

Community Health Needs Assessment

Mercy Hospital St. Louis

FY2025



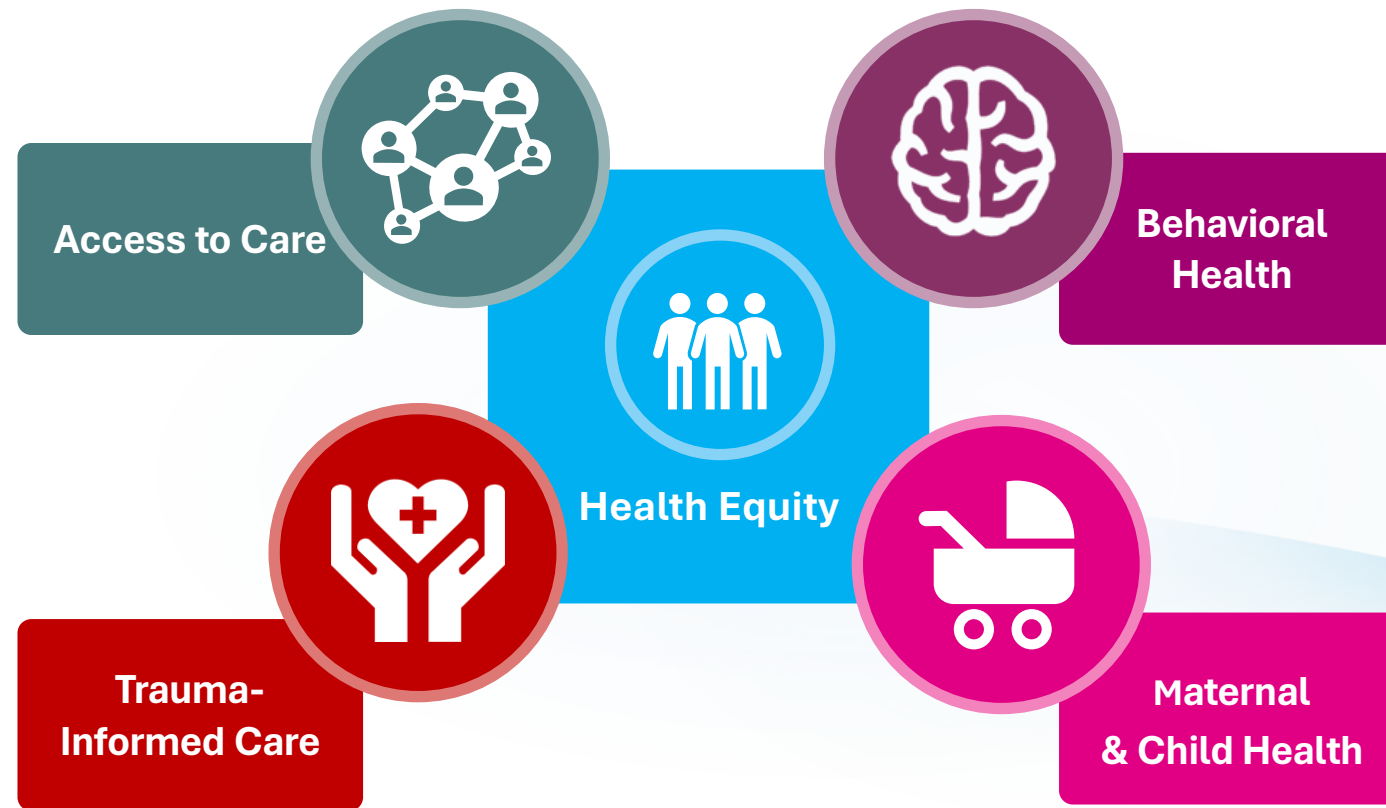
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FY23-25 Impact

Based on the findings of the 2022 Community Health Needs Assessment (CHNA), Mercy Hospital St. Louis chose to address four significant health needs, and through the lens of health equity and with particular concern with racial disparities in health outcomes in our region:





Impact Evaluation of Previous CHNA

Access to Care

Community Health Worker (CHW) Program:

The Community Health Worker (CHW) Program, which was piloted beginning in 2018 and adopted and expanded across Mercy Hospitals in 2019, was further integrated into Mercy Hospital St. Louis' Emergency Department and OB ED, as well as two clinics serving North St. Louis and Ferguson. All uninsured/self-pay patients are screened for pressing social needs, with referrals then made to one of the six (6) CHWs serving these areas. CHW's collaborate closely with Patient Access Representatives, the Care Management team and Social Workers to ensure continuity of care and improve the quality of life of our patients.

CHW's serve in the following primary functions in their service areas:

1. To connect patients to community resources for social needs
2. To assist patients with applying for Medicaid, marketplace insurance, disability, or hospital charity care
3. To assist in scheduling appointments for follow-up care
4. To act as a care navigator and ensure that our patients are empowered and educated in their healthcare.

Mercy Hospital St. Louis expanded our Clinic CHW program to serve North St. Louis County at The Hub – Tabernacle Community Development Corporation.



Impact Evaluation of Previous CHNA

Access to Care – CHW Outcomes

FY 23

- 4,923 patient encounters

FY 24

- 10,750 patient encounters

FY 25 (Q1 –Q3)

- 5,753 patient encounters



Impact Evaluation of Previous CHNA

Access to Care (continued)

Dispensary of Hope (DOH) - The DOH program provides uninsured Mercy patients living at or below 300% of the Federal Poverty Line with lifesaving medications free of cost for up to one year. During the last CHIP cycle, the DOH program was able to assist over **200 patients** and dispensed over **461 prescriptions** through our retail pharmacy and saved those patients over **\$90,000 in prescription costs**.

Community Referral Coordinator Program (CRC)*: 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 St. Louis CRC had over **2,000 encounters** from FY 23 - FY25.

*The CRC contract ended February of 2025.



Impact Evaluation of Previous CHNA

Access to Care *(continued)*

MHSTL Prescription Assistance Program - The Mercy Hospital St. Louis Prescription Assistance launched in October of 2021, providing uninsured Mercy patients living at or below 300% of the Federal Poverty Line with lifesaving medications free of cost for up to one year. During the last CHIP cycle, the DOH program was able to assist over **500 patients** with their prescriptions through our retail pharmacy and saved those patients over **\$29,000 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 aid 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 **550 referrals** were made, **350 appointments** set with an **average kept rate of 68%**.



FY23-25 Impact

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 **490 referrals** into the program, over **330 hospital outreaches** performed.

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 **14,000 unique patients** in the Mercy St. Louis service area have been connected to this service.



FY23-25 Impact

Behavioral Health (*continued*)

Clinical BEACN:

SURP - Substance Use Recovery Program - 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 3,000 referrals have been made to this program in our region.**



FY23-25 Impact

Behavioral Health (*continued*)

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.

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. Over **175 program referrals** were made with **over 170 outreaches performed** and an average of **84% engaging with a recovery coach**.



FY23-25 Impact

Maternal and Child Health

Centering Pregnancy – Centering Pregnancy is an evidence-based framework that provides group prenatal care that is patient centered and relationship-focused to improve health outcomes for moms and babies. Extended clinical visits and facilitative discussions empowered moms to engage in their healthcare beside their community. Following the disruption from COVID-19 the Centering Pregnancy program was discontinued.

Safe Sleep First Project- Safe Sleep First Project (SS1st) focuses on evidence-based frameworks to promote the practice of infant safe sleep, especially for communities of color, where systemic inequalities place babies at greater risk for illness, injury, and death. In St. Louis, Black babies are seven times more likely to die than white babies from SUIDS. Many parents and caregivers are unaware that how their baby sleeps can put them at a higher risk of infant death. For examples, some families co-sleep with their babies as bonding time or to protect them from unsafe living conditions, but this puts them at risk for suffocation. For other families, a crib may simply be too expensive. Most infant deaths can be avoided by practicing the ABCs of Safe Sleep: Babies sleep safest **alone**, on their **back** and in their **crib**, bassinet, or portable crib. Through a regional, multi-sector team, SS1st provides training and resources so that caregivers throughout St. Louis region.



FY23-25 Impact

Maternal and Child Health (*continued*)

NICU Breast Pump Loaner Program- With support of a grant through the Vermont Oxford Network (VON), Mercy Hospital St. Louis' NICU lent hospital-grade mechanical breast pumps to mothers in need and provide education on pump usage, bridging the potential gap of weeks or months for a similar quality pump to be available via State of Missouri programs. Social navigation services were provided to facilitate access to nutritional support, transportation assistance, and other help as needed.

Milk Depot- Mercy Hospital St. Louis manages an on-site collection facility for donor milk to be pumped and/or dropped off and stored. Mercy arranges shipments of donor milk to The Milk Bank for bottling, pasteurization, testing and reallocation to mothers in need. In the previous CHIP cycle, there were over **340 unique donors** that **provided 133,861 oz of milk** with a **net impact of 106,217 oz.**



FY23-25 Impact

Maternal and Child Health (*continued*)

Mercy-Wide Policy: Mercy Kids Care of the Substance-Exposed Newborn – Any infant exposed to maternal substance use in utero will receive non-pharmacological care through environment modifications and integration of parents/caregivers with a primary role. This policy ensured that a formalized standard approach was taken to symptom management that focused on the primary caregiver’s ability to perform the basic skills for infant growth and development.

Maternal SUD Collaborative Care Model - Mercy Hospital St. Louis engaged a multidisciplinary team across Maternal Fetal Medicine, Labor and Birth, Neonatal ICU, Mercy Kids, Mercy vBH and Population Health (SURP) to develop a sustainable model in providing comprehensive, streamlined, and accessible care for pregnant women with Substance Use Disorder (SUD) and their babies. Through a combination of standardized prenatal screening and seamless coordination of consultation, pre-natal care, harm-reduction strategies and comprehensive social and clinical support, Mercy aims to promote women in achieving greater stability while reducing risks for preterm births, low birthweight, and other social and health challenges by developing the recently opened BRAVE clinic in 2025.



FY23-25 Impact

Trauma Informed Care

Program Research and Development

General program research was conducted and due to evolving needs of the community resources were reallocated. Additionally, changes in community partnerships and local leadership affected the continuity necessary for such research initiatives and program development was discontinued in early 2024.

In early 2025, Mercy Hospital St. Louis began the process of developing internal trauma informed care programming utilizing national best practices to inform training that address this need.

Executive Summary

Mercy Hospital St. Louis (MHSTL) is an 859-bed, private room hospital located in St. Louis, Missouri. It is one of five hospitals in Mercy's East Community and the only Level 1 (highest level) trauma center in St. Louis County. MHSTL's campus includes Mercy JFK Clinic, which focuses on serving the health needs of individuals who are uninsured or underinsured; Mercy Heart and Vascular Hospital; the David C. Pratt Cancer Center; and Mercy Children's Hospital, the only full-service pediatric hospital in St. Louis County and one of only two hospitals in the state of Missouri to have a Level III (highest level) neonatal intensive care unit.

MHSTL's primary service area is St. Louis County. Throughout the county, Mercy operates Mercy Clinic physician offices, outpatient hospital services, 65Prime+, and Mercy-GoHeath Urgent Care centers. In 2015, Mercy also opened the world's first virtual care center, located in St. Louis County. It addresses critical community health needs such as transportation barriers to accessing care, which most often impact lower-income and non-ambulatory patients and provider shortages in the surrounding rural communities comprising MHSTL's extended service area.

Executive Summary *(continued)*

Mercy's Mission is to deliver "compassionate care and exceptional service" to every community member, especially the most vulnerable among us. To do so, we must understand the needs of the community and establish strategic programs to address those needs. This is the work of the Community Health needs Assessment (CHNA). Conducted every three years, the CHNA seeks to align with and to bolster regional assessments conducted across both St. Louis city and county, and to engage traditional and non-traditional partners in both medical and community-based agencies and organization in understanding community issues.

While the CHNA demonstrated the legacy of the 'Walking Sisters,' engaging actively out in our community to address urgent needs, it also fulfills a legal imperative of Mercy as a non-profit health care organization. As a part of the Patient Protection and Affordable Care Act (PPACA) passed in March 2012, non-profit hospitals were mandated to conduct a community-based health needs assessment every three years. As a part of that process, each hospital is required to solicit input from those who represent the broad interests of the community served by the hospital as well as those who have special knowledge and expertise of public health and underserved populations. For this's CHNA, we gathered and analyzed health-related information and statistics from both St. Louis County and St. Louis City. Additionally, we sought more granular data concerning Mercy service areas, when available and appropriate.

Executive Summary *(continued)*

Our final Report includes data gathered through surveys of community residents and organizational stakeholders, as well as community conversations conducted within neighborhoods of our larger service area. The CHNA identified 12 priorities of which 4 have been chosen as health needs for the Mercy Hospital St. Louis community. We will strive diligently to address these needs over the next three years.

- Access to Care
- Behavioral Health
- Health and Financial Literacy
- Maternal and Child Health

These 4 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 St. Louis.

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.



David Meiners
President
Mercy Hospital St. Louis

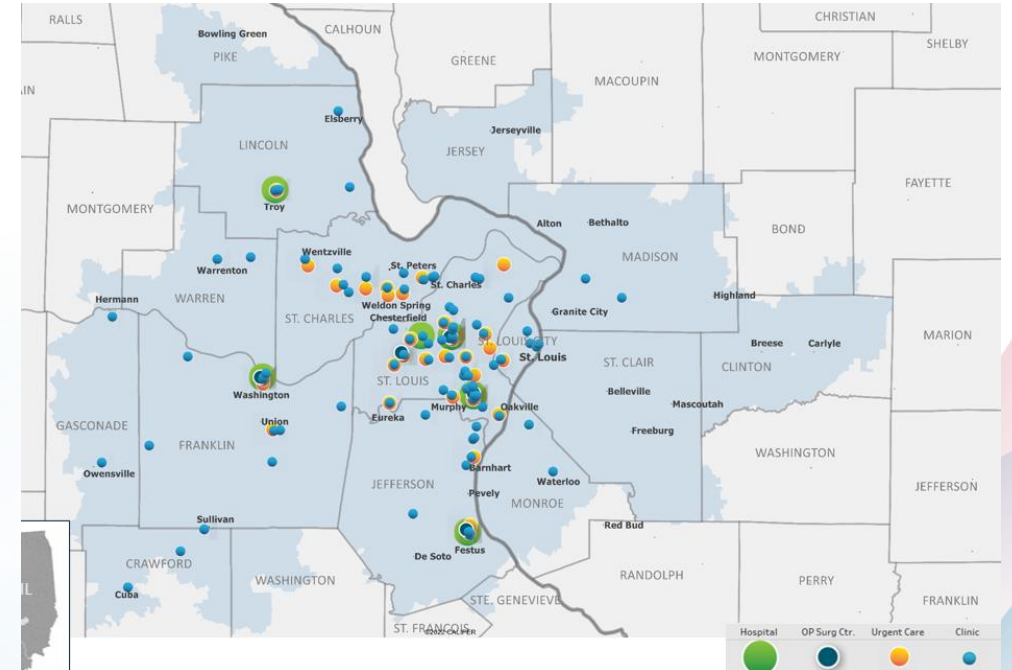
Community Profile

Defining the Community

Mercy Hospital St. Louis (MHSTL) is in Creve Coeur, Missouri, in West St. Louis County. MHSTL has a primary service area that consists of fourteen counties (194 zip codes) across the Missouri-Illinois bi-state area. The service area spans rural, suburban, and urban settings.

St. Louis County is divided into five regions according to its geography and social demographics: Central, Inner North, Outer North, South, and West. For the CHNA, MHSTL defines its primary community as the **West, Central, Inner North, and Outer North** regions of St. Louis County.

Mercy Hospital St. Louis continues to collaborate across the St. Louis region to increase connectivity and eliminate racial and socioeconomic disparities in our region.



Community Profile

Demographics

Age Distribution	West Region	Central Region	Inner North Region	Outer North Region	St. Louis County
Population size (number of persons)	252,073	84,337	121,845	152,114	986,988
Age Distribution					
Under 18	53,629	17,028	29,176	33,366	207,361
18-24 years	22,753	10,851	10,718	13,618	91,311
25-64 years	119,512	41,093	61,297	77,094	482,313
65-84 years	49,009	13,540	18,847	24,961	179,788
85 and over	7,170	1,825	1,807	3,075	26,215

Source: ThinkHealthSTL, 2024

Community Profile

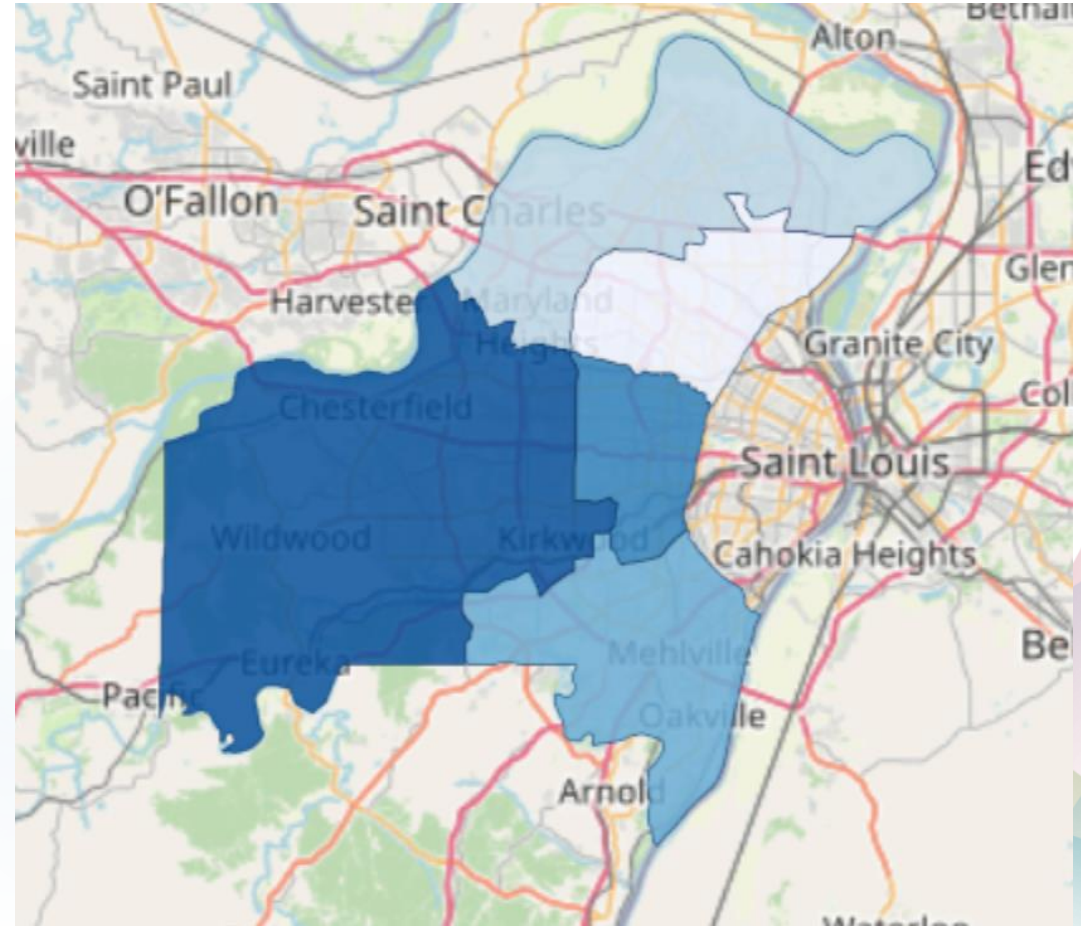
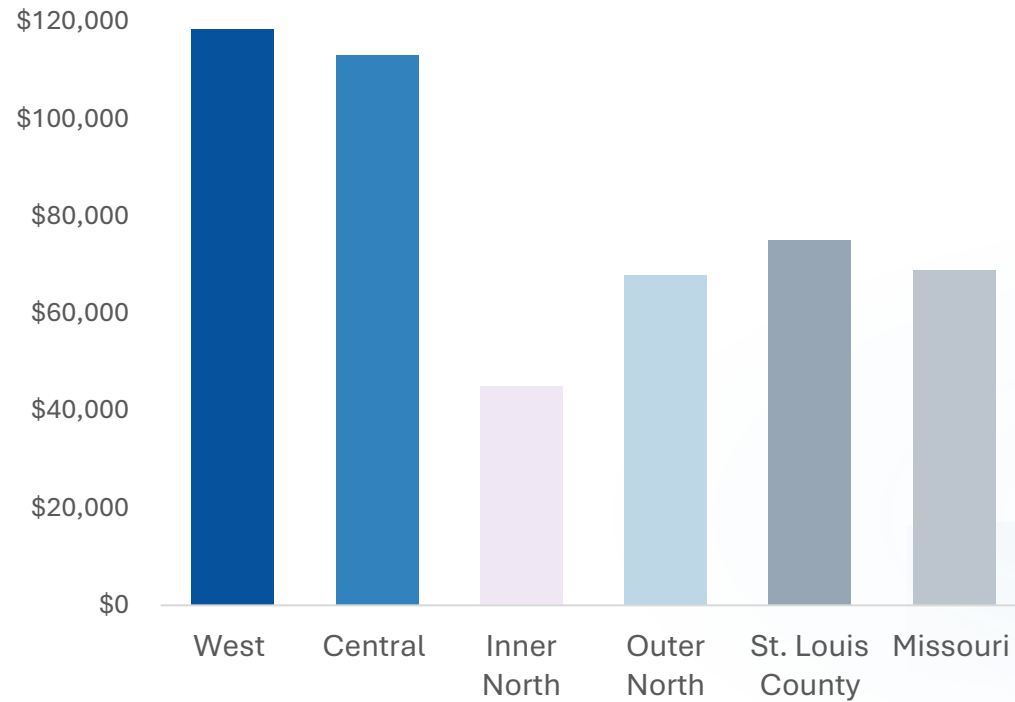
Demographics

Racial Distribution	West Region	Central Region	Inner North Region	Outer North Region	St. Louis County
Population size (number of persons)	252,073	84,337	121,845	152,114	986,988
Race distribution					
White	203,167	60,032	26,077	54,859	608,268
Black or African American	10,243	11,640	83,140	79,553	246,078
American Indian or Alaska native	385	169	528	431	2,436
Asian	19,089	5,635	1,177	4,766	50,137
Native Hawaiian and Other Pacific Islander	83	14	34	64	299
Other (2+ Races, Some Other Race)	19,106	6,847	10,889	12,441	79,770
Ethnicity Distribution					
Hispanic or Latino (of any race)	9,022	3,447	6,885	5,481	40,496

Source: ThinkHealthSTL, 2024

Community Profile

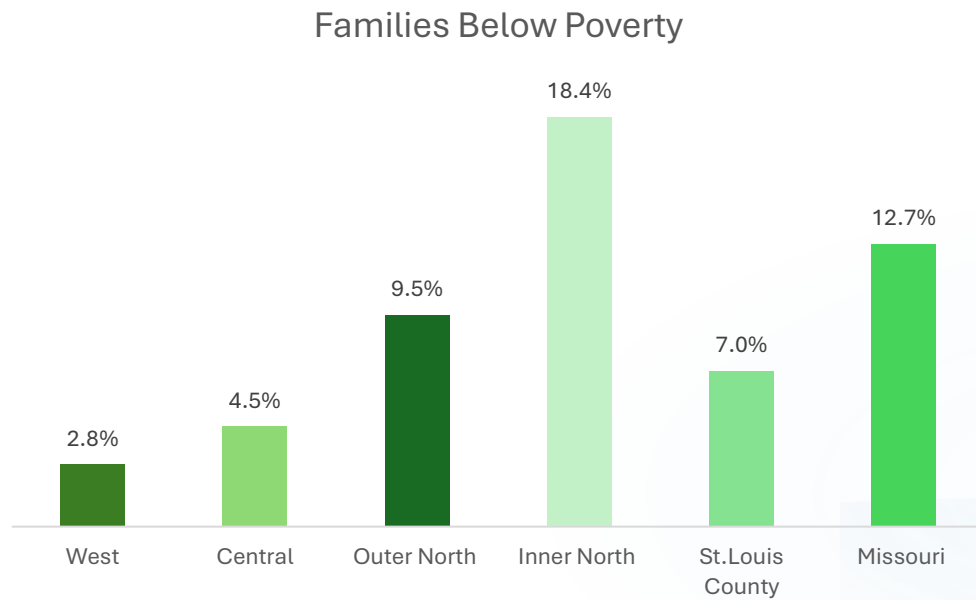
Median Household Income



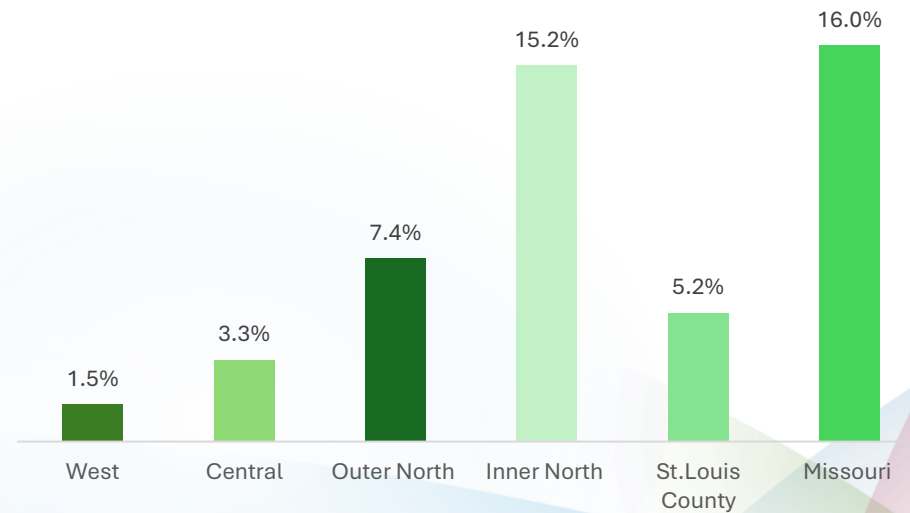
Source: ThinkHealthSTL, 2024

Community Profile

Families below Poverty



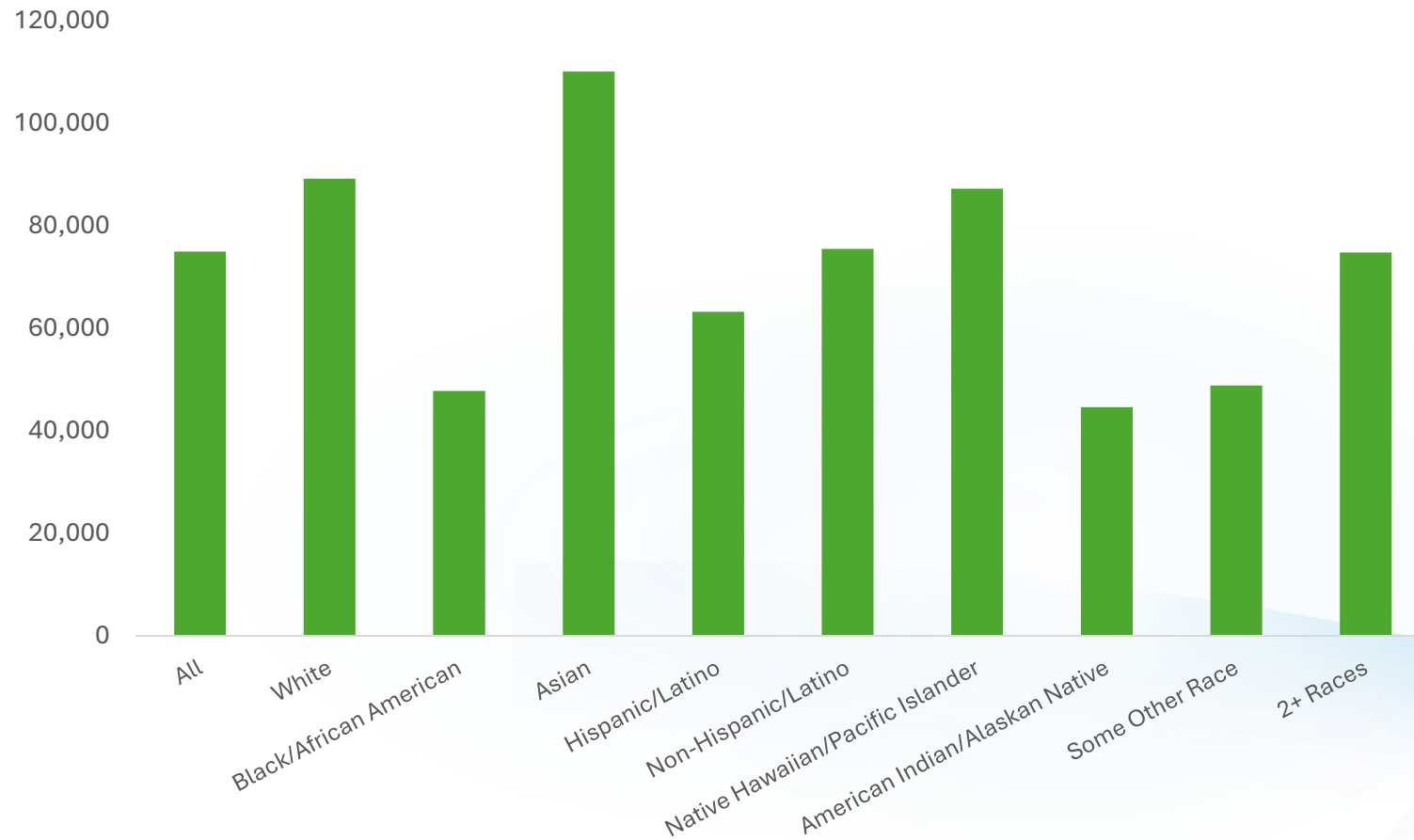
Families Below Poverty with Children



Source: ThinkHealthSTL, 2024

Community Profile

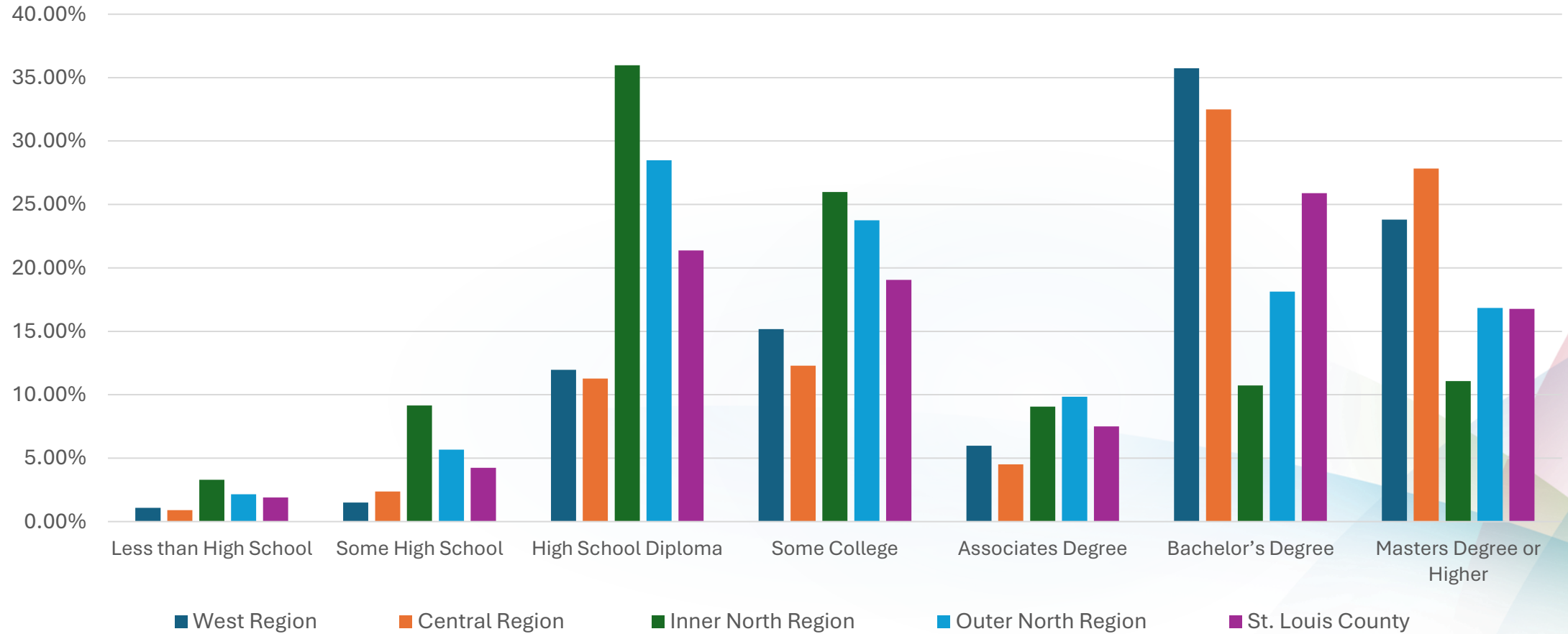
St. Louis County Median Household Income by Race



Source: ThinkHealthSTL, 2024

Community Profile

Education

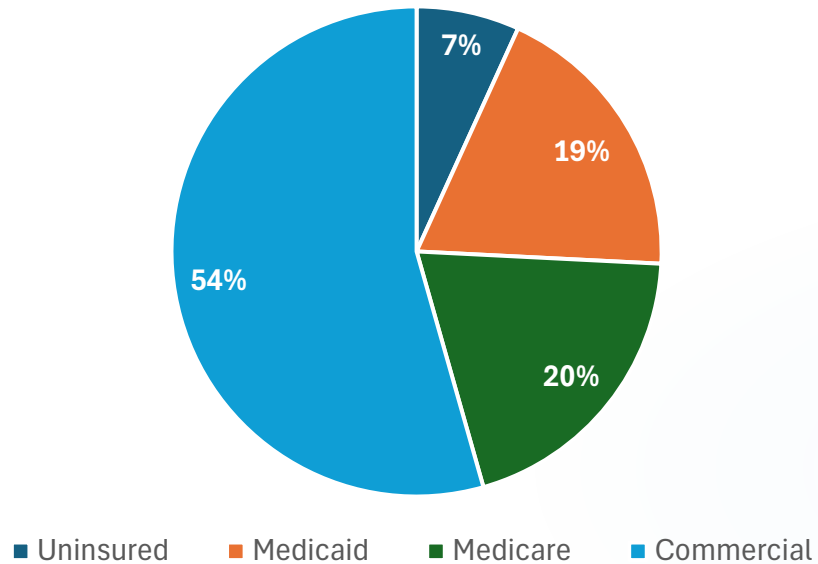


Source: ThinkHealthSTL, 2024

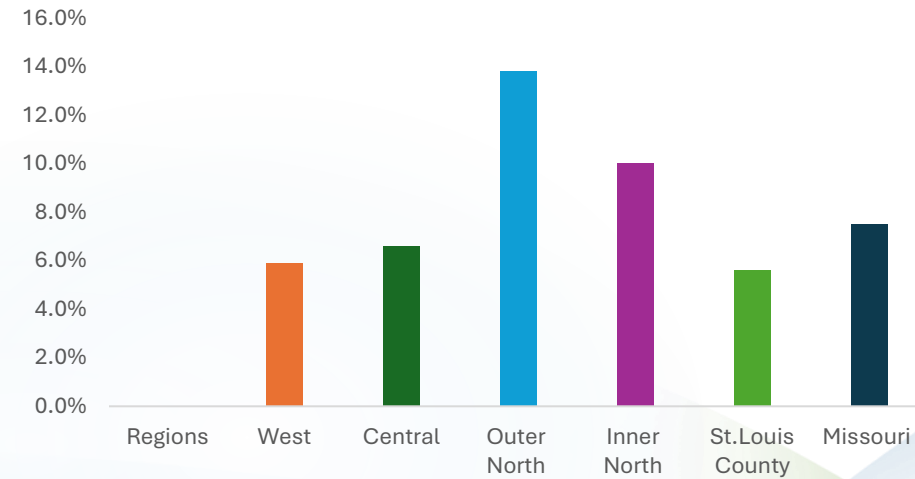
Community Profile

Insurance Status

MHSTL Payor Mix



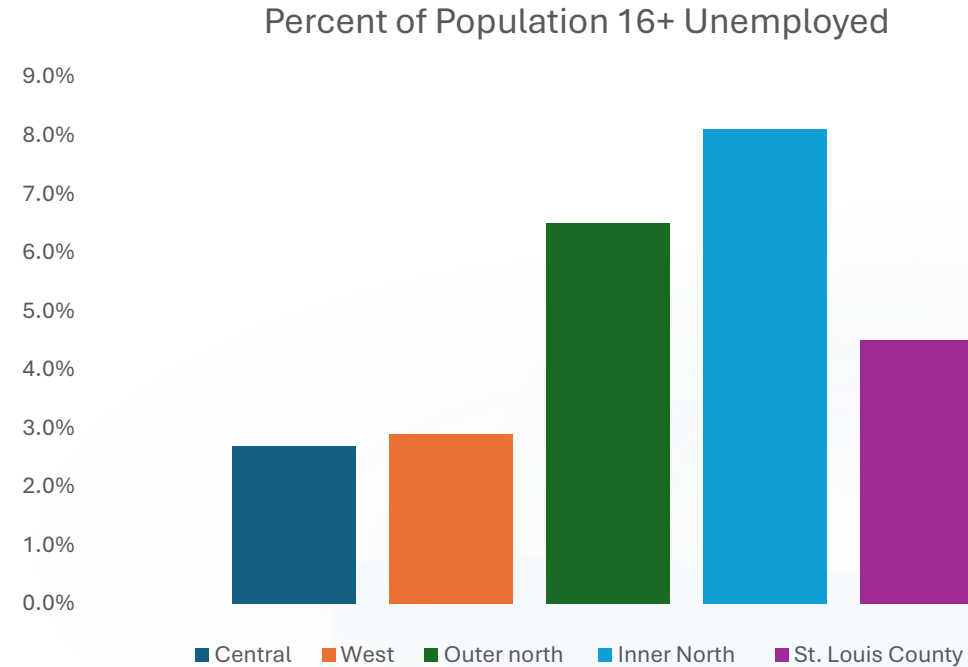
Percent Uninsured by Region



Source: ThinkHealthSTL, 2024

Community Profile

Employment



Source: ThinkHealthSTL, 2024

Community Profile

Access to Care

Provider Type	St. Louis	St. Louis City	Missouri
Primary Care Physicians	820:1	1,030:1	1,420:1
Dentists	1,120:1	1,210:1	1,600:1
Mental Health Providers	280:1	270:1	410:1

Our Assessment Process

Data Collection

To capture relevant data and community voices for this Community Health Needs Assessment, Mercy Hospital St. Louis 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. Community input was also solicited through stakeholder conversations and community conversations, also sponsored by our regional collaborative. The commitment to centering community voice was central to the health needs assessment process. Input from those 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 St. Louis and are listed later in this assessment.

Our Assessment Process

St. Louis Regional 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 and collaborate to ensure each hospital's assets are utilized for optimal collaboration and insight. The 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 leaders 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 (Mid/West)

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. The survey and data summary for Mercy Hospital St. Louis are located in Appendix A and Appendix C.

Over 6,800 community surveys were answered for the region. Mercy Hospital St. Louis' primary service area included 941 of those respondents. Below are survey responses.

Top health concerns for adults:	Top mental health and substance use concerns	Barriers to health care access:	Least available resources:
<ul style="list-style-type: none">- Mental Health- Age Related Illness- Heart Conditions- Obesity and Maintaining weight- Cancers	<ul style="list-style-type: none">- Depression- Anxiety- Alcohol Use- Loneliness- Drug Use- Serious Mental Illness (SMI)	<ul style="list-style-type: none">- Costs associated with getting health care- Scheduling problems- Transportation- Not enough providers- Health insurance not accepted- No health insurance	<ul style="list-style-type: none">- Affordable housing- Public transportation- Mental health and substance use services- Aging services- Good paying jobs

Our Assessment Process

Community Health Needs Survey (North)

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. The data summary for Mercy Hospital St. Louis are located in Appendix D and Appendix E.

Over 6,800 community surveys were answered for the region. Mercy Hospital St. Louis' primary service area included 449 of those respondents. Below are survey responses.

Top health concerns for adults:	Top mental health and substance use concerns?	Barriers to health care access:	Least available resources:
<ul style="list-style-type: none">- Mental Health- Heart Conditions- Diabetes and high blood sugar- Obesity and Maintaining healthy weight- Violence	<ul style="list-style-type: none">- Depression- Drug Use- Alcohol Use- Anxiety- Serious Mental Illness- Domestic Violence	<ul style="list-style-type: none">- Costs associated with getting health care- Scheduling problems- Transportation- Not enough providers- Health insurance not accepted- No health insurance	<ul style="list-style-type: none">- Aging Services- Good Schools- Mental health and Substance Use Services- Affordable Housing- Good Paying Jobs

Our Assessment Process

Community Stakeholder Conversations *(continued)*

Below is the summary of response from the community stakeholder conversation for the West Region held at St. Luke's Institute for Health Education on July 23, 2024. Community stakeholder conversation summary is in appendix C and appendix E.

Primary Health Concerns:

- Mental Health and Substance Use
- Healthcare Access
- Maternal Health
- Health Literacy

Barriers to Achieving Optimal Health Outcomes:

- Social Determinants of health (SDOH) housing, transportation and food specified.
- Education and Literacy (nutritional, health, and financial)
- Access to resources and providers



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

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. To further our understanding, The Collaborative and trusted partner organizations conducted 6 community conversations. 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:

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

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
- Increase Utilization of Community Strengths and Assets
- Addressing Literacy

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.

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.

Prioritized Needs

Prioritization Process

Once primary and secondary data for the CHNA was compiled, it was summarily presented to the Community Health Council of Mercy Hospital St. Louis in April 2025. Councilmembers were responsible for prioritizing health needs by reviewing the data, evaluating the strengths and resources of the community and representing the hospital's strategic plan. A preliminary list of twelve needs were identified using a strategy grid, by assessing the severity of need as well as the availability of resources to address the need along a matrix. The initial identified needs included:

- Access to Care
- Health and Financial Literacy
- Mental and Behavioral Health
- Affordable Housing
- Transportation
- Age Related Illness
- Obesity/Healthy Lifestyle
- Food Insecurity
- Diabetes
- Substance Use
- Cancers
- Maternal and Infant health

Prioritized Needs

Prioritization Process

Utilizing a strategy grid the Council came to unanimous consensus based off the following 5 criteria:

1. Magnitude of Need
2. Feasibility to Change
3. Alignment with Mission/Strategic Goals
4. Resources Available
5. Importance to Community

Four final priorities were selected for the 2025 CHNA. The Council determined that **Maternal and Infant Health**, **Mental Health and Substance Use** would be addressed jointly under **Behavioral Health, Health and Financial Literacy** and **Access to care**. Three out of these four needs will be carried over from the 2023 CHNA, while Health and Financial Literacy is a newly identified need.

MHSTL will maintain current implementation strategies that have demonstrated positive impact in these priority areas and will continue to seek out programs, interventions and community partnerships to further efforts to address all prioritized needs.

Prioritized Needs



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. Barriers to access includes the high cost of care, lack of health insurance coverage or inadequate insurance coverage, limited availability of services, and transportation barriers. Those with limited access to care are not as able to obtain preventative services or treatment for acute or chronic disease, resulting in further exacerbation of their conditions, increased cost of care and, at times, a reduction in quality of life.

Many people across the St. Louis region face such barriers to obtain needed healthcare services. A lack of access to such services means that members of our community may not be able to access much needed appointments or medications in a timely manner. These factors are interrelated to the Social Determinants of Health (SDOH). Social determinants such as economic stability, education access, neighborhood and built environment, and social and community context all influence the ways individuals navigate the health system and access healthcare when they need it.

Prioritized Needs



Behavioral Health

For the purposes of this CHNA, Behavioral Health encompasses MHSTL's efforts to address mental health and substance use disorders in the community. Mental health includes our emotional, psychological, and social well-being.

1 in 5 U.S adults experience mental illness each year

1 in 20 U.S adults experience serious mental illness each year

People with depression have a 40% higher risk of developing cardiovascular and metabolic diseases than the general populations.

Source: NAMI, 2024

Our efforts will continue to grow over the next several years as we partner to expand access to behavioral health services, including the implementation of more virtual behavioral health services.

Prioritized Needs

Mental Health Index

Resource Availability

Mental Health and Substance Use Services:

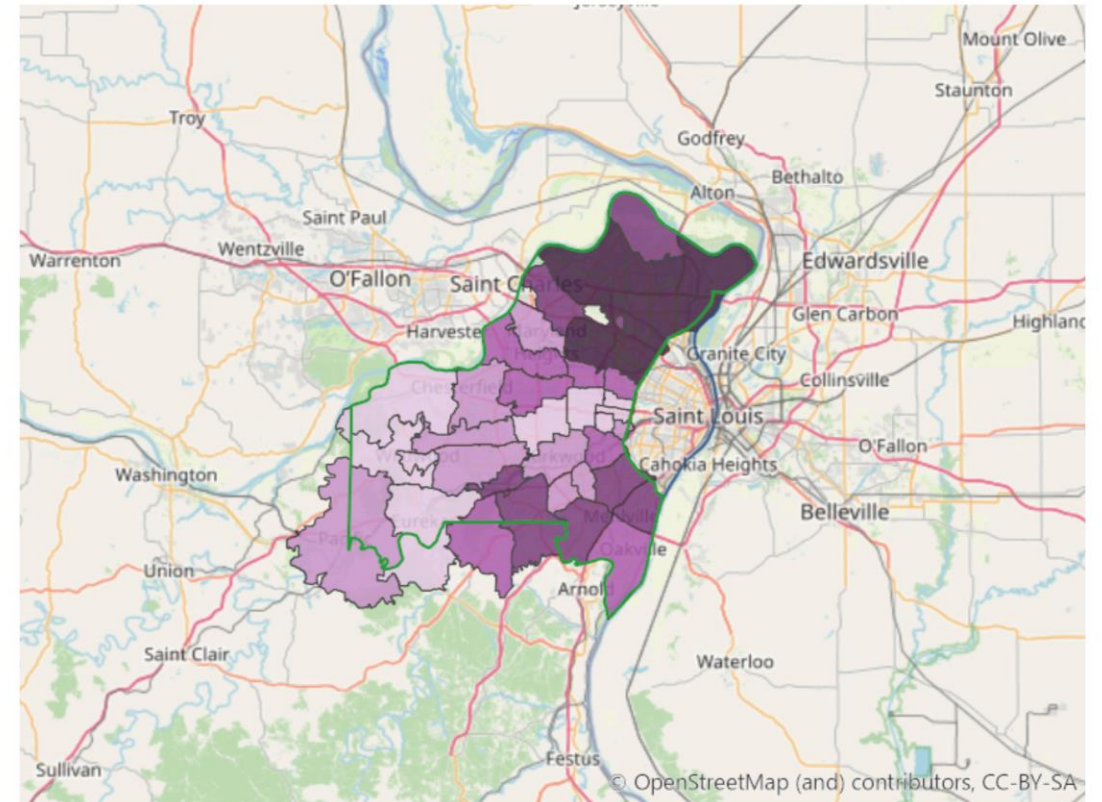
- 32% of respondents answered “Poor Availability”
- 35% of respondents answered “Sometimes Available”

2024 Mental Health Index

Zip Code: St. Louis

Measurement Period: 2024

Data Source: Conduent Healthy Communities Institute



MAP LEGEND

greater need →

Index values are not comparable across measurement periods. Index values and rankings are specific to a measurement period, showing the relative ranking of a location in comparison to other similar locations at that time.

April 14, 2025

www.thinkhealthstl.org

Source: *ThinkHealthSTL*, 2024

Prioritized Needs



Health and Financial Literacy

Health and financial literacy are critical components for achieving better health outcomes in our community. Health literacy enables individuals to understand and act upon health information, make informed decisions about their care, and more effectively manage chronic conditions. Financial literacy, on the other hand, empowers individuals to navigate healthcare costs, insurance options, and budget for medical expenses, ensuring they can access necessary services without financial strain.

By enhancing both health and financial literacy, we aim reduce unnecessary hospitalizations, improve chronic disease management, and foster economic stability, ultimately leading to healthier and more resilient communities.

Mercy Hospital St. Louis will invest in developing educational programs and resources that promote these literacies to empower individuals to take control of their health and financial well-being.

Prioritized Needs



Maternal & Child Health

Maternal and Child Health focuses on health issues concerning women, children, and families, including access to prenatal care, infant and maternal mortality prevention, maternal and child health, newborn screening, child immunizations, child nutrition, and services for children with special health care needs. As emphasized by the American Hospital Association, a “commitment to women’s health, healthy pregnancy and a good start for all children is a cornerstone to improving the nation’s health.”³

In St. Louis, infant mortality has long been a key indicator of the status of Maternal and Child Health overall, especially as it demonstrates the harsh reality of health disparities in the region. Black infants are three times more likely to die before their first birthday than white infants in St. Louis, and there is a 3.5 times greater rate of pregnancy-associated deaths for Black women than white women in the state of Missouri.⁴

MHSTL remains committed to collaborating with key leaders to improve infant and maternal outcomes, particularly related to perinatal care access and utilization and safe sleep efforts.

Resources

1. Think Health STL. (2024). Demographic data. Retrieved February 2025, from <https://www.thinkhealthstl.org/demographicdata>
2. National Alliance on Mental Illness. (April, 2023). Mental health by the numbers. Retrieved April 2025, from <https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/>
3. FLOURISH St. Louis, Generate Health. (2022). Retrieved March 2025, from <https://flourishstlouis.org/>
4. Hoyert, D. L. (2023). Health E-Stat 100: Maternal mortality rates in the United States, 2023. National Center for Health Statistics. Retrieved from <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2023/maternal-mortality-rates-2023.htm>



Your life is our life's work.

Appendices

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Appendix A

St. Louis Regional Collaborative Survey 2024



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	2	3	4	5	
	Never	Rarely	Sometimes	Often	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.

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

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.

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

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

Version: English

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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!

Version: English

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Appendix A

Appendix B: Mid/West Community Health Survey Summary Report

Mid/West St. Louis County

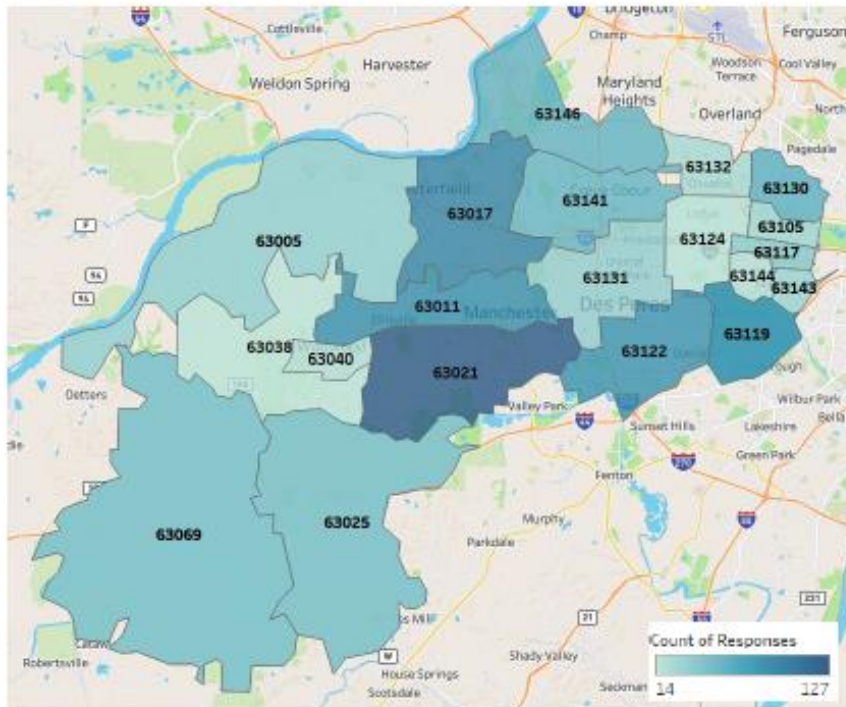
Key Survey Findings



2024 Community Health Needs Assessment Survey

In Mid/West County, 941 community members responded to the community health needs survey. The number of survey respondents in Mid/West St. Louis City ZIP codes ranged between 14 and 127.

Survey Respondents by ZIP code



Notes

Over 21% of respondents in Mid/West County did not complete the optional demographic survey questions (non-respondents range from n=203 to 314, depending on the question).

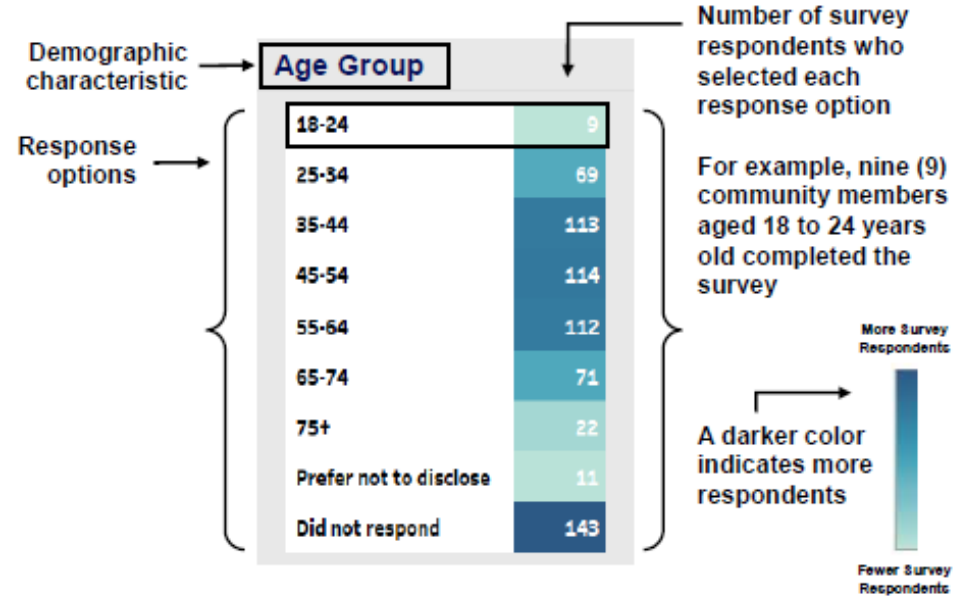
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=941).

Most respondents:

- Are between the age of 55 and 64 years old (16%)
- Are women (61%)
- Are White (65%)
- Are non-Hispanic (62%)
- Speak English at home (76%)
- Have a master's, professional, or doctorate degree (38%)
- Are employed full time (46%)
- Have a household income of \$200,000 or more (16%)

Additional details for each demographic characteristic are provided on the next handout. An example of how to read the demographic visuals is provided to the right.

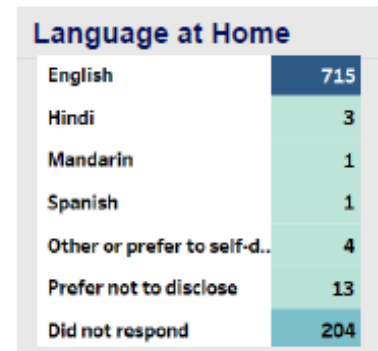
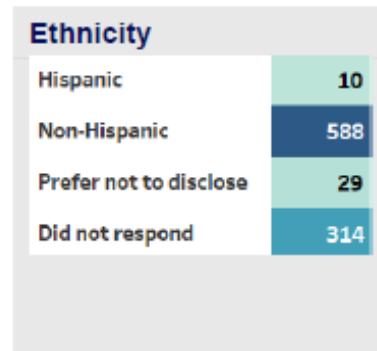
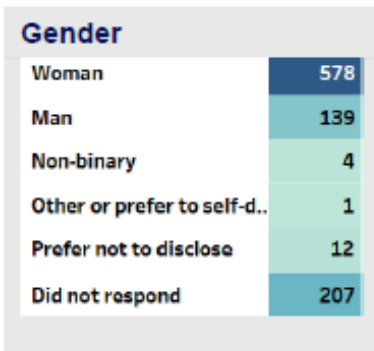
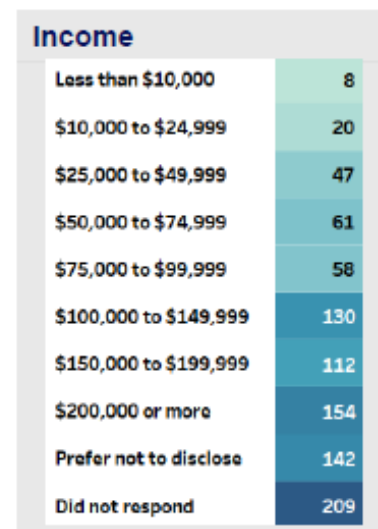
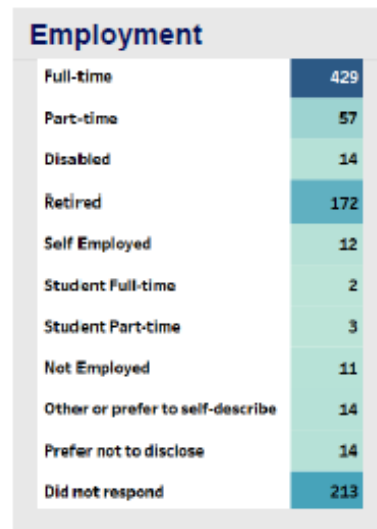
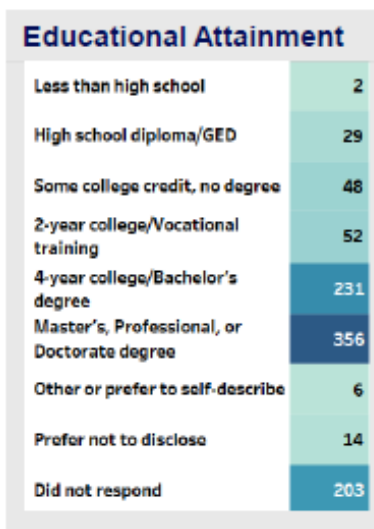
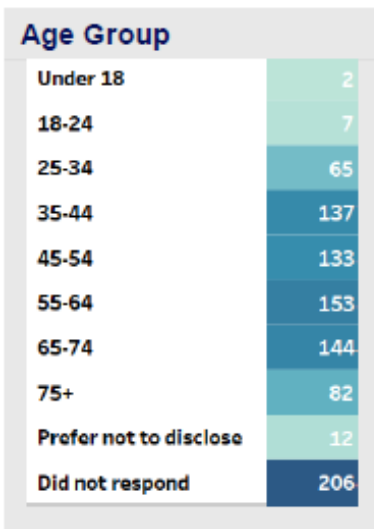
Example: Survey Respondents by Age Group



Notes

Who responded to the survey?

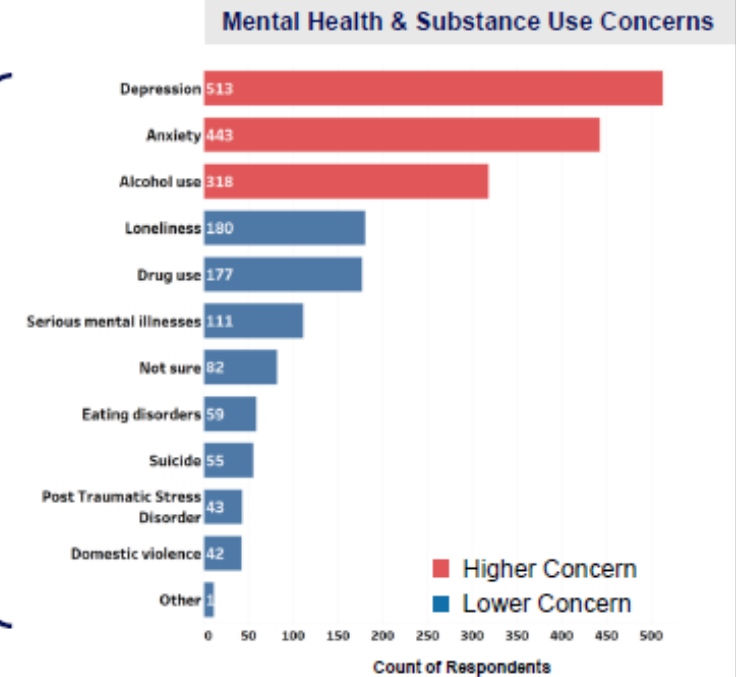
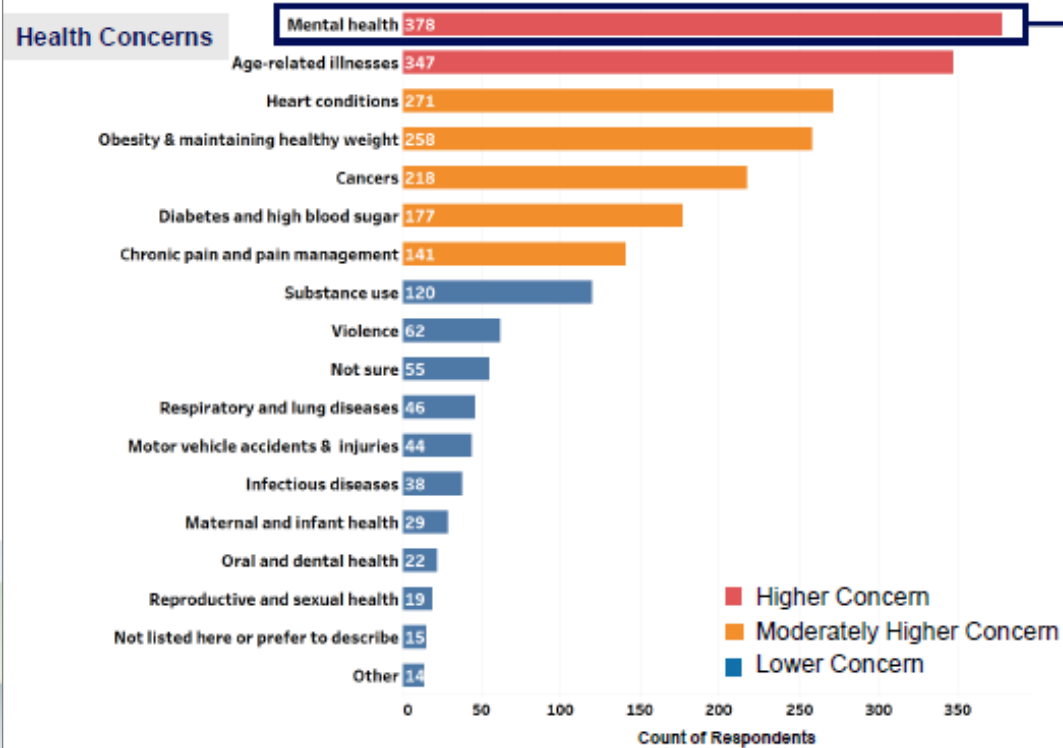
941
Total Respondents in
MidWest County



Thinking about yourself or other adults in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

941
Total Respondents in
Mid/West County

Community members identified **mental health**, **age-related illnesses**, **heart conditions**, **obesity**, and **cancers** as the top health concerns in Mid/West County. Among mental health and substance use-related needs, **depression**, **anxiety**, **alcohol use**, **loneliness**, and **drug use** are top of mind for community members.



Notes

Thinking about yourself or other adults in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

941

Total Respondents In
MidWest County

The table below details the top health concerns among respondents by race. Most of the top health concerns remained consistent across groups with some differences in the order of concerns. Notably, **infectious diseases** were identified as a top concern among respondents of another race.

Health Concerns by Race

■ Higher Concern
■ Moderately Higher Concern
■ Lower Concern

Top Concerns	All Respondents n=941	White n=610	Black or African American n=42	Another Race* n=47	Did not respond or prefer not to disclose n=242
1	Mental health	Mental health	Diabetes	Diabetes	Mental health
2	Age-related illnesses	Age-related illnesses	Age-related illnesses	Mental health	Age-related illnesses
3	Heart conditions	Heart conditions	Obesity	Obesity	Obesity
4	Obesity	Obesity	Heart conditions	Heart conditions	Heart conditions
5	Cancers	Cancers	Mental health	Age-related illnesses	Cancers
6	Diabetes	Diabetes	Chronic pain and pain management	Chronic pain and pain management	Diabetes
7	Chronic pain and pain management	Chronic pain and pain management	Cancers	Cancers	Chronic pain and pain management
8	Substance use	Substance use	Substance use	Infectious diseases	Substance use

Notes: Bolded items are those that were not identified as a top concern among all respondents. Due to small sampling, several racial categories are combined in the *Another Race* category, including American Indian or Alaska Native; Asian; Middle Eastern or North African; Native Hawaiian or Other Pacific Islander; and Other or prefer to self-describe.

Thinking about yourself or other adults in the community where you live, what are the top mental health & substance use problems? (Respondents selected up to 3 items.)

941
Total Respondents in
MidWest County

The table below details the top mental health and substance use concerns among respondents by race. Most of the top concerns remained consistent across groups with some differences in the order of concerns. Notably, **suicide** was identified as a top concern among White respondents, and **domestic violence** was identified as a top concern among Black or African American respondents.

Mental Health & Substance Use Concerns by Race

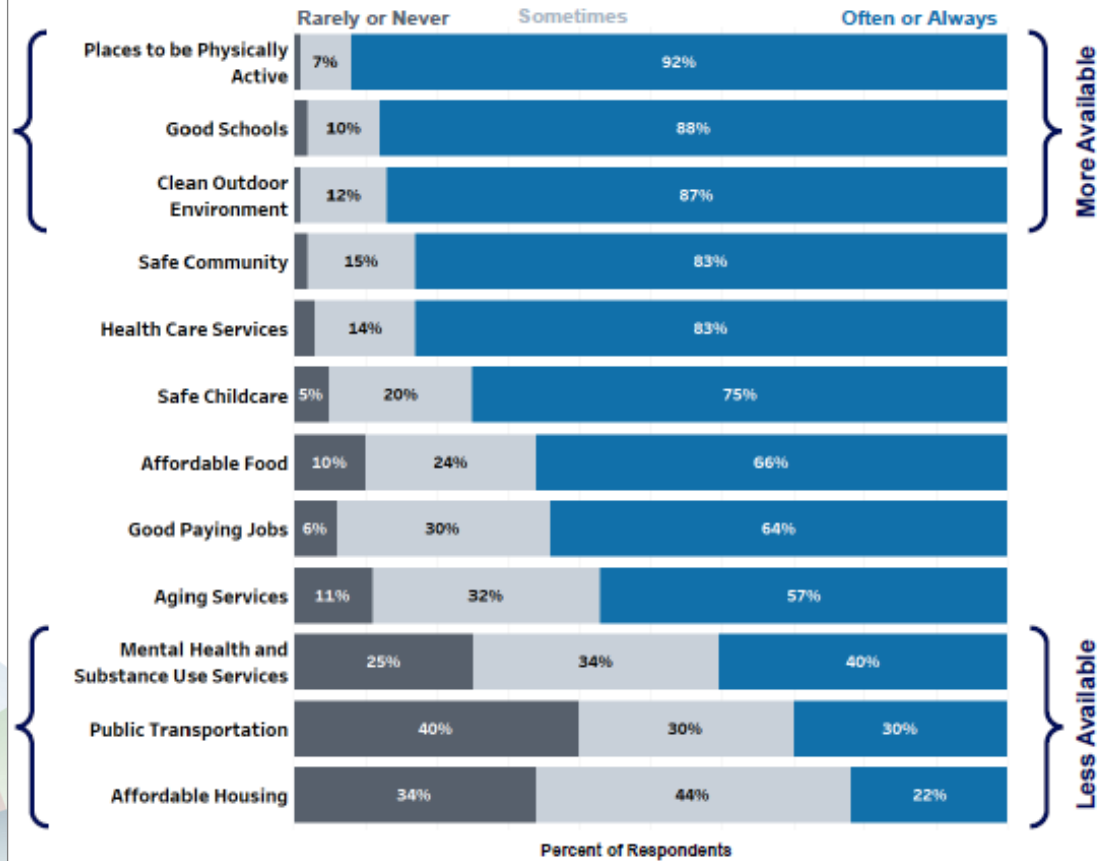
■ Higher Concern
■ Lower Concern

Top Concerns	All Respondents n=941	White n=610	Black or African American n=42	Another Race* n=47	Did not respond or prefer not to disclose n=242
1	Depression	Depression	Depression	Anxiety	Depression
2	Anxiety	Anxiety	Anxiety	Depression	Anxiety
3	Alcohol use	Alcohol use	Alcohol use	Alcohol use	Alcohol use
4	Loneliness	Loneliness	Drug use	Loneliness	Loneliness
5	Drug use	Drug use	Loneliness	Not sure	Drug use
6	Serious mental illnesses	Serious mental illnesses	Serious mental illnesses	Drug use	Serious mental illnesses
7	Not sure	Not sure	Domestic violence	Eating disorders	Not sure
8	Eating disorders	Suicide	Not sure	Serious mental illnesses	Domestic violence

Notes: Bolded items are those that were not identified as a top concern among all respondents. Due to small sampling, several racial categories are combined in Another Race category, including American Indian or Alaska Native; Asian; Middle Eastern or North African; Native Hawaiian or Other Pacific Islander; and Other or prefer to self-describe.

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

941
Total Respondents in MidWest County



Community members rated the availability of several resources in MidWest County.

Places to Physically Active, Good Schools, and Clean Outdoor Environment were rated as being more available, with almost 90% of respondents indicating that the resources were often or always available in their community.

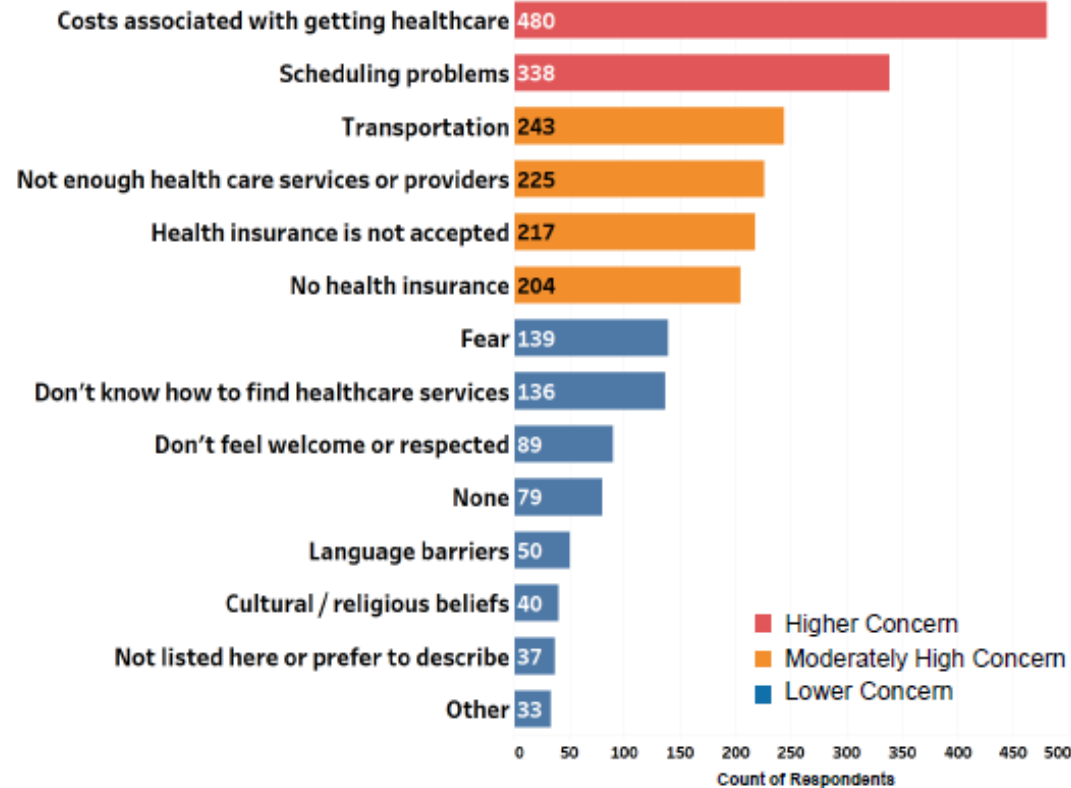
Mental Health and Substance Use Services, Public Transportation, and Affordable Housing were reported to be less available, with 40% or less of respondents indicating that the resources were often or always available in their community.

Notes

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

941
Total Respondents in
Mid/West County

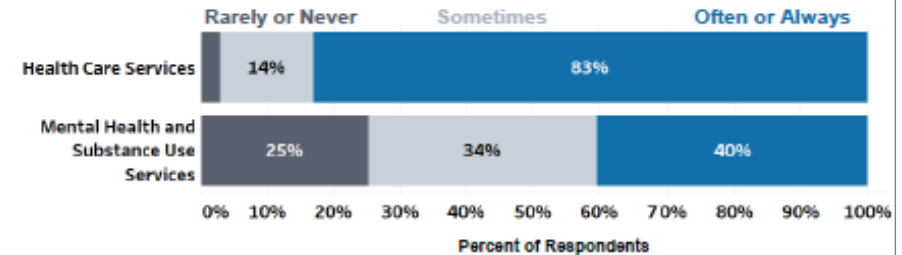
Barriers to Health Care Access



Eighty-three percent (83%) of community members who responded to the survey indicated that health care services were often or always available in Mid/West County. Only 40% indicated that mental health and substance use services had good availability.

Costs, scheduling problems, and transportation were most frequently identified as barriers to accessing health care.

Health Care Service Availability



Notes

Appendix A

Appendix C: Mid/West Stakeholder Conversation Summary

Stakeholder Conversation Summary Report

Geographic Region: Mid-West

Location: St. Luke's Institute for Health Education

Date: July 23, 2024

Number of Participants: 11

Executive Summary

As part of the Collaborative's Community Health Needs Assessment (CHNA), six stakeholder conversations were conducted across the region to gather insights into the health needs and barriers facing diverse populations. The conversations held in the Mid-West region focused on critical health challenges such as mental health, substance use, social determinants of health (SDOH), and access to care.

The group identified mental health as a top priority, noting that the pandemic has exacerbated issues such as anxiety, depression, and substance abuse. Participants consistently cited housing and transportation as significant barriers to health and emphasized the need for better coordination of services to address these challenges. This report synthesizes the key findings from these conversations and offers practical recommendations for improving healthcare access, addressing social determinants of health, and fostering meaningful community engagement.

Introduction

On July 23, 2024, the Collaborative hosted a stakeholder conversation at St. Luke's Institute for Health Education as part of the broader effort to conduct a Community Health Needs Assessment (CHNA) across the St. Louis region. Participants included representatives from community-based organizations, healthcare providers, and social service agencies, all focused on identifying critical health needs and addressing systemic barriers impacting the health and well-being of the Mid-West region's residents.

This report synthesizes insights from the Mid-West region conversations, highlighting key health concerns, recurring themes, and actionable recommendations. The report aims to inform strategic actions that healthcare systems and community organizations can undertake to improve health outcomes and foster stronger community engagement.

Key Health Priorities and Recurring Themes

Mental Health and Substance Use

Mental health emerged as a top priority in both conversations. Participants were surprised that mental health emerged as the number one concern despite the stigma traditionally associated with it. Mental health issues, including anxiety, depression, and substance abuse, have been exacerbated by the pandemic and economic instability.

Fentanyl abuse was identified as an epidemic in certain areas, with participants stressing the need for comprehensive mental health services. They suggested that shifting the language from "mental health" to "wellness" could help reduce stigma and encourage more community engagement. Access to mental health services remains limited, and improving both access and education around mental health was seen as critical to preventing the need for clinical interventions.

Social Determinants of Health (SDOH)

Housing and transportation were consistently identified as major social determinants affecting health outcomes in the Mid-West region. Many participants noted that the CHNA survey data did not adequately reflect the housing needs of communities facing homelessness and instability. Affordable housing, particularly multifamily units, is lacking, and rental assistance programs are limited.

Public transportation options, such as Metro's \$2 service, are available but underutilized due to a lack of awareness. Participants emphasized the need for better communication and coordination around transportation resources to improve access to care and other services.

Access to Healthcare Services

Access to healthcare, particularly for mental health and maternal health services, was a persistent challenge. Participants expressed frustration with long wait times, the shortage of healthcare providers accepting Medicaid, and logistical barriers such as transportation and scheduling. The link between housing insecurity and poor health outcomes, particularly in maternal and infant health, was highlighted. Stakeholders noted that families often struggle to access the resources they need during pregnancy and post-birth due to these systemic challenges.

Challenges and Gaps Identified

Data Representation

Stakeholders raised concerns about the underrepresentation of vulnerable populations in the CHNA survey. Participants noted that traditional survey outreach often excludes

those most affected by housing instability, domestic violence, and mental health challenges. For example, the survey failed to capture the realities of unhoused populations or families living in precarious housing situations.

Stakeholders recommended using community health workers, churches, schools, and grassroots organizations to reach underrepresented populations in future surveys.

Fragmented and Inaccessible Care

The lack of coordination between healthcare providers, community organizations, and social services saw a lack of coordination as a major barrier to effective care. While many resources exist, they are difficult for residents to navigate. Participants emphasized that better integration and communication between service providers would help community members more easily access the help they need. One participant specifically noted the need for a more comprehensive relationship between hospitals and community mental health organizations to ensure seamless referrals and support.

Community Engagement Strategies

Leveraging Trusted Community Organizations

Partnering with trusted community organizations, such as churches, grassroots groups, and local agencies, was seen as essential for reaching vulnerable populations. These organizations have established relationships with residents and can help distribute surveys, gather feedback, and connect individuals to services. Participants suggested working with food pantries, shelters, and schools to engage the community effectively.

Meeting the Community Where They Are

Bringing healthcare services directly to residents was strongly recommended. Participants suggested mobile clinics or community events at schools, churches, grocery stores, and libraries were suggested as ways to engage with residents in familiar, accessible spaces. This approach reduces logistical barriers such as transportation and ensures that healthcare systems can reach more people.

Incentivizing Participation

Participants suggested offering incentives, such as food, transportation passes, or child care, to encourage participation in community conversations and surveys. These incentives make it easier for people to attend and show respect for their time and input.

Ensuring Continuous Engagement

Maintaining long-term relationships with the community was emphasized as critical. Participants recommended hosting regular community meetings, establishing advisory boards, or conducting follow-up surveys to keep the community involved in decision-making processes. Transparency about how feedback is being used and sharing measurable outcomes were seen as essential to maintaining trust and ongoing participation.

Opportunities for Improvement

Strengthening Mental Health Services

Expanding access to mental health services, particularly for substance use disorders and serious psychological illnesses, was a key recommendation. Participants called for more resources to address the mental health crisis, particularly in underserved areas. Schools were identified as key partners in expanding mental health support, with suggestions to embed mental health counselors in schools to provide early intervention.

Addressing Social Determinants of Health

Housing, transportation, and food insecurity were repeatedly mentioned as barriers to health. Improving access to affordable housing, public transportation, and ensuring food security for families were identified as critical steps toward improving overall health outcomes. Participants recommended creating more partnerships between healthcare providers and local government agencies to address these systemic issues.

Coordinating Care Across Organizations

Better coordination between healthcare systems, community organizations, and social services was a recurring theme. Participants suggested creating a centralized database of resources available to the community and ensuring that healthcare providers are aware of all the services that residents can access.

Recommendations for Next Steps

- **Co-Design Future Surveys:** Collaborate with community leaders and residents to design future CHNA surveys to ensure the voices of underrepresented populations are captured. Surveys should be available in multiple languages and paper [formats](#), and distributed through trusted community organizations.
- **Expand School-Based Health Services:** Schools are critical access points for healthcare, especially for mental health. Expanding school-based health programs and embedding mental health counselors in schools will help address mental health needs early.

- **Invest in Mobile Health Services:** Mobile health clinics should be prioritized to bring healthcare services to neighborhoods, schools, and community events. These clinics can help overcome transportation barriers and provide care where it is most needed.
- **Strengthen Partnerships with Community-Based Organizations:** Collaborate with local organizations that have established trust with residents to ensure more effective outreach and service delivery. Working closely with CBOs will help address social determinants of health and tailor services to meet the community's needs.

Conclusion

The stakeholder conversations in the Mid-West region underscored significant health challenges, particularly around mental health, housing, and access to care. Addressing these challenges requires a collaborative approach that involves healthcare systems, schools, community organizations, and local government. By investing in mental health services, addressing social determinants of health, and engaging the community in meaningful ways, healthcare systems can make substantial progress in improving health outcomes for all residents.

Acknowledgments

The St. Louis Regional Hospital Collaborative and Key Strategic Group extend our sincere thanks to the participants of the Mid-West stakeholder conversations for their time, insights, and dedication. We also thank St. Luke's Institute for Health Education for hosting the meeting and providing a welcoming space for these critical discussions.

Appendix A

Appendix D: North St. Louis County Survey Summary Report

North St. Louis County

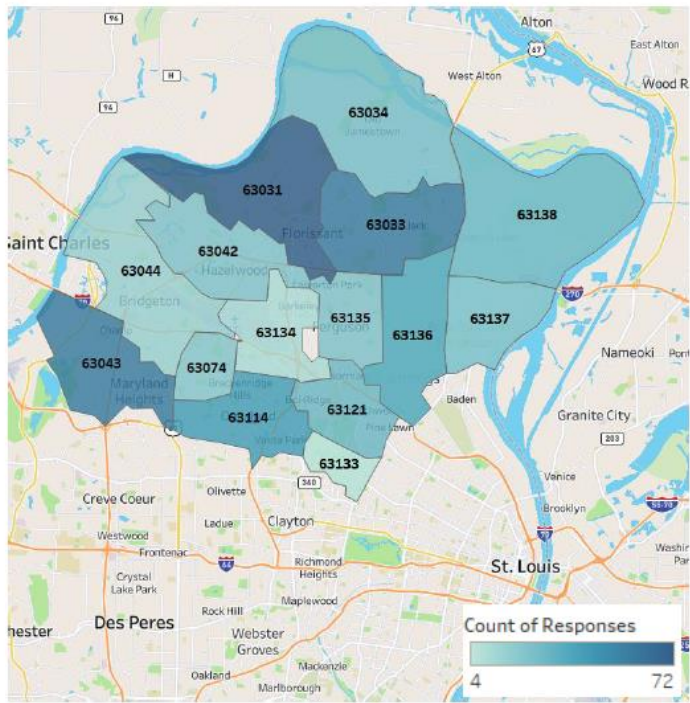
Key Survey Findings



2024 Community Health Needs Assessment Survey

In North County, 449 community members responded to the community health needs survey. The number of survey respondents in North County ZIP codes ranged between 4 and 72.

Survey Respondents by ZIP code



Notes

Over 20% of respondents in North County did not complete the optional demographic survey questions (non-respondents range from n=91 to 171, depending on the question).

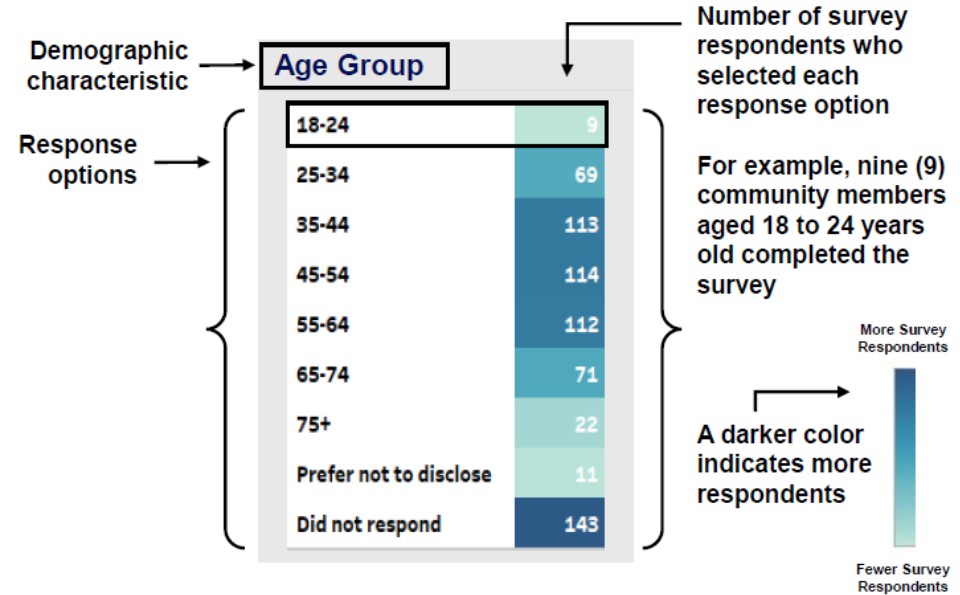
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=449).

Most respondents:

- Are between the age of 55 and 64 years old (19%)
- Are women (63%)
- Are White (35%)
- Are non-Hispanic (55%)
- Speak English at home (78%)
- Have a 4-year college or Bachelor's degree (24%)
- Are employed full time (60%)
- Have a household income between \$100,000 to \$149,999 (14%)

Additional details for each demographic characteristic are provided on the next handout. An example of how to read the demographic visuals is provided to the right.

Example: Survey Respondents by Age Group



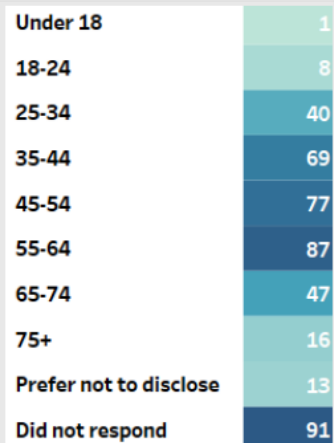
Notes

Who responded to the survey?

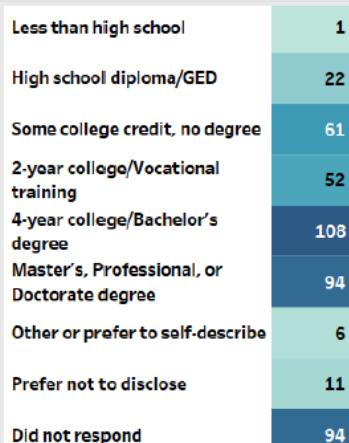
449

Total Respondents in North County

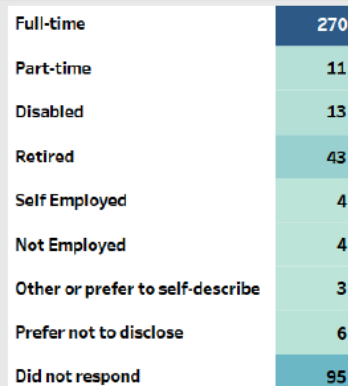
Age Group



Educational Attainment



Employment



Income

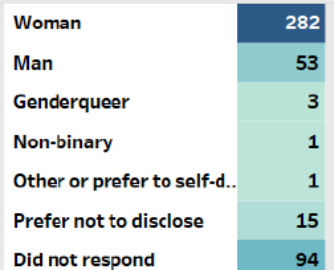


More Survey Respondents



Fewer Survey Respondents

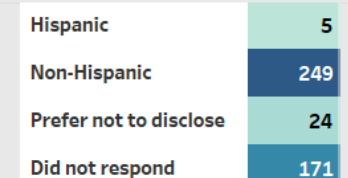
Gender



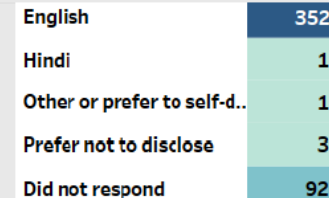
Race



Ethnicity



Language at Home

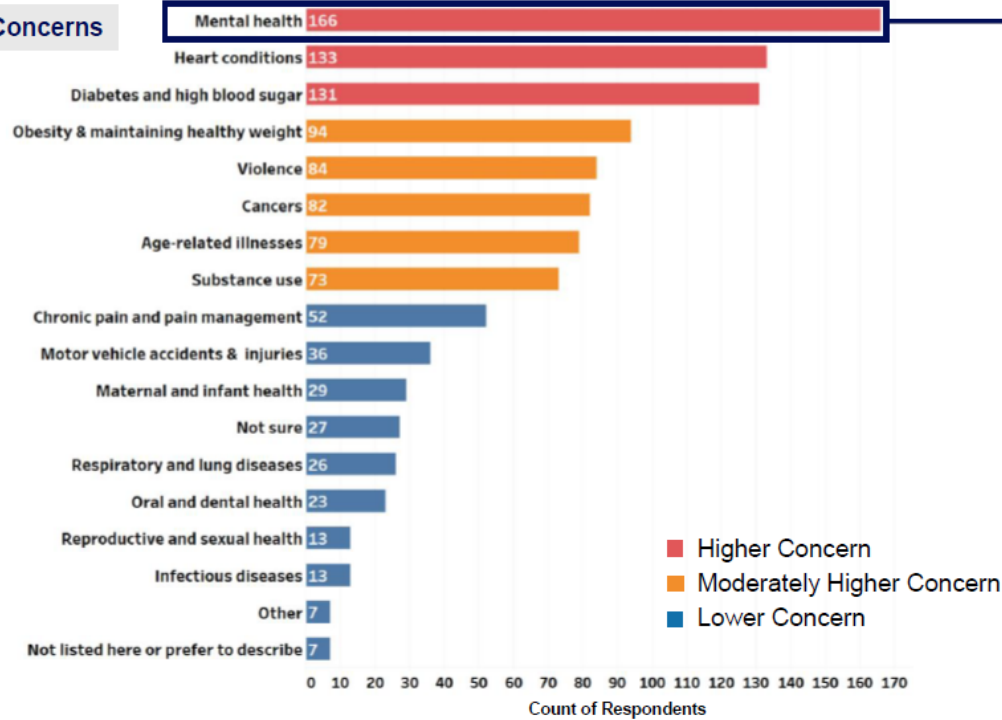


Thinking about yourself or other adults in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

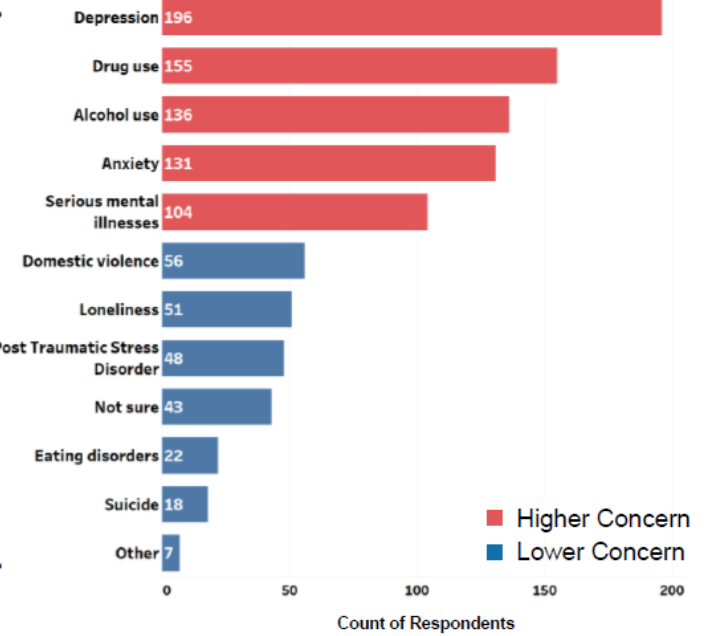
449
Total Respondents in North County

Community members identified **mental health, heart conditions, diabetes, obesity, and violence** as the top health concerns in North County. Among mental health and substance use-related needs, **depression, drug use, alcohol use, anxiety, and serious mental illnesses** are top of mind for community members.

Health Concerns



Mental Health & Substance Use Concerns



Notes

Thinking about yourself or other adults in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

449

Total Respondents in North County

The table below details the top health concerns among respondents by race. Most of the top health concerns remained consistent across groups with some differences in the order of concerns. Notably, **chronic pain and pain management** were identified as a top concern by respondents who are Black or African American or another race. Additionally, **environmental health** was identified as a top concern by respondents of another race.

Health Concerns by Race

■ Higher Concern
■ Moderately Higher Concern

Top Concerns	All Respondents n=449	White n=159	Black or African American n=150	Another Race* n=14	Did not respond or prefer not to disclose n=126
1	Mental health	Mental health	Diabetes	Substance use	Mental health
2	Heart conditions	Heart conditions	Heart conditions	Obesity	Obesity
3	Diabetes	Age-related illnesses	Mental health	Heart conditions	Diabetes
4	Obesity	Violence	Obesity	Age-related illnesses	Substance use
5	Violence	Diabetes	Cancers	Mental health	Heart conditions
6	Cancers	Cancers	Violence	Violence	Age-related illnesses
7	Age-related illnesses	Obesity	Chronic pain and pain management	Chronic pain and pain management	Cancers
8	Substance use	Substance use	Substance use	Environmental health*	Violence

Notes: Bolded items are those that were not identified as a top concern among all respondents. Due to small sampling, several racial categories are combined in the *Another Race* category, including: American Indian or Alaska Native; Asian; Middle Eastern or North African; Native Hawaiian or Other Pacific Islander; and Other or prefer to self-describe. Conditions related to environmental health was described by at least two respondents in open-ended responses.

Thinking about yourself or other adults in the community where you live, what are the top mental health & substance use problems? (Respondents selected up to 3 items.)

449

Total Respondents in
North County

The table below details the top mental health and substance use concerns among respondents by race. Most of the top concerns remained consistent across groups with some differences in the order of concerns. Notably, **eating disorders** were identified as a top concern among respondents of another race, and among this same group, **Post Traumatic Stress Disorder** ranked much higher in the order of top concerns.

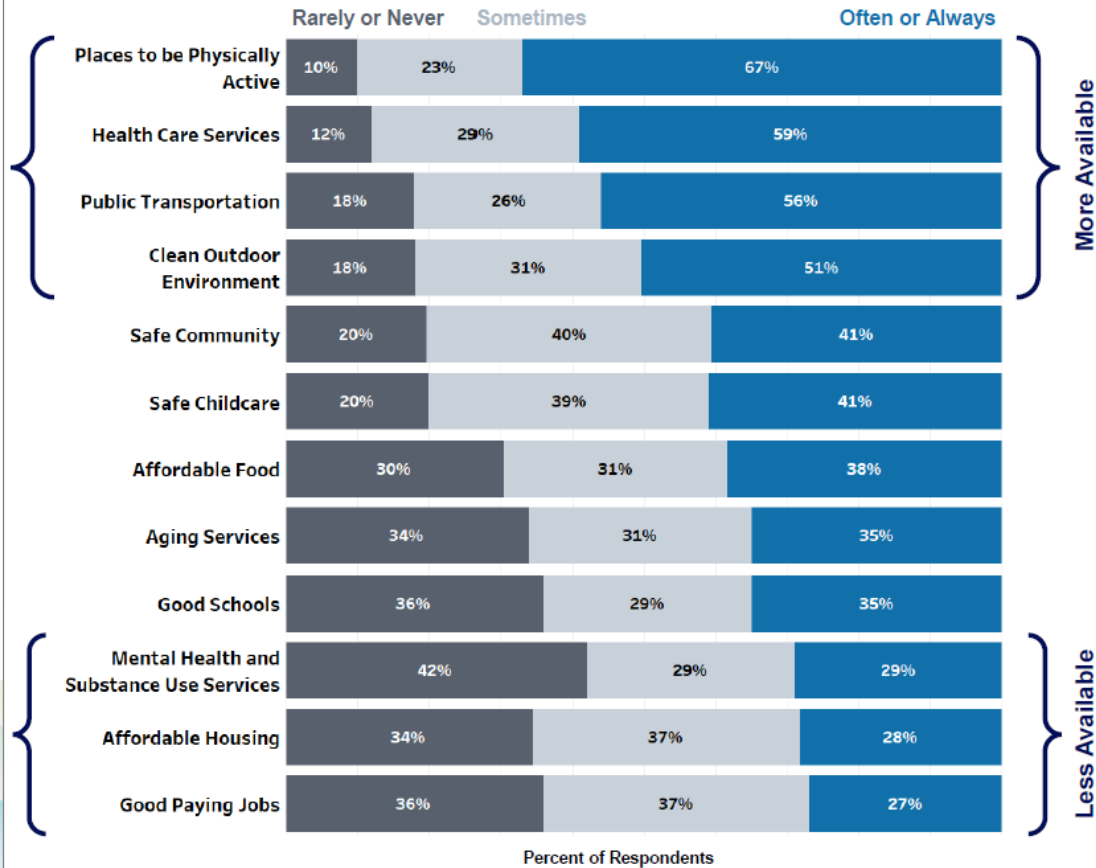
Mental Health & Substance Use Concerns by Race

■ Higher Concern
■ Lower Concern

Top Concerns	All Respondents n=449	White n=159	Black or African American n=150	Another Race* n=14	Did not respond or prefer not to disclose n=126
1	Depression	Depression	Depression	Post Traumatic Stress Disorder	Drug use
2	Drug use	Anxiety	Drug use	Depression	Depression
3	Alcohol use	Alcohol use	Alcohol use	Anxiety	Alcohol use
4	Anxiety	Drug use	Serious mental illnesses	Serious mental illnesses	Serious mental illnesses
5	Serious mental illnesses	Serious mental illnesses	Anxiety	Loneliness	Anxiety
6	Domestic violence	Domestic violence	Domestic violence	Eating disorders	Not sure
7	Loneliness	Loneliness	Post Traumatic Stress Disorder	Drug use	Post Traumatic Stress Disorder
8	Post Traumatic Stress Disorder	Not sure	Loneliness	Alcohol use	Domestic Violence

Notes: Bolded items are those that were not identified as a top concern among all respondents. Due to small sampling, several racial categories are combined in *Another Race* category, including American Indian or Alaska Native; Asian; Middle Eastern or North African; Native Hawaiian or Other Pacific Islander; and Other or prefer to self-describe.

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



Community members rated the availability of several resources in North County.

Places to be physically active, health care services, public transportation, and clean outdoor environment were rated as being more available, with over 50% of respondents indicating that the resources were often or always available in their community.

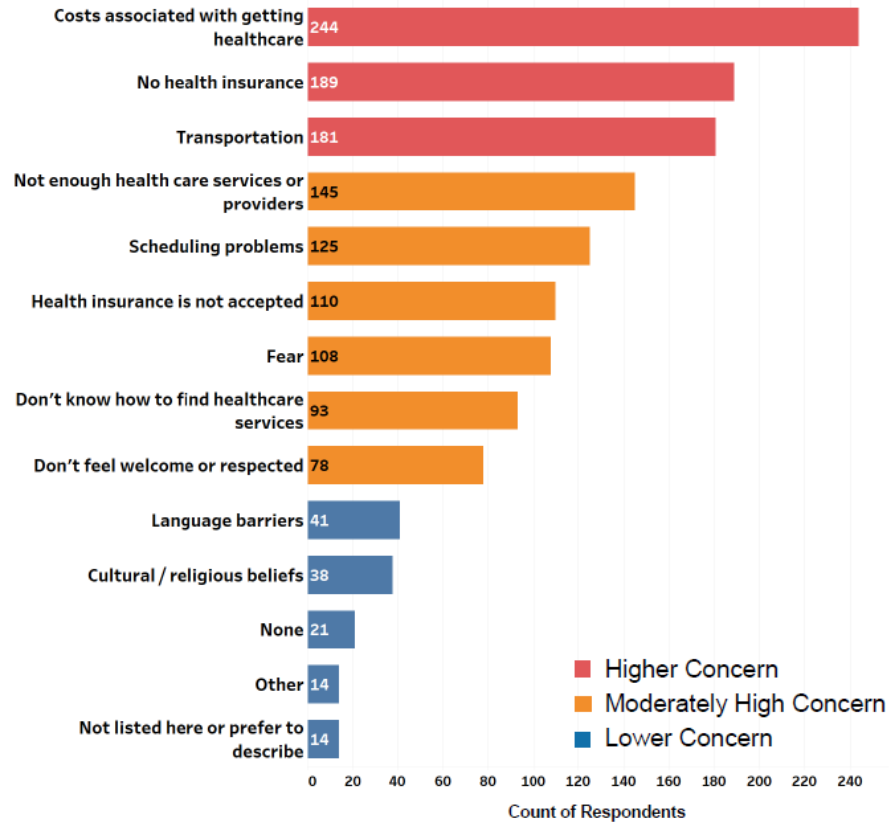
Mental health and substance use services, affordable housing, and good paying jobs, were reported to be less available, with less than 30% indicating that the resources were often or always available in their community.

Notes

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

449
Total Respondents in North County

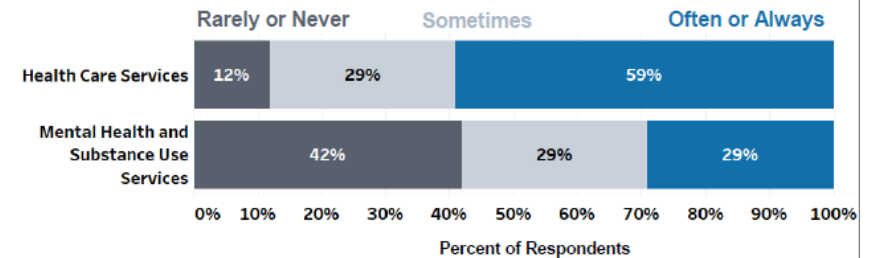
Barriers to Health Care Access



More than fifty percent (59%) of community members who responded to the survey indicated that health care services were often or always available in North County. Only 29% indicated that mental health and substance use services had good availability.

Costs, lack of insurance, and transportation were most frequently identified as barriers to accessing health care.

Health Care Service Availability



Notes

Appendix A

Appendix E: North Stakeholder Conversation Summary

Stakeholder Conversation Summary Report

Geographic Region: North County

Location: Beyond Housing Date: July 16, 2024

Number of Participants: 30

Executive Summary

As part of the Collaborative's Community Health Needs Assessment (CHNA), six stakeholder conversations were conducted across the region to gather insights into the health needs and barriers facing diverse populations. The conversation held in North County focused on critical health challenges such as mental health, substance use disorders (SUD), access to care, and the social determinants of health.

Mental health emerged as a top priority, particularly within Communities of Color, where stigma and limited access to culturally competent care exacerbate existing disparities. Social determinants such as transportation, housing instability, and food insecurity emerged as significant factors affecting health outcomes. Mistrust between marginalized communities and healthcare institutions continues to present challenges in accessing care. This report synthesizes these findings and offers practical recommendations for addressing these barriers, improving community engagement, and enhancing healthcare services through integrated and community-driven models.

Introduction

On July 16, 2024, the Collaborative held a stakeholder conversation at Beyond Housing in North County, part of the broader effort to conduct a Community Health Needs Assessment (CHNA) across the St. Louis region.

Participants included representatives from community-based organizations, healthcare institutions, and service providers, all focused on identifying health priorities and addressing systemic barriers impacting the health and well-being of the region's diverse populations.

This report synthesizes insights from the North County conversation, highlighting key health concerns, recurring themes, and actionable recommendations. The report aims to inform the strategic actions that healthcare systems and community organizations can undertake to improve health outcomes and foster stronger community engagement.

Key Health Priorities and Recurring Themes

Mental Health and Substance Use Disorders (SUD)

All stakeholder groups identified mental health as the most pressing health issue. Participants emphasized the need for accessible, affordable, and culturally competent mental health services, especially in communities dealing with trauma, stress, and insufficient resources. The groups specifically highlighted mental health and substance use disorders, with many communities grappling with both issues simultaneously.

Many pointed to the stigma surrounding mental health, particularly in Communities of Color, as a major barrier to seeking help. Stakeholders stressed the importance of normalizing mental health care, reducing stigma, and integrating mental health services within the community to improve access.

Social Determinants of Health (SDOH)

North County stakeholders identified transportation, housing instability, and food insecurity as significant social determinants affecting health outcomes in their region. The group also identified affordable housing as a pressing issue, with participants noting the negative health impacts of housing instability. North County residents also identified limited public transportation as another critical barrier, where residents face long commutes and inadequate transit options to access healthcare and other services. Addressing these social determinants is essential for improving overall health outcomes and reducing health disparities in the region.

Access to Care

Access to healthcare remains a major challenge due to barriers such as long appointment wait times, a lack of nearby clinics, and difficulties navigating the healthcare system. Geographic disparities in healthcare availability were noted, particularly in lower-income areas with few urgent care centers and hospitals. Participants emphasized the need for more culturally competent care and improved health literacy to help patients understand their treatment plans and feel empowered to manage their health.

Trust and Mistrust in Healthcare Systems

The recurring theme of mistrust between marginalized communities and healthcare institutions emerged throughout the conversation. Historical experiences of systemic neglect, racism, and poor communication have eroded trust in the healthcare system. To rebuild this trust, participants recommended sustained, transparent engagement where hospitals demonstrate accountability and show measurable progress in addressing community concerns.

Challenges and Gaps Identified

Survey Representation and Data Limitations

Participants expressed concerns about the limited representation of marginalized communities in the CHNA survey. The reliance on online surveys excluded individuals without reliable internet access or digital literacy. Future assessments should employ more inclusive methods, such as in-person outreach and partnerships with trusted community organizations, to accurately represent community needs.

Fragmented and Inaccessible Care

Healthcare delivery in North County is often fragmented, leaving patients to navigate disjointed systems that fail to provide continuous, holistic care. Long wait times for specialty services and inadequate insurance coverage exacerbate these challenges, particularly for low-income populations. Stakeholders suggested that mobile clinics and community-based health services could help address these barriers by providing care where needed most.

Sustainability of Community Engagement Efforts

Participants raised concerns about the sustainability of current community engagement initiatives, many of which are short-lived and fail to deliver long-term, measurable results. Stakeholders recommended that healthcare systems invest in continuous, meaningful engagement, ensuring community input directly informs policies and practices.

Community Engagement Strategies

Meeting Communities Where They Are

Participants recommended engaging communities in their own spaces, emphasizing conducting outreach at trusted community locations such as churches, schools, community centers, and local events. This approach reduces barriers to participation and creates environments where residents feel comfortable sharing their concerns. Participants suggested hosting forums in libraries or using door-to-door outreach to ensure engagement in familiar, accessible environments.

Leveraging Trusted Community Leaders and Organizations

Groups repeatedly emphasized working with trusted community leaders—including clergy, grassroots organizers, and established community health workers (CHWs)—as essential for building credibility within the community. Healthcare systems should form long-term partnerships with these leaders and ensure they have the resources to drive engagement efforts effectively.

Utilizing Community Health Workers (CHWs)

Participants viewed CHWs as critical assets in bridging the gap between healthcare systems and underserved populations. Stakeholders recommended expanding CHW programs, particularly in areas where residents face transportation, language, and health literacy barriers. CHWs are key in providing culturally competent care, building trust, and connecting residents to necessary services. Sustainable funding for these roles is crucial.

Ensuring Diverse and Inclusive Participation

To ensure inclusivity, stakeholders recommended using multiple methods to engage underrepresented groups, including offering surveys in multiple languages, providing digital and paper formats, and offering incentives such as gift cards or meals. Participants saw collaborating with organizations that serve specific populations—such as immigrant communities and minority groups—as essential for effective, culturally tailored outreach.

Transparency and Accountability in Engagement

Participants emphasized transparency in engagement as critical to rebuilding trust. Healthcare systems should clearly communicate the purpose of engagement efforts, provide regular updates on how community input is used, and share measurable outcomes with the community. This feedback loop is essential to demonstrating that community voices drive meaningful change.

Sustaining Momentum

Participants stressed the need for ongoing engagement beyond one-time meetings or surveys. Recommendations included holding regular community forums, partnering with local organizations for continuous dialogue, and creating advisory groups that include community members in decision-making. Utilizing digital platforms, such as social media, can also help keep residents informed and engaged between in-person events.

Opportunities for Improvement

Mobile and Pop-Up Clinics

Groups saw the expansion of mobile health clinics and pop-up services as an effective strategy for improving access to care in underserved areas. These clinics could offer primary care, mental health services, and substance use treatment, bringing care directly into the community and addressing geographic and transportation barriers.

Address Social Determinants of Health

Hospitals and healthcare providers must integrate social determinants of health into their strategic planning and service delivery. This includes addressing transportation, housing, and food insecurity through partnerships with local organizations and advocating for policies that improve the social conditions impacting health.

Conclusion

The stakeholder conversations in North County underscored the significant health challenges faced by the community, including mental health, access to care, and social determinants of health. By investing in community-driven approaches, expanding mobile health services, and strengthening partnerships with trusted community organizations, healthcare systems can take concrete steps toward health equity and improve resident outcomes.

Acknowledgments

The St. Louis Regional Hospital Collaborative and Key Strategic Group sincerely thank the North County stakeholder conversation participants for their time, insights, and dedication. We also thank Beyond Housing for hosting the meeting and providing a welcoming space for these critical discussions.