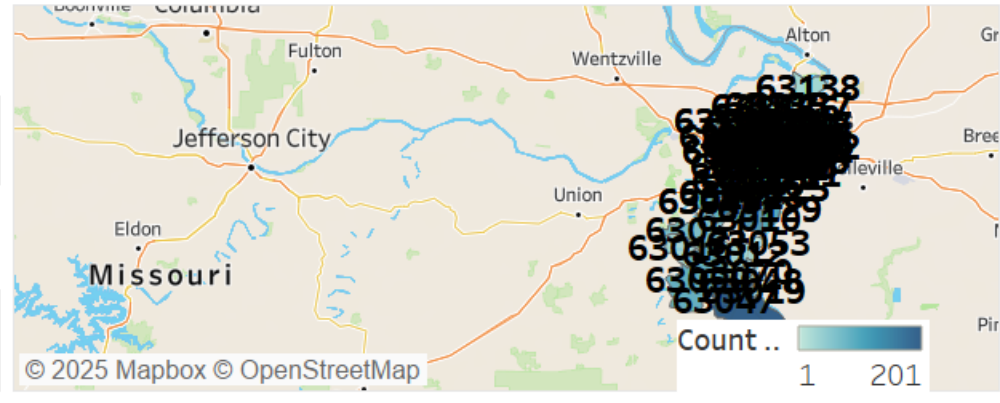
Aging Services



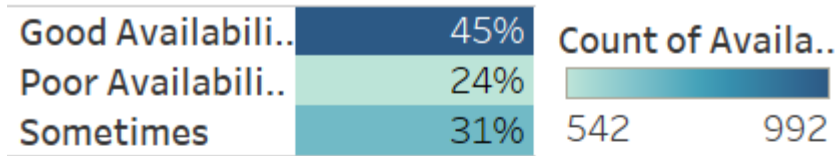
MSA or similar (STL MSA)
Multiple values

County Name (STL MSA)
All

Zip (Stl Msa)
Multiple values

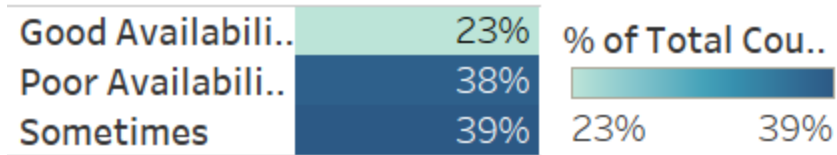


Affordable Food



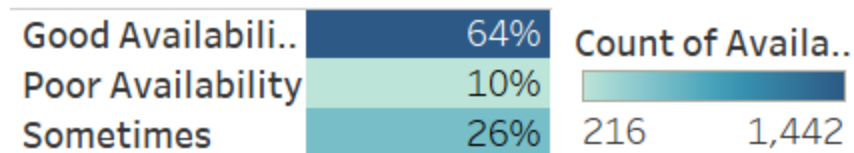
% of Total Count of Availability Affordable healthy foods (CHNA!data!Availability) broken down by Availability Affordable healthy foods (CHNA!data!Availability) (group). Color shows count of Availability Affordable healthy foods (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Affordable healthy foods (CHNA!data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Affordable Housing



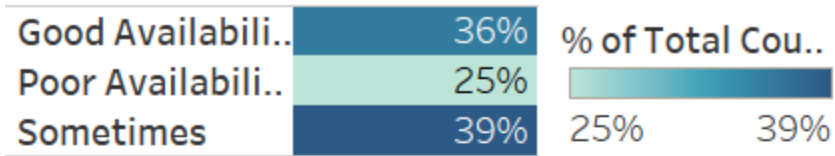
% of Total Count of Availability Affordable housing (CHNA!data!Availability) broken down by Availability Affordable housing (CHNA!data!Availability) (group). Color shows % of Total Count of Availability Affordable housing (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Affordable housing (CHNA!data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Clean Outdoor Environment



% of Total Count of Availability
Clean outdoor environment
(CHNA!data!Availability)
broken down by Availability
Clean outdoor environment
(CHNA!data!Availability)
(group). Color shows count of
Availability Clean outdoor
environment
(CHNA!data!Availability). The
marks are labeled by % of Total
Count of Availability Clean
outdoor environment
(CHNA!data!Availability). The
data is filtered on County Name
(STL MSA) and Zip (Stl Msa).
The County Name (STL MSA)
filter keeps 22 of 22 members.
The Zip (Stl Msa) filter keeps 31
of 364 members. Percents are
based on the whole table.

Good Paying Jobs



% of Total Count of Availability

Good paying jobs

(CHNA!data!Availability)

broken down by Availability

Good paying jobs

(CHNA!data!Availability)

(group). Color shows % of

Total Count of Availability

Good paying jobs (CHNA!da-

ta!Availability). The marks are

labeled by % of Total Count of

Availability Good paying jobs

(CHNA!data!Availability). The

data is filtered on County

Name (STL MSA) and Zip (Stl

Msa). The County Name (STL

MSA) filter keeps 22 of 22

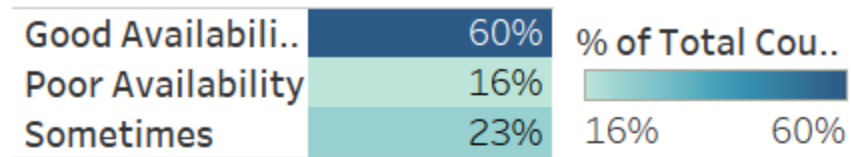
members. The Zip (Stl Msa)

filter keeps 31 of 364

members. Percents are based

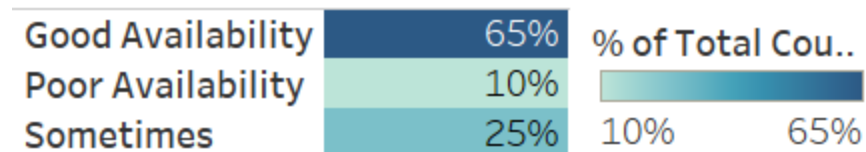
on the whole table.

Good Schools



% of Total Count of Availability
Good schools
(CHNA!data!Availability)
broken down by Availability
Good schools
(CHNA!data!Availability)
(group). Color shows % of Total
Count of Availability Good
schools
(CHNA!data!Availability). The
marks are labeled by % of Total
Count of Availability Good
schools
(CHNA!data!Availability). The
data is filtered on County Name
(STL MSA) and Zip (Stl Msa).
The County Name (STL MSA)
filter keeps 22 of 22 members.
The Zip (Stl Msa) filter keeps 31
of 364 members. Percents are
based on the whole table.

Health Care Services



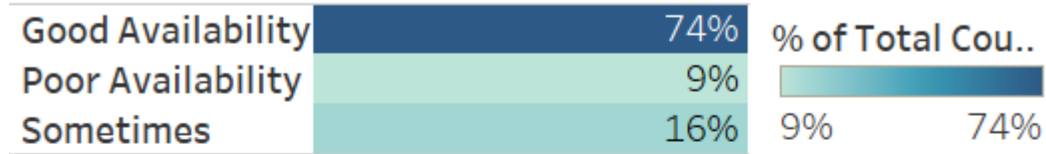
% of Total Count of Availability Health care services (CHNA!data!Availability) broken down by Availability Health care services (CHNA!data!Availability) (group). Color shows % of Total Count of Availability Health care services (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Health care services (CHNA!data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Mental Health and Substance Use Services



% of Total Count of Availability Mental health and substance use services (CHNA!data!Availability) broken down by Availability Mental health and substance use services (CHNA!data!Availability) (group). Color shows % of Total Count of Availability Mental health and substance use services (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Mental health and substance use services (CHNA!data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Places to be Physically Active



% of Total Count of Availability Places to be physically active, such as community parks (CHNA!data!Availability) broken down by Availability Places to be physically active, such as community parks (CHNA!data!Availability) (group). Color shows % of Total Count of Availability Places to be physically active, such as community parks (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Places to be physically active, such as community parks (CHNA!data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Public Transportation



% of Total Count of Availability Public transportation (CHNA!data!Availability) broken down by Availability Public transportation (CHNA!data!Availability) (group). Color shows % of Total Count of Availability Public transportation (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Public transportation (CHNA!data!Availability). The data is filtered on MSA or similar (STL MSA), County Name (STL MSA) and Zip (Stl Msa). The MSA or similar (STL MSA) filter excludes St. Francois County, MO. The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Safe Community



% of Total Count of Availability Safe community (CHNA\data!Availability) broken down by Availability Safe community (CHNA\data!Availability) (group). Color shows % of Total Count of Availability Safe community (CHNA\data!Availability). The marks are labeled by % of Total Count of Availability Safe community (CHNA\data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Aging Services



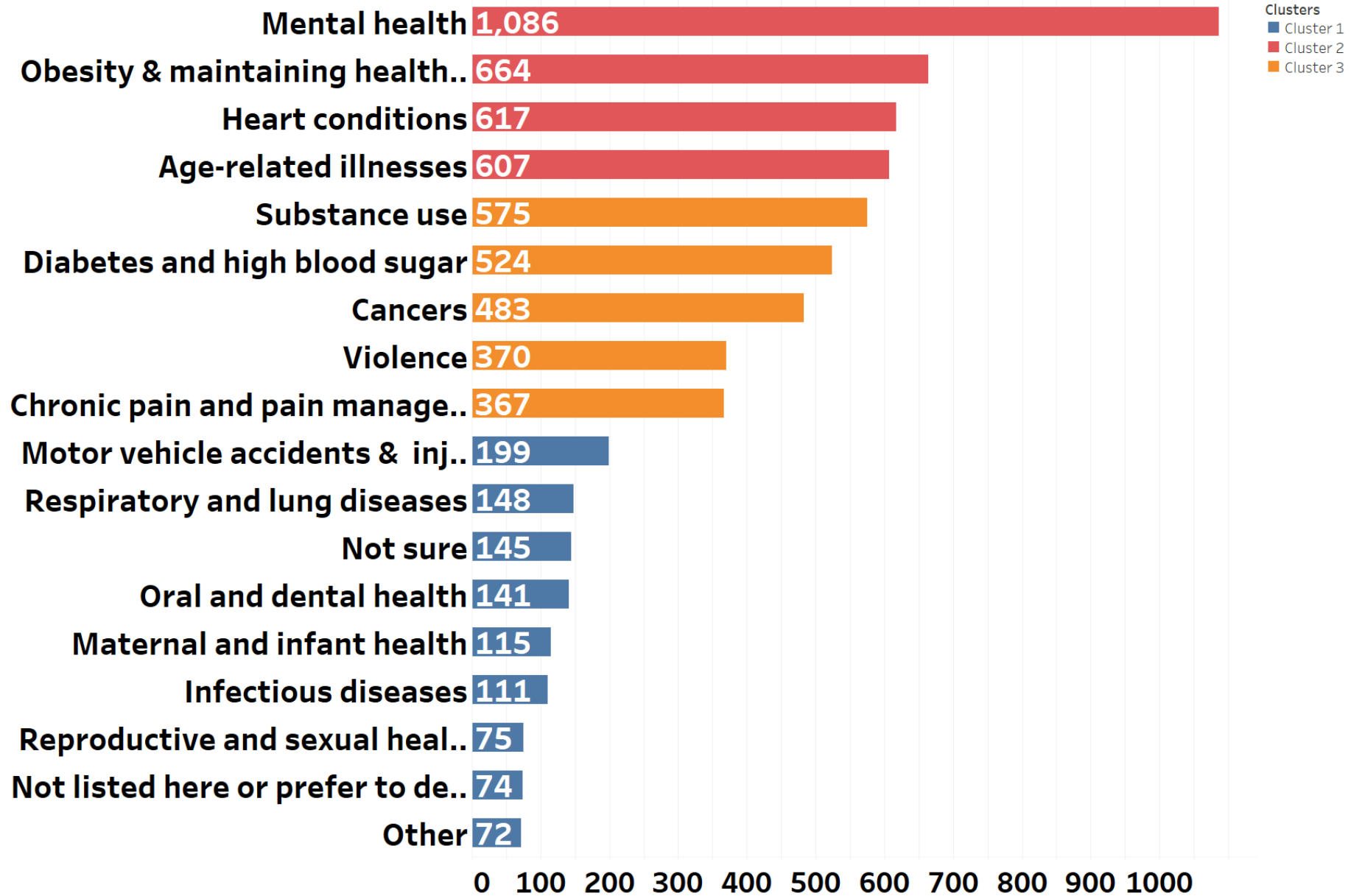
% of Total Count of Availability Services that support people as they age (CHNA\data!Availability) broken down by Availability Services that support people as they age (CHNA\data!Availability) (group). Color shows % of Total Count of Availability Services that support people as they age (CHNA\data!Availability). The marks are labeled by % of Total Count of Availability Services that support people as they age (CHNA\data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Safe Childcare



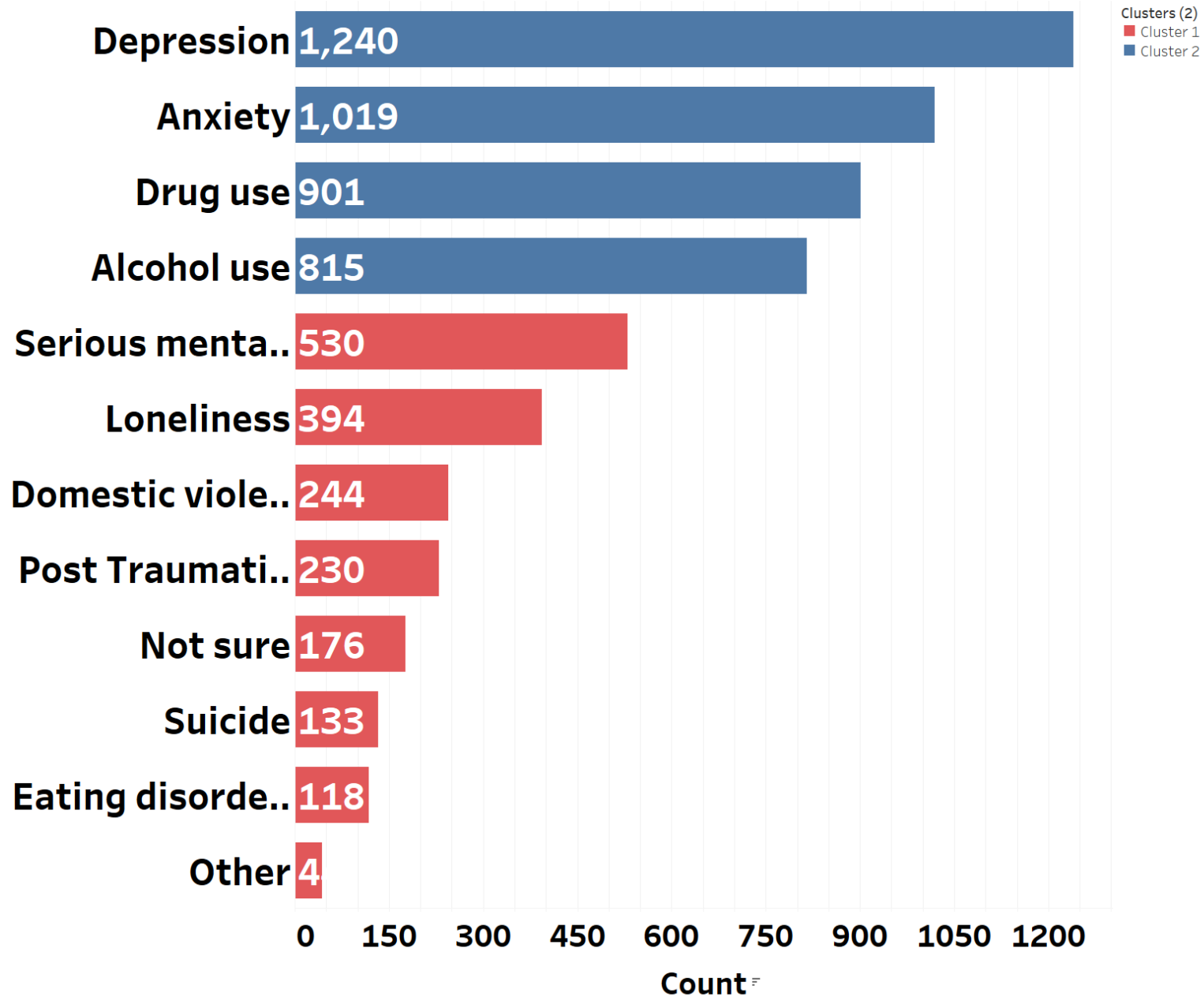
% of Total Count of Availability Safe childcare (CHNA!data!Availability) broken down by Availability Safe childcare (CHNA!data!Availability) (group). Color shows % of Total Count of Availability Safe childcare (CHNA!data!Availability). The marks are labeled by % of Total Count of Availability Safe childcare (CHNA!data!Availability). The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 of 364 members. Percents are based on the whole table.

Adult Health numbers

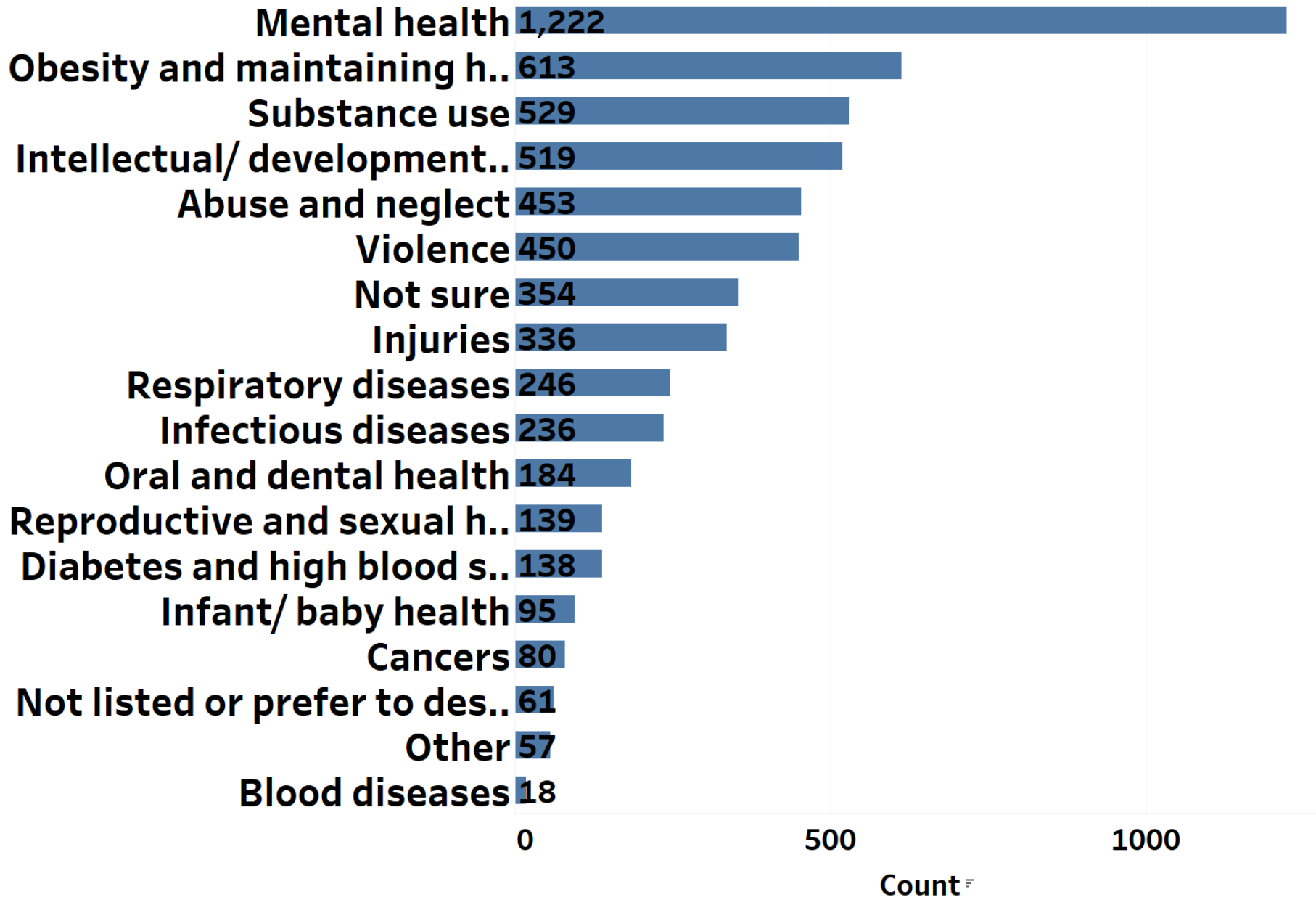


Count of Health top 3 Adults (CHNA!LongHealthAdult) for each Health top 3 Adults (CHNA!LongHealthAdult) (group) 1. Color shows details about Clusters. The marks are labeled by count of Health top 3 Adults (CHNA!LongHealthAdult). The data is filtered on Race1, County Name (STL MSA) and Zip (Stl Msa). The Race1 filter keeps multiple members. The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 members.

Adult Mental Health numbers

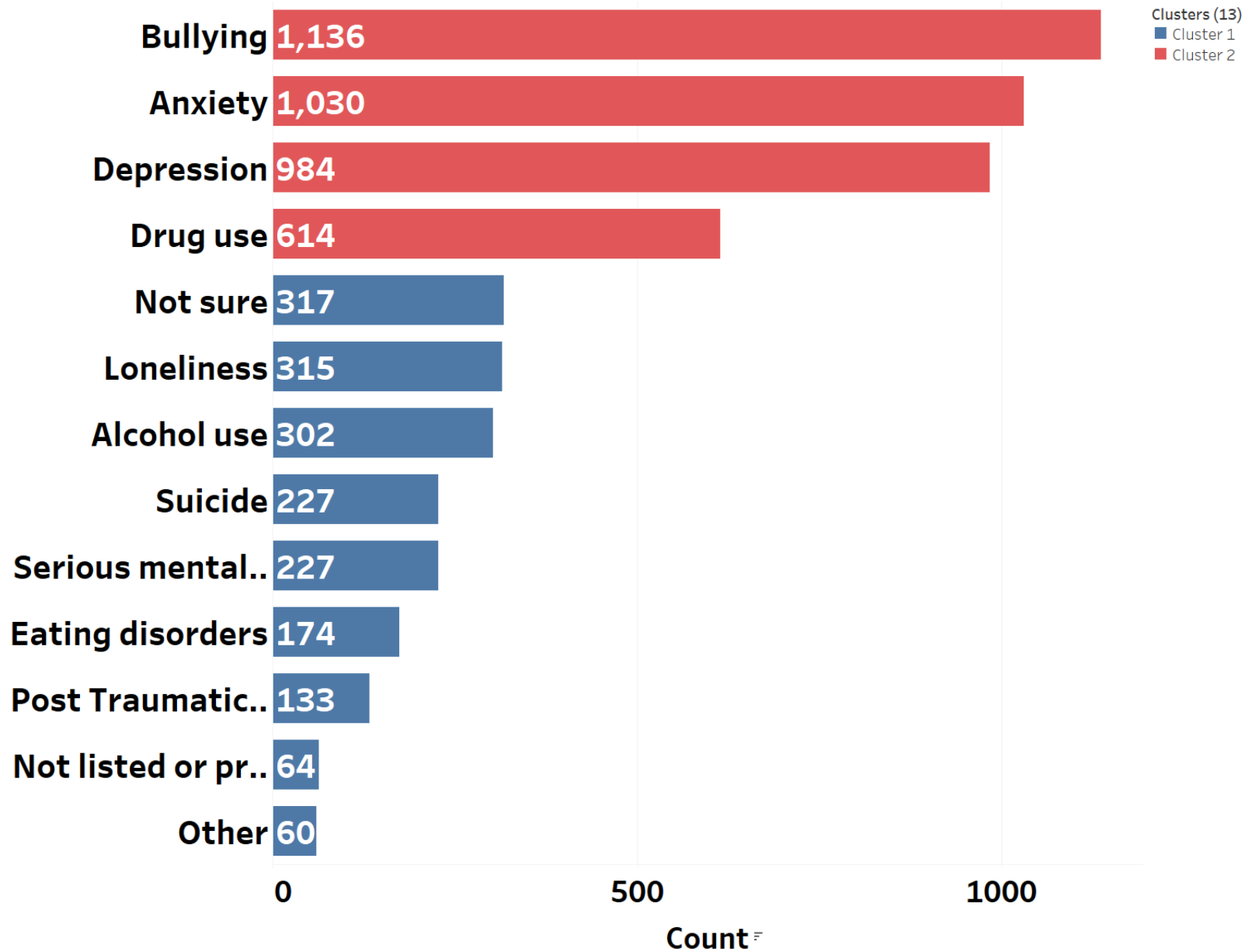


Count of Mental Health top 3 Adults Long for each Mental Health top 3 Adults Long (group). Color shows details about Clusters (2). The marks are labeled by count of Mental Health top 3 Adults Long. The data is filtered on Race1, County Name (STL MSA) and Zip (Stl Msa). The Race1 filter keeps multiple members. The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 members.



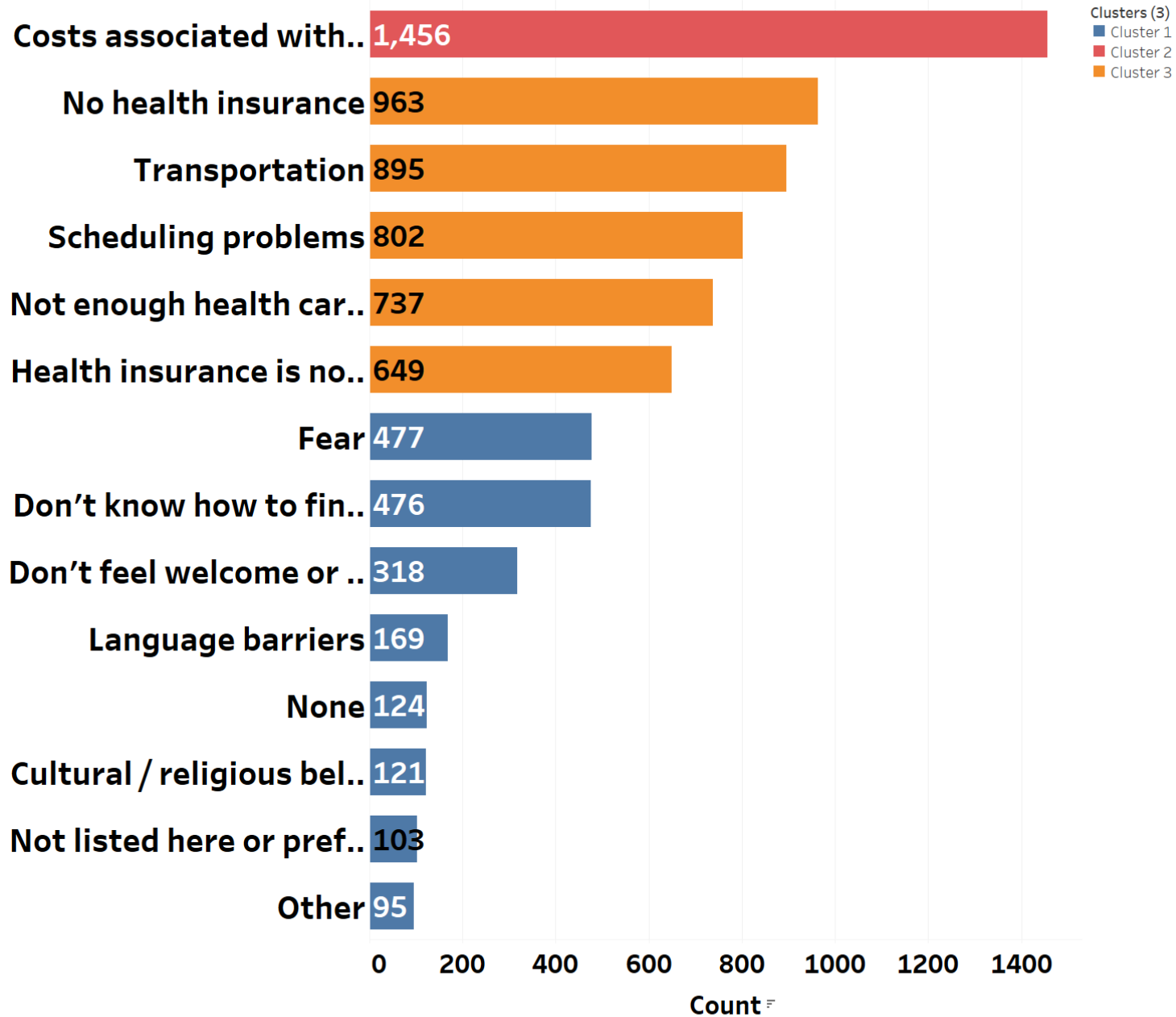
Count of Health top 3 Children (CHNA!LongHealthChild) for each Health top 3 Children (CHNA!LongHealthChild) (group). The marks are labeled by count of Health top 3 Children (CHNA!LongHealthChild). The data is filtered on Race1, County Name (STL MSA) and Zip (Stl Msa). The Race1 filter keeps multiple members. The County Name (STL MSA) filter keeps 22 of 22 members. The Zip (Stl Msa) filter keeps 31 members.

Child Mental Health numbers



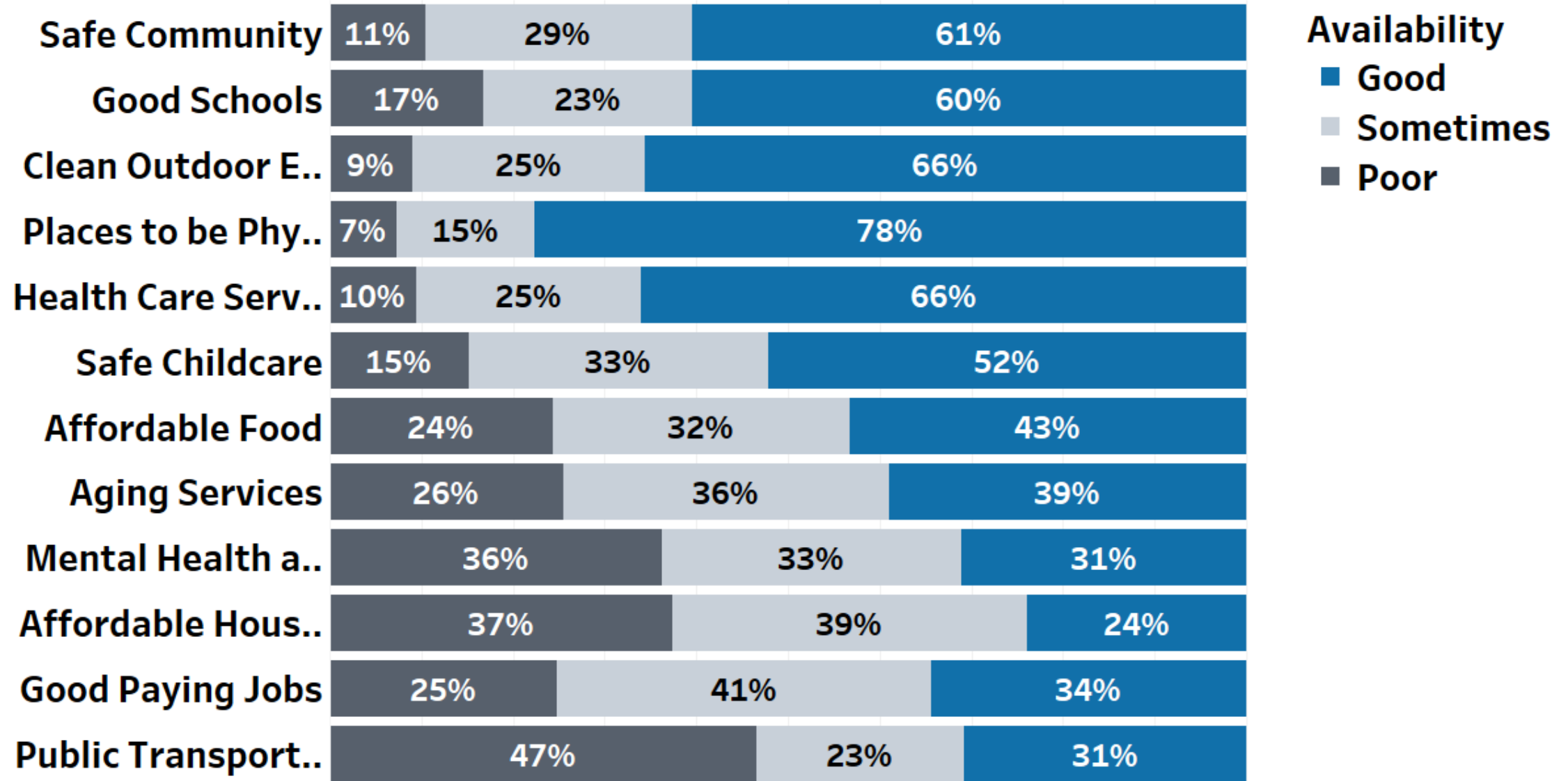
Count of Mental Health top 3 Children (CHNA!Long!MentalHealthChild) for each Mental Health top 3 Children (CHNA!Long!MentalHealthChild) (group). Color shows details about Clusters (13). The marks are labeled by count of Mental Health top 3 Children (CHNA!Long!MentalHealthChild). The data is filtered on Race1, County Name (STL MSA) and Zip (Stl Msa). The Race1 filter keeps multiple members. The County Name (STL MSA) filter keeps multiple members. The Zip (Stl Msa) filter keeps 31 members.

Barriers to Health Care Access



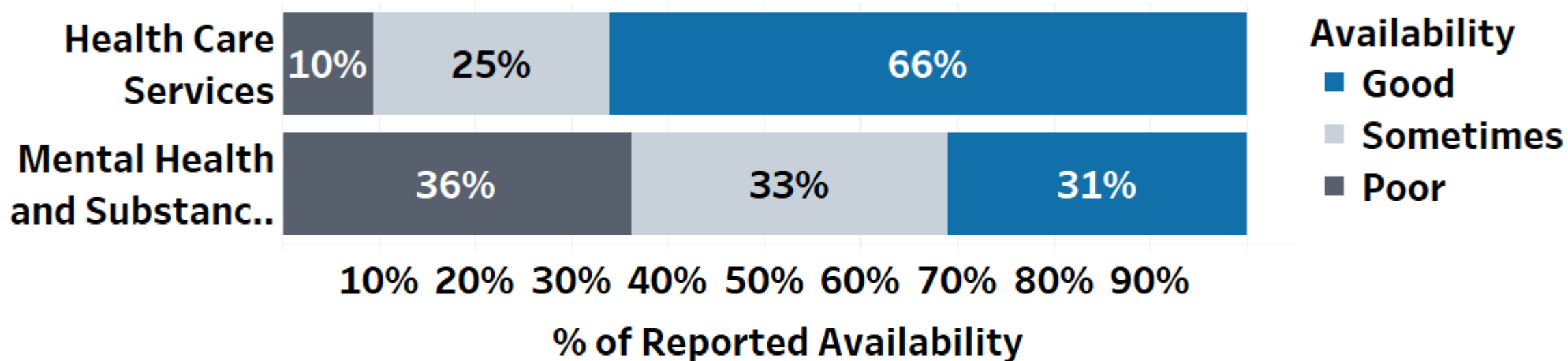
Count of Barriers health care (CHNA!LongBarriers) for each Barriers health care (CHNA!LongBarriers) (group). Color shows details about Clusters (3). The marks are labeled by count of Barriers health care (CHNA!LongBarriers). The data is filtered on County Name (STL MSA), Race1 and Zip (Stl Msa). The County Name (STL MSA) filter keeps 22 of 22 members. The Race1 filter keeps multiple members. The Zip (Stl Msa) filter keeps 31 members.

Community Resource Availability



% of Total Percent Reporting for each Domain. Color shows details about Availability. The marks are labeled by Calculation2. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps multiple members. The Zip (Stl Msa) filter keeps 31 members. Percents are based on each row of the table.

Community Resource Availability_Health



% of Total Percent Reporting for each Domain. Color shows details about Availability. The marks are labeled by Calculation2. The data is filtered on County Name (STL MSA) and Zip (Stl Msa). The County Name (STL MSA) filter keeps multiple members. The Zip (Stl Msa) filter keeps 31 members. The view is filtered on Domain, which keeps Health Care Services and Mental Health and Substance Use Services. Percents are based on each row of the table.

Stakeholder Conversation Summary Report

Geographic Region: South County

Location: SSM St. Clare Hospital

Date: July 9, 2024

Number of Participants: 18

Executive Summary

The St. Louis Regional Hospital Collaborative, with support from Key Strategic Group, hosted a series of six regional stakeholder conversations as part of the ongoing Community Health Needs Assessment (CHNA) process. These meetings brought together representatives from various community-based organizations, healthcare providers, and service organizations to discuss key health challenges across the St. Louis region. This report focuses on the insights gathered from the South County conversation held at SSM St. Clare Hospital.

Participants engaged in facilitated discussions around health priorities, social determinants of health, and the challenges and opportunities for improving health equity in their communities. Key themes emerged, particularly around the urgent need for expanded mental health services, addressing substance abuse, and tackling food insecurity. The conversation also emphasized the need for a more equitable and inclusive approach to future community engagement, ensuring that all voices, particularly those of vulnerable and underrepresented populations, are heard and considered in ongoing efforts.

Introduction

On July 9, 2024, the Collaborative conducted a stakeholder conversation at SSM St. Clare Hospital, bringing together local community-based organizations, healthcare providers, and public health professionals. This conversation aimed to capture diverse perspectives on health disparities, service gaps, and community needs in South County. Trained moderators facilitated discussions, and scribes captured detailed notes, synthesizing key themes into this report. The goal of the meeting was to collaboratively identify strategies to address health disparities and improve community health outcomes.

Survey Process and Participant Feedback

The Collaborative briefed participants on the survey methodology used for collecting data for the CHNA and invited them to provide feedback. Participants raised concerns regarding the survey's sample diversity, with several attendees noting that middle-aged, educated white women predominantly provided the responses, potentially skewing the results. Participants questioned the geographical focus of the survey and discussed how certain underrepresented populations, particularly low-income individuals and older adults without reliable internet access, were not adequately reached. The group emphasized the need for broader outreach strategies to ensure more inclusive data collection in future assessments.

Key Health Concerns Identified

Three primary health concerns consistently arose in all discussion groups:

1. **Mental Health:** There was a strong consensus that mental health is the most pressing health issue in South County. Participants highlighted a growing demand for mental health services, especially among low-income and uninsured individuals. They also pointed to significant gaps in service provision, particularly in culturally competent and trauma-informed care.
2. **Substance Abuse:** Frequent discussions included the co-occurrence of mental health issues and substance use disorders. Participants expressed concern about the lack of integrated care models that address both issues holistically and recommended more comprehensive support systems for individuals with addiction.
3. **Food Insecurity:** Discussions around food insecurity focused on access to food and nutrition quality. While food pantries provide essential services, many offer primarily non-perishable, unhealthy items that contribute to long-term health issues such as obesity and diabetes. Participants stressed the importance of shifting focus from food security to nutrition security, with educational programs on healthy eating and culturally relevant nutrition as central components.

Social Determinants of Health (SDOH)

Several social determinants of health emerged as barriers to achieving optimal health outcomes in South County:

- **Transportation:** Participants cited transportation limitations as a significant obstacle to accessing healthcare, employment, and other essential services. Participants noted that while public transit exists, it is unreliable, costly, and not user-friendly, particularly for older adults or those with mobility challenges.

- **Education:** The group identified a lack of education around health, nutrition, and healthcare resources as a critical driver of poor health outcomes. Many individuals lack the knowledge or resources to make healthy choices, which exacerbates chronic diseases such as obesity, diabetes, and cardiovascular conditions.
- **Access to Culturally Competent Care:** Several participants highlighted the lack of culturally competent mental health and healthcare services, particularly for Communities of Color and immigrant populations. They noted that mistrust of healthcare systems, language barriers, and stigma hinder access to essential care.

Prioritizing Community Health Needs

When tasked with prioritizing health needs, participants consistently identified mental health, substance abuse, and food insecurity as top priorities. Participants viewed these issues as interconnected and emphasized the need for a holistic, collaborative approach that involves healthcare providers, community organizations, and public health agencies to address them.

Participants also advocated for strengthening partnerships between hospitals and community-based organizations to ensure services are accessible and tailored to the specific needs of underserved populations. Recommendations included creating co-located services in accessible community settings, such as schools or churches, and expanding telehealth options to mitigate transportation barriers.

Suggestions for Community Conversations and Engagement

To improve future community engagement, participants recommended:

- Meeting people where they are by holding conversations in trusted, accessible locations such as community centers, food pantries, and faith-based institutions.
- Utilizing traditional and digital outreach strategies to reach underrepresented groups, including low-income populations, Communities of Color, and older adults.
- Forming partnerships with local non-profits and community leaders to foster trust and ensure that outreach efforts are authentic and community-driven.

Next Steps

As the conversation concluded, participants emphasized the importance of sustained action following the CHNA process and proposed the following immediate steps:

- **Pop-Up Clinics:** To increase access to healthcare, particularly for low-income and uninsured populations, participants suggested creating pop-up clinics in community spaces such as grocery store parking lots. These clinics could provide preventive care, mental health services, and social support resources.
- **Ongoing Collaboration:** Participants called for continued collaboration between hospitals, public health agencies, and community organizations. They stressed the need for hospitals to be more proactive in reaching out to vulnerable populations and creating long-term partnerships that foster trust and transparency.

Acknowledgments

The St. Louis Regional Hospital Collaborative and Key Strategic Group would like to extend our gratitude to the participants of the South County stakeholder conversation for their time, expertise, and insights. We also thank SSM St. Clare Hospital for hosting the meeting and providing a welcoming space for this important dialogue.

Stakeholder Conversation Meeting Agenda

St. Louis Regional Hospital Collaborative

Community Health Needs Assessment

Stakeholder Conversation Agenda

July 9th, 2024, 8:30am-10:00am

SSM Health St. Clare Hospital – Community Meeting Room

Welcome and Introductions (10 minutes)

- Opening remarks from Kyle Grate, President - SSM Health St. Clare Hospital
- Brief introduction to the session's objectives and structure
- Explain the current efforts of the Collaborative

Presentation of Survey Process (12 minutes)

- Survey development & dissemination
- Key findings

Gallery Walk & Facilitated Discussion (25 minutes)

- Discussion prompts:
 - Does anything about the data surprise you?
 - Based on the community you serve, is the survey data aligned with the identified needs of the community?
 - Does it resonate with your experiences and awareness?
 - What best practices/tactics should be implemented to capture underrepresented survey respondents?
 - What's missing?

Prioritizing Community Health Needs (15 minutes)

- Discussion prompts:
 - What do you feel are the most critical health needs?
 - Considering health-related social needs and social determinants of health, how should hospitals prioritize these needs from a community health lens?
 - In what ways should community be embedded in this process?

Capturing Ideas for Community Conversations (15 minutes)

- Brainwriting prompts:
 - What specific information should we seek from community members?
 - How can we ensure diverse and inclusive participation from all community segments?
 - Where would you like to see the Collaborative active in your community?

Recap and Next Steps (10 minutes)

- Summary
- Next steps & action items
- Feedback

Closing Remarks and Adjournment (3 minutes)

St. Louis Regional Hospital Collaborative

Comprehensive Community Conversation Summary Report

Prepared by Key Strategic Group



Executive Summary

The St. Louis Regional Health Collaborative (the Collaborative) conducted six community conversations with diverse regional organizations to inform its Community Health Needs Assessment (CHNA). These conversations, held between September and December 2024, engaged community members from varied demographic and cultural backgrounds, including youth, older adults, immigrant populations, and those experiencing housing instability. The findings reflect a broad spectrum of experiences and highlight shared barriers such as financial strain, transportation challenges, and systemic inequities in healthcare. At the same time, the conversations brought forward unique needs such as culturally competent care for refugees, accessible mental health resources for youth and older adults, and integrated healthcare navigation support.

"I often have to choose between paying for my medications and buying groceries for the week. It's a constant battle," shared one participant, emphasizing the pervasive financial strain.

In total, **60 participants** shared their insights and expertise across six community conversations:

- Beyond Housing: 5 participants
- Boys & Girls Club of Greater St. Charles: 10 participants
- Vision for Children at Risk: 14 participants
- St. Patrick Center: 9 participants
- St. Louis Oasis: 12 participants
- International Institute of St. Louis: 10 participants

The Collaborative compensated participants for their time and expertise with gift cards and provided food and childcare where necessary to foster a welcoming environment. This comprehensive report explores the themes and findings from these discussions, emphasizing their significance in guiding strategic action for equitable healthcare improvements.

Introduction

The St. Louis Regional Health Collaborative recognizes that achieving health equity requires understanding the lived experiences and perspectives of the communities it serves. The Collaborative and trusted partner organizations conducted six community conversations to that end. In this vital dialogue, these organizations connected with diverse groups, amplifying the voices of youth, older adults, immigrant communities, and individuals experiencing housing instability.

The conversations aimed to uncover these communities' barriers, strengths, and aspirations in relation to healthcare access and delivery. Each session provided participants a space to share their unique challenges and offer insights into the systems and practices that could better meet their needs. This report builds on those conversations, presenting a nuanced analysis of themes and actionable recommendations to guide future efforts.

Methodology

The Collaborative employed an intentional and inclusive methodology to ensure the authenticity and depth of community engagement. Key components included:

- **Partnership with Trusted Organizations:** The Collaborative chose organizations such as Beyond Housing, St. Louis Oasis, and the International Institute of St. Louis because of their deep roots within the community. These partners helped recruit participants and provided culturally relevant spaces for dialogue.
- **Structured Facilitation:** Facilitators used open-ended prompts designed to elicit meaningful responses while maintaining flexibility to follow the flow of conversation. They also employed frameworks such as human-centered design to explore needs while ensuring participants felt heard.
- **Equitable Practices:** Participants were compensated for their time and expertise, reinforcing the value of their contributions. The Collaborative also provided food and childcare to ensure accessibility.

- **Data Collection and Analysis:** Key Strategic Group synthesized the conversations' detailed notes and transcripts to identify recurring themes and community-specific insights. They then integrated quantitative data, such as demographic information and thematic frequency, into visual charts for clarity.

Findings: Cross-Cutting Themes and Insights

1. Barriers to Healthcare Access

Access to healthcare remains a significant challenge for many residents across the St. Louis region. The conversations illuminated a range of barriers that intersect with socioeconomic, geographic, and systemic inequities:

- **Financial Strain:** Participants consistently pointed to the prohibitive healthcare costs, from high deductibles and copays to out-of-pocket expenses for medications and treatments. For many, these costs represent insurmountable obstacles, leading to delayed or foregone care. The unpredictability of medical billing further compounds this issue, creating anxiety and mistrust among patients.

Example: One participant skipped critical follow-up appointments because they feared receiving a surprise bill. This fear worsened their health outcomes over time.

- **Transportation Challenges:** Limited public transit options and the geographical distribution of healthcare facilities make accessing care particularly difficult for low-income residents, older adults, and individuals without personal vehicles. Participants highlighted the need for localized healthcare services and reliable transit solutions to bridge this gap.

Recommendation Impact: Investments in transportation solutions such as mobile clinics or community shuttles can significantly reduce missed appointments and improve healthcare outcomes.

- **Complex Healthcare Navigation:** Many participants described the healthcare system as opaque and intimidating. Issues ranged from understanding insurance policies and Medicaid coverage to navigating referral networks. These challenges

disproportionately impact marginalized groups, further entrenching inequities in access and outcomes.

2. Mental Health as a Priority

Mental health emerged as a recurring and urgent theme across all conversations.

Participants emphasized:

- **The Stigma of Mental Illness:** Cultural and societal stigmas surrounding mental health continue to deter individuals from seeking care. Participants stressed the importance of normalizing mental health discussions and integrating services into primary care settings.
- **The Role of Isolation:** Social isolation, particularly among older adults and immigrant populations, was identified as a key driver of mental health challenges. Participants called for programs that foster connection and community resilience.
- **Integration of Services:** Participants frequently recommended a holistic approach to healthcare that incorporates mental health support into physical health services.. They noted that addressing mental health alongside physical health could lead to more comprehensive and effective care.

3. Culturally Competent Care

For immigrant and refugee participants, cultural competency emerged as a critical factor in their healthcare experiences. Key concerns included:

- **Language Barriers:** Many participants reported difficulty accessing interpretation services, leading to miscommunication and frustration. They underscored the need for reliable and professional language support at all points of care.

4. Community Strengths and Assets

While challenges were significant, participants also highlighted existing strengths within their communities, including:

- **Peer Support Networks:** Informal support systems among friends, family, and neighbors are vital in navigating healthcare challenges.

Example: The International Institute session participants described how community WhatsApp groups help them share healthcare resources.

Recommendations

1. **Enhance Cultural Competency:**

- Develop mandatory training programs for healthcare providers on implicit bias, cultural sensitivity, and trauma-informed care.
- Increase investment in multilingual staff and professional interpreters to address language barriers.

2. **Address Financial Barriers:**

- Simplify billing systems and provide transparent cost information to patients.

3. **Improve Transportation Accessibility:**

- Partner with local transit authorities to develop community-specific transportation solutions.
- Explore mobile healthcare units to bring services directly to underserved areas.

4. **Expand Mental Health Resources:**

- Integrate mental health services into primary care settings and community programs.
- Create targeted initiatives to reduce stigma and promote mental health awareness across diverse populations.

5. **Leverage Community Partnerships:**

- Strengthen collaborations with trusted organizations to enhance outreach and resource delivery.
- Support community-driven initiatives that empower residents to advocate for their healthcare needs.

Conclusion and Call to Action

The findings from these community conversations underscore the urgency of addressing systemic barriers to healthcare while building on local communities' strengths and resilience. By implementing the recommendations outlined in this report, the St. Louis Regional Health Collaborative can take meaningful steps toward creating a more equitable and inclusive healthcare system.

The Collaborative encourages healthcare providers, policymakers, and community organizations to:

- 1. Prioritize equity-driven initiatives that reflect the lived experiences of diverse populations.**
- 2. Invest in community-centered solutions such as mobile clinics, peer networks, and culturally tailored programs.**
- 3. Establish accountability frameworks to monitor progress and ensure sustainable impact.**

Together, these efforts can foster a healthcare ecosystem that meets the needs of the St. Louis region and sets a standard for equity and inclusion on a broader scale.

Acknowledgment of Limitations

This study represents the voices of 60 participants but may not capture the full diversity of the St. Louis region. Future studies could expand recruitment to include rural areas, additional demographic groups, and longitudinal engagement to explore evolving needs over time.

Gratitude

The St. Louis Regional Health Collaborative extends its deepest gratitude to the participants who shared their time, experiences, and expertise during these community conversations. Your voices are invaluable in shaping the path toward equitable healthcare. We also thank our partner organizations for their leadership and dedication:

Prepared by Key Strategic Group

- Beyond Housing
- Boys & Girls Club of Greater St. Charles
- Vision for Children at Risk
- St. Patrick Center
- St. Louis Oasis
- International Institute of St. Louis

Together, we are building a stronger, healthier St. Louis region.

Appendix

The following section contains summary reports for each partner organization's individual community conversation. These summaries offer detailed insights into the unique discussions held within each community group. By reviewing these reports, readers can gain a deeper understanding of the specific barriers, priorities, and strengths identified by participants in each session.

Included in the appendix are:

[Beyond Housing Community Conversation Summary Report](#)

[Vision for Children at Risk Community Conversation Summary Report](#)

[Boys and Girls Club of Greater St. Charles County Community Conversation Summary Report](#)

[St. Patrick Center Community Conversation Summary Report](#)

[St. Louis Oasis Community Conversation Summary Report](#)

[International Institute of St. Louis Community Conversation Summary Report](#)

These documents serve as standalone resources that complement the themes and findings synthesized in the main report.

Community Health Needs Assessment – Primary Data Review



Our Assessment Process

Respondent Demographics

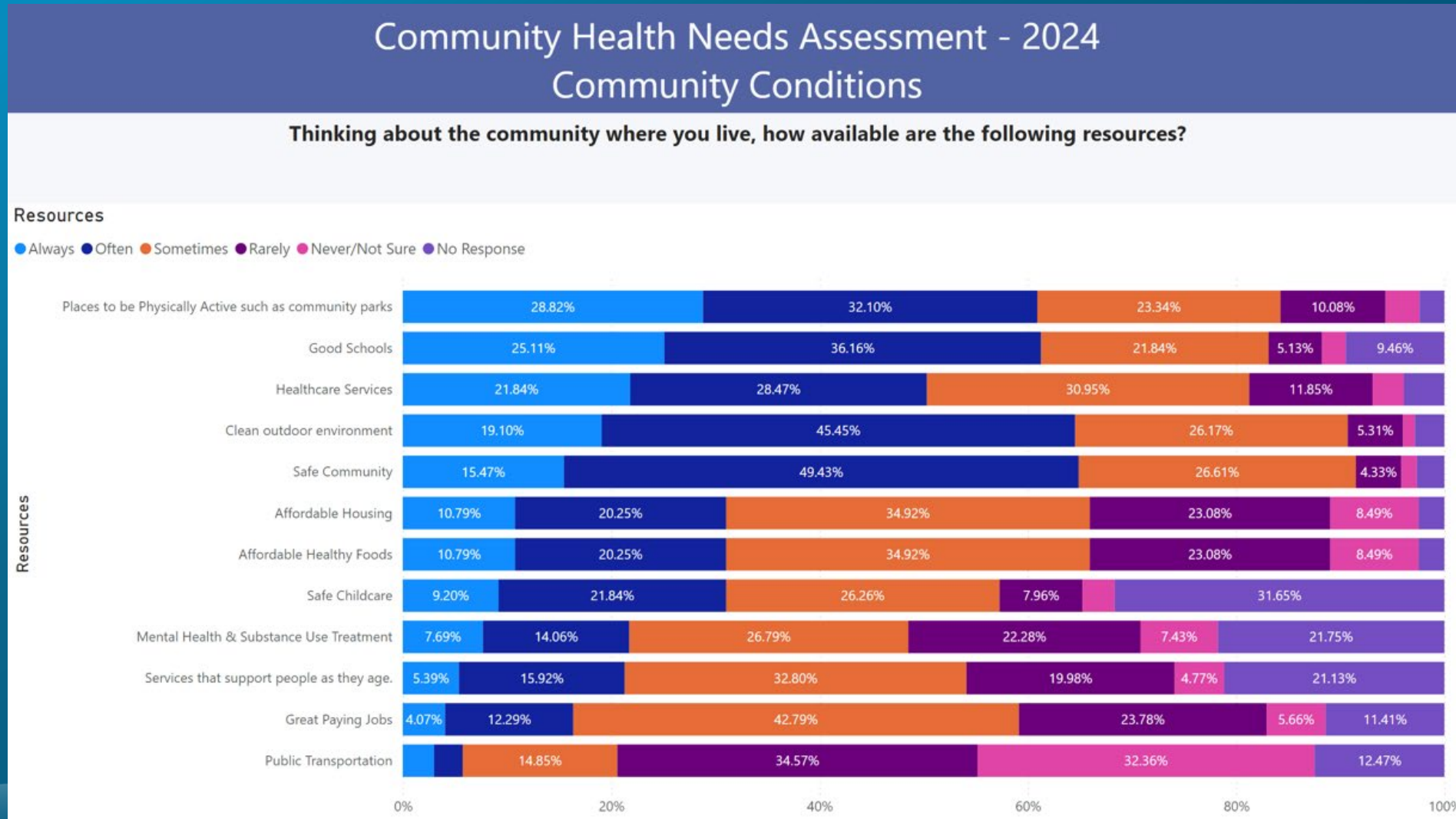
Community Health Needs Assessment - 2024 Respondent Demographics

Who responded to the survey?

Age group	Count	%	Education	Count	%	Employment	Count	%	Household Income	Count	%
0-17	1	0.08%	2-year college/Vocational training	202	15.91%	Active Military Duty	1	0.08%	\$0-\$9,999	68	5.35%
18-24	18	1.42%	4-year college/Bachelor's degree	251	19.76%	Disabled	117	9.21%	\$10,000 to \$24,999	143	11.26%
25-34	115	9.06%	High school diploma/GED	118	9.29%	Full-time	574	45.20%	\$100,000 to \$149,999	176	13.86%
35-44	230	18.11%	Less than high school	28	2.20%	Not Employed	43	3.39%	\$150,000 to \$199,999	88	6.93%
45-54	223	17.56%	Master's, Professional, or Doctorate degree	211	16.61%	Part-time	73	5.75%	\$200,000 or more	43	3.39%
55-64	232	18.27%	Other	12	0.94%	Prefer not to Disclose	254	20.00%	\$25,000 to \$49,999	167	13.15%
65-74	158	12.44%	Prefer not to Disclose	267	21.02%	Retired	175	13.78%	\$50,000 to \$74,999	127	10.00%
75+	37	2.91%	Some college, no degree	181	14.25%	Self Employed	29	2.28%	\$75,000 to \$99,999	90	7.09%
Prefer not to Disclose	256	20.16%	Total	1270	100.00%	Student Full-time	3	0.24%	Prefer not to Disclose	368	28.98%
Total	1270	100.00%				Student Part-time	1	0.08%	Total	1270	100.00%
						Total	1270	100.00%			
Gender	Count	%	Race	Count	%	Ethnicity	Count	%	Language	Count	%
Genderqueer	5	0.39%	American Indian or Alaska Native	20	1.57%	Hispanic	17	1.34%	English	993	78.19%
Man	149	11.73%	Asian	1	0.08%	Non-Hispanic	824	64.88%	English,ASL	4	0.31%
Non-binary	1	0.08%	Black or African American	19	1.50%	Prefer not to Disclose	429	33.78%	English,ASL,Spanish	1	0.08%
Other	5	0.39%	Other	8	0.63%	Total	1270	100.00%	English,Bosnian	3	0.24%
Prefer not to Disclose	258	20.31%	Prefer not to Disclose	281	22.13%				English,French	2	0.16%
Trans man	2	0.16%	White	281	22.13%				English,French,ASL,Spanish ,Other	1	0.08%
Trans woman	1	0.08%	Total	1270	100.00%				English,French,Spanish	1	0.08%
Woman	849	66.85%							English,Other	3	0.24%
Total	1270	100.00%							English,Spanish	5	0.39%
									English,Spanish,Other	1	0.08%
									Other	2	0.16%
									Prefer not to Disclose	254	20.00%
									Total	1270	100.00%

Our Assessment Process

Survey Results



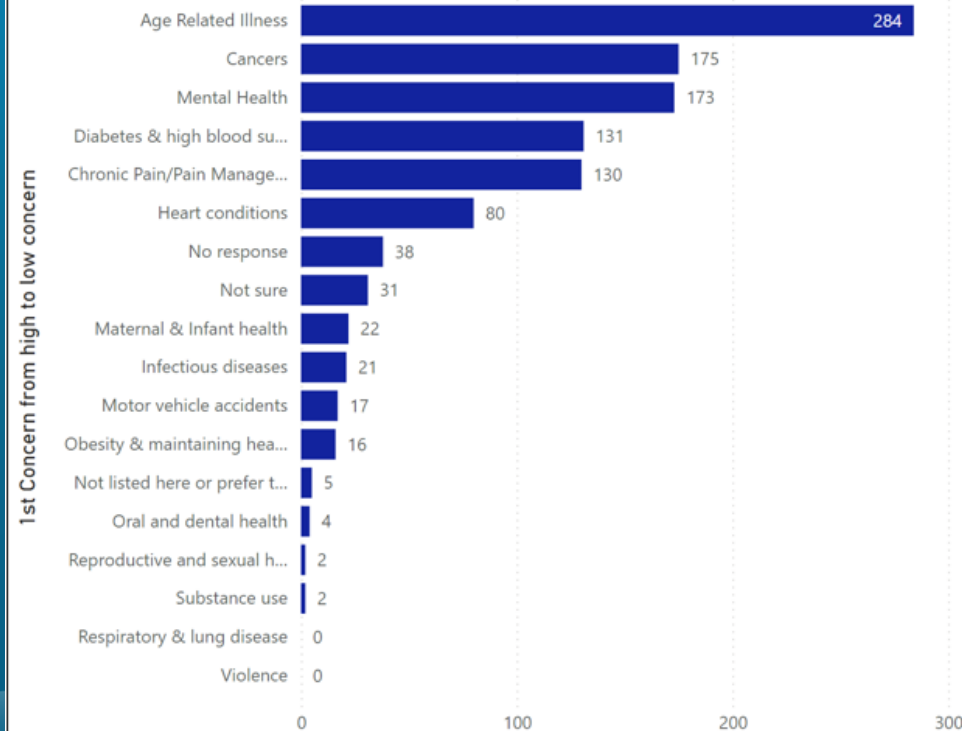
Our Assessment Process

Survey Results

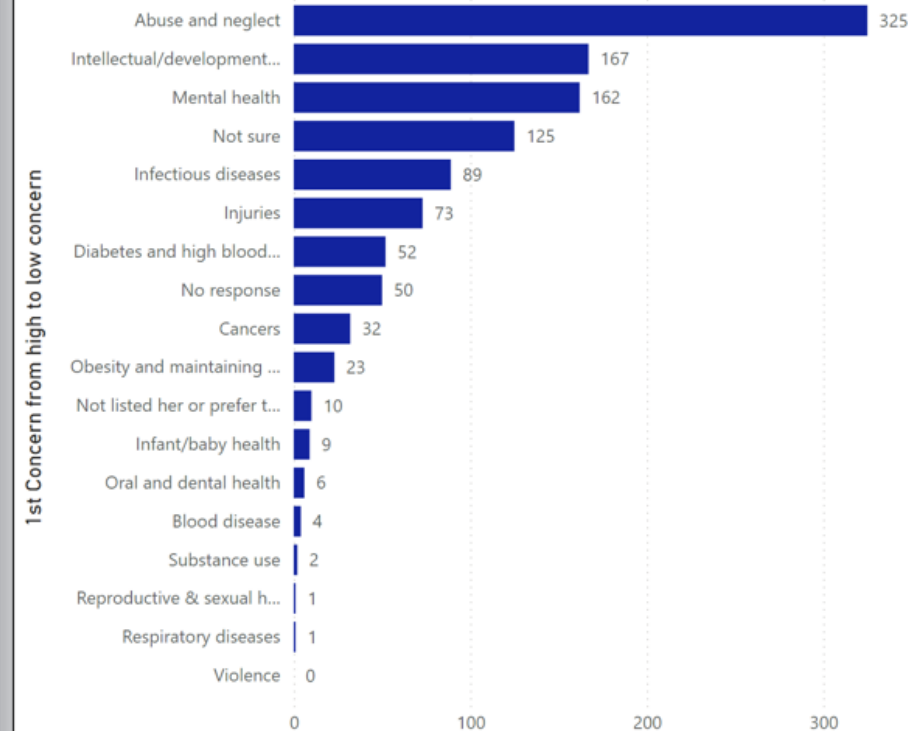
Community Health Needs Assessment - 2024 Health Concerns

Thinking about the community where you live, what are the top health concerns?

Adult Health Concerns



Child Health Concerns



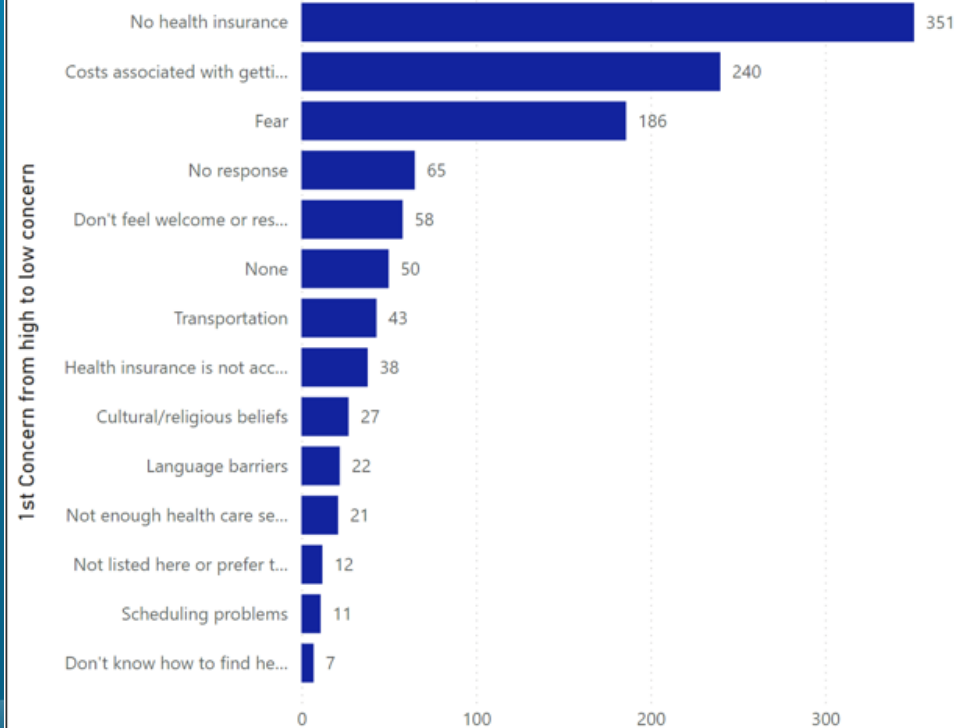
Our Assessment Process

Survey Results

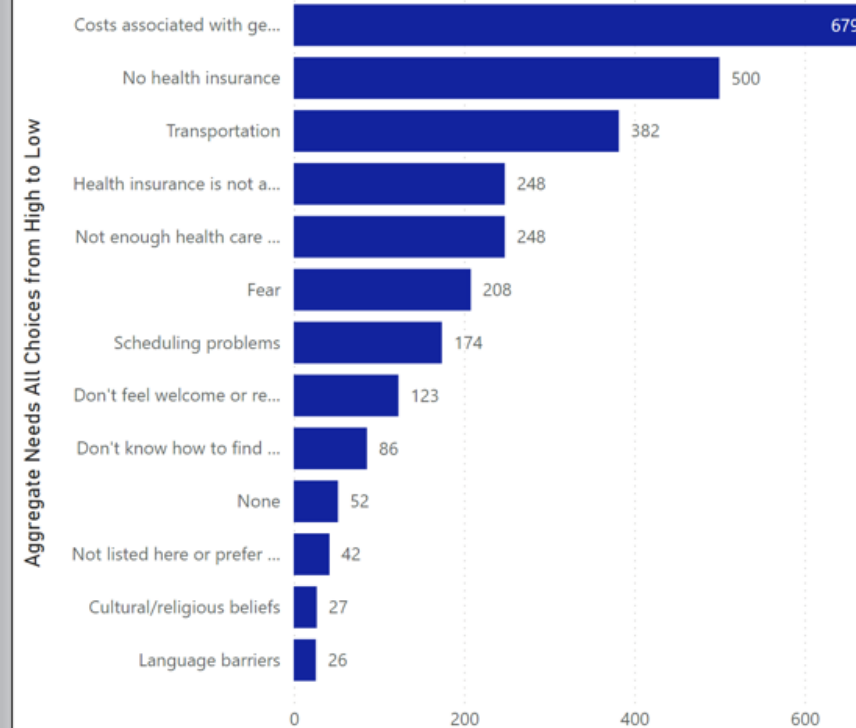
Community Health Needs Assessment - 2024 Barriers to Health Care

Thinking about the community where you live, what barriers prevent access to health care?

Barriers



Barriers Aggregated



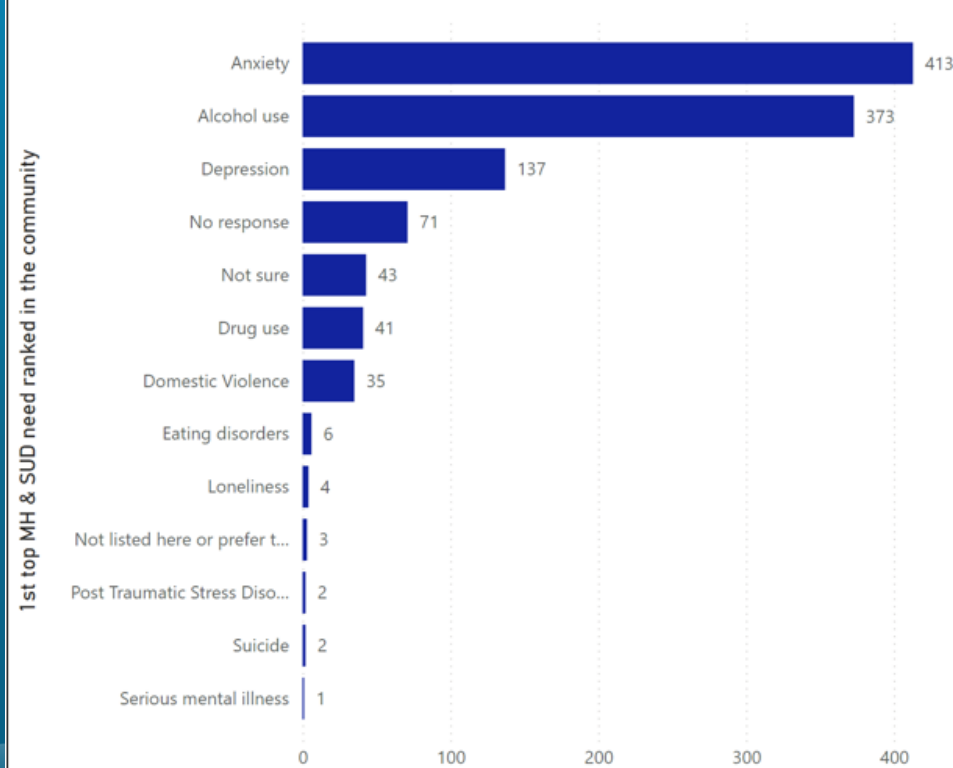
Our Assessment Process

Survey Results

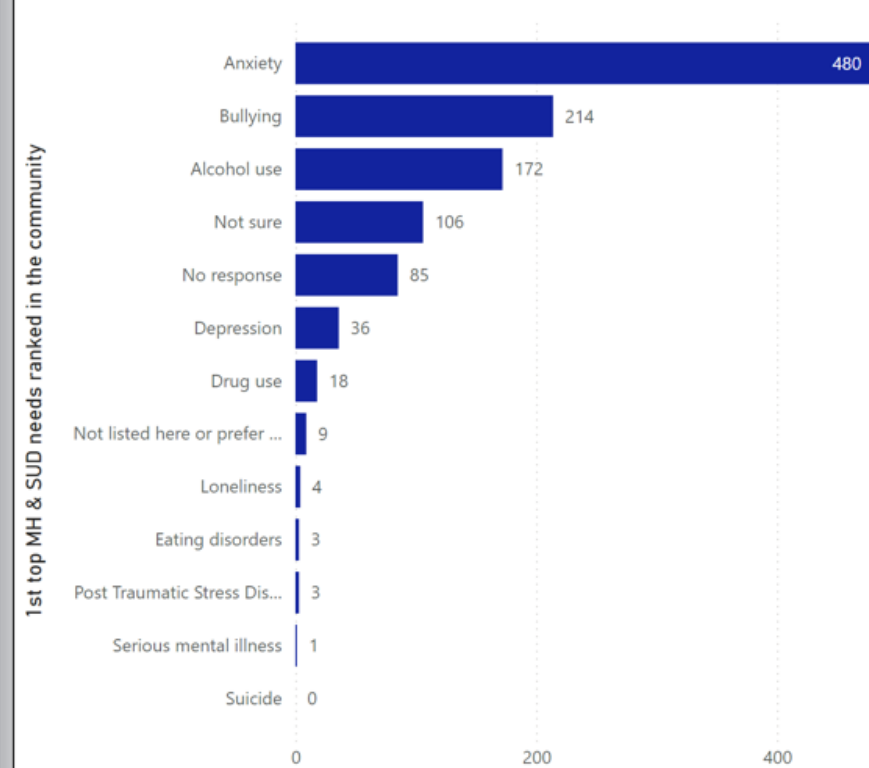
Community Health Needs Assessment - 2024 Mental Health & Substance Abuse

Thinking about the community where you live, what are the top mental health and substance abuse concerns?

Adult Concerns



Child Concerns



Our Assessment Process

Partner Collaboration Day



Mental Health (anxiety, depression, loneliness, suicide)



Substance Use (drug and alcohol)



Physical Health (obesity, weight mgt, diabetes, pain mgt)



Children (mental health, abuse/neglect, obesity/weight)



Barriers to Healthcare Access (access, cost, transportation, scheduling, fear)

Our Assessment Process

Partner Collaboration Day

Mental Health – Identified Themes

Opportunities/Concerns:

- Provider hours don't always work best for working families (3:00 and 4:00 pm sessions fill quickly)
- We need a human element (instead of just call a number or visit a website)
- Money and financial burdens cause difficulties
- People are afraid to seek help because they don't want to be stuck in inpatient care
- Medications are provided, but sometimes getting refills are difficult
- We need legislators and people in power involved in key conversations
- Lack of providers (psychiatrists specifically and youth focused)
- Long wait times
- Youth specific interventions are needed

Highlights:

- Community Health Workers and helping to remove barriers
- Telehealth has added additional access opportunities
- Social workers have integrated into our schools
- 988 and Behavioral Health Crisis Center

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Substance Use – Identified Themes

Opportunities/Concerns:

- Alcohol abuse is not being adequately addressed (and therefore limited resources)
- Lack of inpatient treatment centers in Jefferson County
- Transportation makes it difficult to access services and support
- Lack of reentry services in our community (related to sobriety)
- We have seen an increase in xylazine abuse
- Vaping among students (new gateway)
- You often need insurance to access services
- The community isn't aware of all the resources that are available

Highlights:

- Jefferson County Drug Prevention Coalition
- Opioid Settlement Funds
- Jefferson County Treatment Court
- Increased availability of Narcan
- Mercy's StepOne Program

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Physical Health – Identified Themes

Opportunities/Concerns:

- We need to be more proactive (education is needed)
- Access to healthy (non-processed) foods is difficult for those that rely on food pantries
- We lack “physical activity community events” (fun runs, health fairs, etc.)
- People don’t always understand the benefits they have (insurance, Medicaid, etc.)
- We have a lack of PCPs and chiropractors in our communities
- Obesity, diabetes, and pain management need a holistic approach
- We need additional mobile services (to increase access)
- It’s difficult to get involved (finances and transportation)
- Physical health issues are leading to mental health and substance use concerns

Highlights:

- Farmers Markets are more prevalent
- Senior Expos
- New pain management clinic
- JCHD has a registered dietician on staff

Our Assessment Process

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Children – Identified Themes

Opportunities/Concerns:

- We need to be more FREE parent education (mental health, nutrition education)
- We lack qualified/quality foster parents in Jefferson County
- We need safe, affordable childcare (current 2–4-year waitlists)
- We need programs that promote healthy lifestyles for children (exercise, food, etc.)
- We have a lack adequate pediatric care
- Autism services and support decline as kids age (much harder after age 12)
- Serious mental illness in young kids is an increasing concern in our schools
- Lack of individual and family therapy options in our county
- Severe shortage of early childhood programs

Highlights:

- Churches and community centers are stepping up
- School districts are getting creative (Jefferson R7, Hillsboro, Northwest)
- Family Services is increasing their efforts and taking a more proactive approach

Our Assessment Process

Partner Collaboration Day

Barriers to Healthcare – Identified Themes

Opportunities/Concerns:

- Transportation, cost of healthcare and scheduling
- There are a lot of people in crisis (who need seen quickly)
- Resource navigators are needed (overwhelming for patients)
- Our county needs adequate housing/shelter options
- Providers limit the insurance they accept (especially Marketplace)
- Copays (fear what they need to pay upfront)
- Patients are reluctant to complete “new patient paperwork”
 - Literacy concerns, embarrassment, intimidation

Highlights:

- Compass has expanded services in our county
- Medicaid Expansion
- Telehealth options
- Community Health Workers and Resource Navigators (we still need more)
- EZMO

Mercy 

Your life is our life's work.