

Community Health Needs Assessment

Mercy Hospital St. Louis

Fiscal Year 2022





Our Mission

As the Sisters of Mercy before us,
we bring to life the healing ministry of Jesus
through our compassionate care
and exceptional service.

Our Values

Dignity
Excellence
Justice
Service
Stewardship

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Impact Evaluation of Previous CHNA

Based on the findings of the 2019 Community Health Needs Assessment (CHNA), Mercy Hospital St. Louis chose to address four significant health needs, all through the lens of health equity and with particular concern with racial disparities in health outcomes in our region:



Impact Evaluation of Previous CHNA

Mercy Hospital St. Louis' (MHSL) identified priorities were in alignment with the three overarching regional priorities identified through the St. Louis Partnership for a Healthy Community (STLPHC):

- Address the social determinants of health as root causes of community health
- Eliminate the disparities in health and promote health and racial equity
- Improve the local public health system to be able to collectively address the needs of the region

Mercy Hospital St. Louis committed to aligning strategic efforts around the four priority areas with the objectives of the STLPHC through participation and engagement in the following action teams:

- Improving Access to Community Health (encompassing behavioral health), led by the Behavioral Health Network of Greater St. Louis and the St. Louis Regional Health Commission
- Chronic Disease Prevention and Management, led by Healthier Together STL
- Maternal, Child, and Family Health, led by Generate Health STL

See Appendix A for more on the STLPHC, or view the overview outlined in the Assessment Process section.



Impact Evaluation of Previous CHNA

Access to Care – Community Health Workers

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 through the piloting of a social needs screening program beginning in December 2020. New workflows were adopted to screen all uninsured/self-pay ED patients for pressing social needs, with referrals then made to one of three (3) CHWs serving the hospital.

CHWs serve three primary functions in the Emergency Department:

- To connect patients to community resources for social needs
- To assist patients with applying for Medicaid, marketplace insurance, disability, or hospital charity care
- To collaborate with Community Referral Coordinators to establish patients with primary care

CHWs also 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.



Impact Evaluation of Previous CHNA

Access to Care – CHW Clinic Expansion

Mercy Hospital St. Louis hired a CHW to serve the Ferguson community through integration within Mercy Clinic Primary Care – Ferguson, which opened in July 2021. Prior to the clinic's opening, this co-worker built relationships with local agencies, stakeholders, non-profits and individuals, dedicated time to COVID-19 education and vaccination events, and assessing community needs.

Once the clinic opened its doors, the CHW continued community engagement and worked collaboratively with clinic staff to serve these primary functions:

- To connect patients to community resources for social needs
- To assist patients with applying for Medicaid, marketplace insurance, disability, or hospital charity care, particularly to remove barriers to accessing the clinic
- To support patients in navigating the health care system, including specialty care
- To help plan and implement a prescription assistance program, a nutrition support program, holiday outreach programs, and Narcan outreach
- To coordinate community classes at the clinic's education space.



Impact Evaluation of Previous CHNA

Access to Care – CHW Outcomes

535 patients served
813 encounters
FY2020⁺

643 patients served
1,212 encounters
FY2021

1,953 patients served
4,567 encounters
FY2022 Q1-Q3

- From FY20-FY22, Mercy Hospital St. Louis' CHW program saw a **265%** increase in patients served, with a **462%** increase in patient encounters
- By the close of Q3FY22, CHWs served **28%** of all self-pay ED patients

+Nov 2019 – June 2020



Impact Evaluation of Previous CHNA

Access to Care – Community Referral Coordinator (CRC)

The Community Referral Coordinator (CRC) program, implemented through the Integrated Health Network (IHN), connects patients from inpatient units and/or the emergency department with a primary care home for follow-up and preventative care. The CRC focuses on serving underinsured and uninsured patients; however, it works with all patients in need of a medical home. Community Referral Coordinators are employees of the IHN who work on-site in the hospital.

1,734 patient encounters
66% appointments kept
FY2020

1,840 patient encounters
70% appointments kept
FY2021

884 patient encounters
67% appointments kept
FY2022 Q1-Q2*



Impact Evaluation of Previous CHNA

Behavioral Health (Mental Health & Substance Use)

Through partnership with Behavioral Health Network, Mercy Hospital St. Louis implements several behavioral health programs for Emergency Department and inpatients:

- **Emergency Room Enhancement Project (ERE)** and the **Youth Emergency Room Enhancement Project (Y-ERE)**: focus on enhancing support for adult and youth high utilizers of ER with the primary goal of reducing preventable hospital contacts across the region by fostering engagement through support, intensive outreach and improving outcomes through connection to community.
- **Engaging Patients in the Care Coordination Program (EPICC)**: focus on intensive referral and linkage services by Recovery Coaches, peers with lived experience, to impact those who have overdosed on opioids to establish immediate linkages to substance use and medication assisted treatment services.
- **Hospital Community Linkages (HCL) Project**: focus on enhancing transitions from hospital inpatient psychiatric care settings to community care at the region's safety-net Community Mental Health Centers (CMHCs).



Impact Evaluation of Previous CHNA

Behavioral Health (Mental Health & Substance Use)

	FY2020	FY2021	FY2022
ERE	210 patient referrals 85% engagement rate ERE FY2020	341 patient referrals 75% engagement rate ERE FY2021	282 patient referrals 77% engagement rate ERE FY2021
EPICC	102 patient referrals 89% connection rate EPICC FY2020	155 patient referrals 86% connection rate EPICC FY2021	110 patient referrals 76% connection rate EPICC FY2021
HCL	140 patient encounters 59% appointments kept HCL FY2020	209 patient encounters 88% appointments kept HCL FY2021	140 patient encounters 80% appointments kept HCL FY2021



Impact Evaluation of Previous CHNA

Chronic Disease Prevention and Management (Diabetes)

Diabetes Prevention Program (DPP)

DPP implementation was impacted by the COVID-19 pandemic and co-worker staffing in Mercy's East region. However, since May 2020, **113** referrals were made to DPP, with 17 participants successfully completing the program. Two CHWs were trained in the DPP curriculum in order to support Mercy's diabetes prevention efforts within our underserved populations.

St. Louis Regional Diabetes Collaborative

Mercy Hospital St. Louis continued ongoing participation in the St. Louis Diabetes Collaborative, along with representatives from Mercy Hospital South, Christian Hospital (BJC), Missouri Baptist Medical Center (BJC), Barnes-Jewish West County Hospital (BJC), St. Luke's Hospital, St. Luke's Des Peres Hospital, Oasis, Washington University in St. Louis, and the St. Louis County Department of Public Health. While this group planned to co-develop and pilot a regional clinical diabetes education program to reduce risks for diabetic patients, the pandemic halted collaborative meetings and postponed the program. The collaborative is committed to reassessing needs in FY23.



Impact Evaluation of Previous CHNA

Maternal & Child Health

Centering Pregnancy

Centering Pregnancy is a national, evidence-based program for prenatal care that includes monthly individual health check-ups with additional time and attention in a group setting. Since 2017, Mercy Family Medicine physicians have partnered with Good Shepherd Family Children & Family Services to provide Centering Pregnancy on-site to Good Shepherd clients. Due to the COVID-19 pandemic, restrictions on in-person group meetings and limited occupancy in residential homes, the Centering Pregnancy program could not be implemented.

Generate Health | FLOURISH St. Louis

Continuing in collaboration with Generate Health, Mercy Hospital St. Louis served as a partner on the Infant Health Action Team and has committed to ongoing engagement with the Safe Sleep First initiative. This initiative is also supported by Barnes Jewish Hospital and SSM Health in decreasing Maternal/Child Health and infant mortality rates by addressing disparities and providing education and resources related to safe sleep practices.

Impact Evaluation of Previous CHNA

COVID-19 Pandemic Response

Recognizing the ongoing economic hardship, stress and emotional trauma that the COVID-19 pandemic continues to bring to individuals and families, and understanding that it is often the most vulnerable that are impacted the most in times of crisis, Mercy continued to engage with community partners in COVID-19. In particular, individuals experiencing homelessness may be at increased risk of infection and complication from the COVID-19 virus. Community Health Leaders across Mercy's hospitals worked with local partner agencies to develop comprehensive plans for safely discharging COVID-19 patients to a designated location if they do not require hospitalization but lack housing. At Mercy Hospital St. Louis, the Community Health Leader collaborated with local social service and homeless serving agencies and healthcare providers in order to successfully enact a plan that aligns local resources with regional protocols. Other community services offered by Mercy Hospital St. Louis during the COVID-19 pandemic include:

- Community COVID-19 testing sites
- Community-based mass vaccination event in North St. Louis County, in partnership with Southeast Ferguson Community Association (SEFCA) and Riverview Gardens School District
- Community education materials and events, focusing on racial inequity

Executive Summary

Mercy Hospital St. Louis (MHSL) is a 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. MHSL'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.

MHSL's primary service area is St. Louis County. Throughout the county, Mercy operates Mercy Clinic physician offices, outpatient hospital services and Mercy-GoHealth 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 MHSL'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 organizations in understanding community issues.

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 a 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 a part of that process, each hospital is required to solicit input from those who represent the broad interests of the community served by the hospital as well as those who have special knowledge and expertise in the area of public health and underserved populations. For this year's CHNA, we gathered and analyzed health-related information and statistics from both St. Louis County and the City of St. Louis and sought out more granular data concerning Mercy service areas, when available and appropriate.

Executive Summary *(continued)*

Our final report includes data garnered through surveys of community residents and organizational stakeholders, as well as focus groups conducted within neighborhoods of our larger service area. The CHNA identified seven top-priorities of which five 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
- Maternal and Child Health
- Behavioral Health
- Trauma-Informed Care
- Health Equity

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. I welcome any thoughts you may have on ways to achieve our goal for a healthier community.



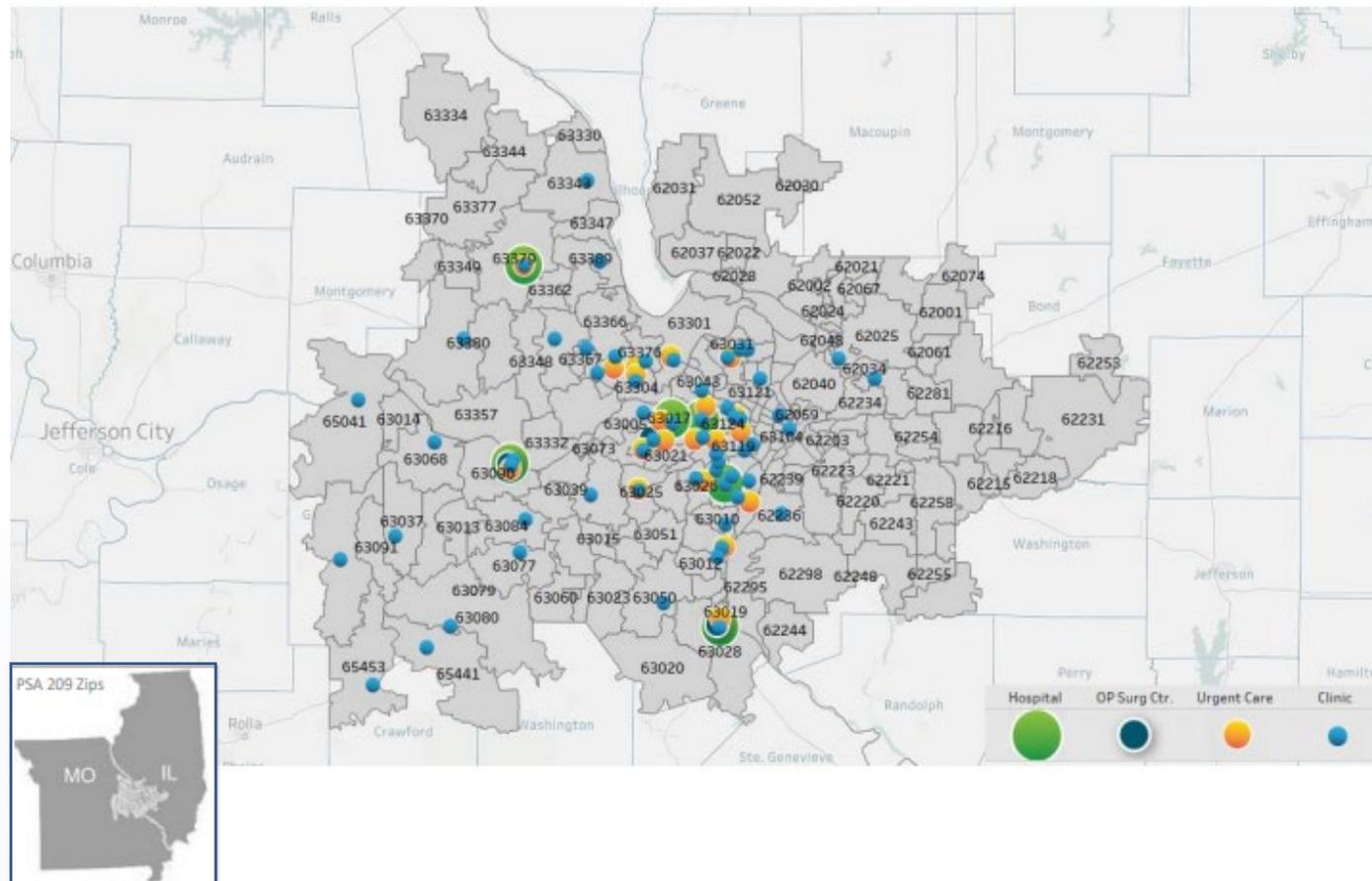
A handwritten signature in black ink that reads "David Meiners".

David Meiners, M.D.
President
Mercy St. Louis

Community Profile

Defining the Community

Mercy Hospital St. Louis (MHSL) is located in Creve Coeur, MO, in West St. Louis County, and has an extended 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.





Community Profile

Defining the Community

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 purpose of the CHNA, MHSL defines its primary community as the **West, Inner North, and Outer North** regions of St. Louis County, as well as **St. Louis City**. This accounts for Mercy's location, as well as historical and persisting health inequities across the St. Louis region.

While MHSL has not previously included St. Louis City within its definition of community, the opening of Mercy Clinic North St. Louis, as well as evolving collective efforts to increase connectivity and eliminate racial and socioeconomic disparities across our region, require us to think and work more collaboratively with partners across both St. Louis City and County.

Community Profile

St. Louis Community Overview

St. Louis County and St. Louis City are respectively ranked **26th** and **111th** of 115 counties in Missouri for health outcomes, according to County Health Rankings and Roadmaps (2022). See Appendix for full County Health Rankings Report for each community.

					
	Total Population	Median Household Income	Bachelor's Degree or Higher	Total Housing Units	No Health Care Insurance
St. Louis City	301,578	\$43,896	36.33%	176,729	10.8%
St. Louis County	1,004,125	\$67,420	43.65%	440,960	6.1%

Source: St. Louis Partnership for a Healthy Community, 2022 CHA

Community Profile

Demographics

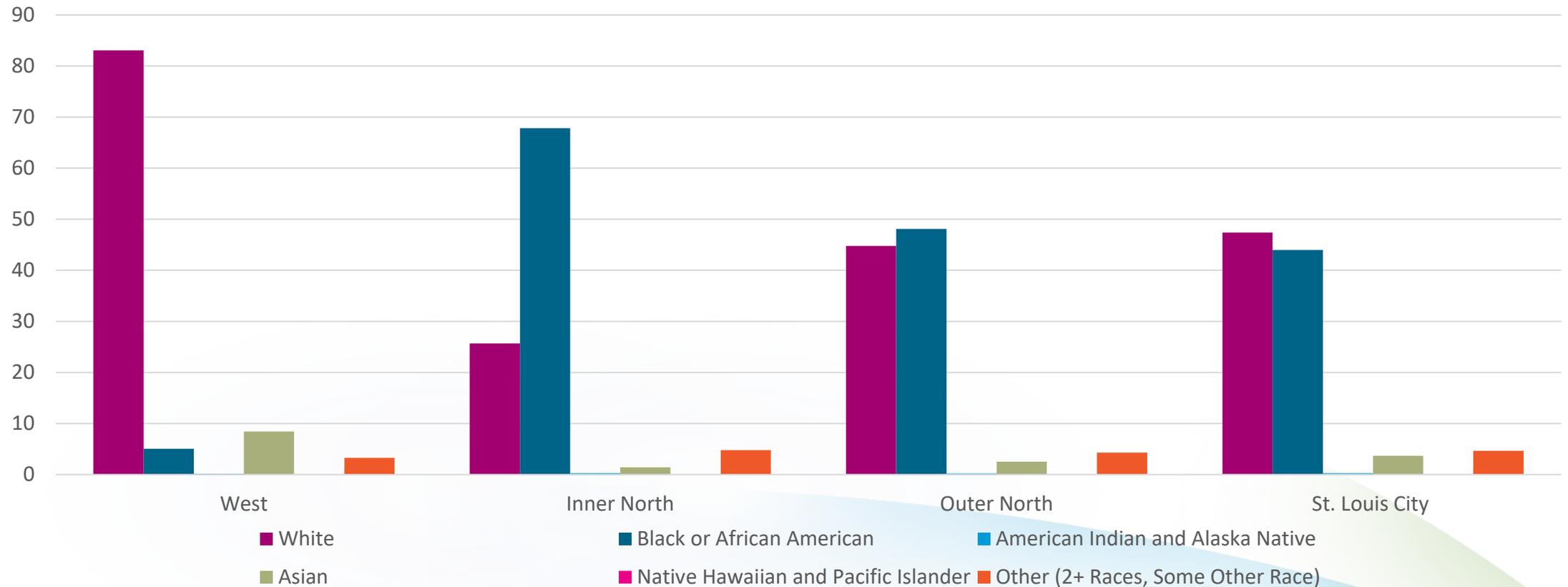
Age and Racial Distribution	West Region	Inner North Region	Outer North Region	St. Louis City	St. Louis County
Population size (number of persons)	304,849	176,413	180,798	293,051	992,691
Age distribution					
Under 18 years	20.66%	25.95%	21.89%	19.34%	21.61%
18 to 44 years	31.20%	35.52%	34.77%	41.41%	33.47%
45-64 years	26.82%	23.29%	25.10%	23.60%	25.25%
65 years and over	21.32%	15.25%	18.25%	15.67%	19.67%
Race distribution					
White	83.05%	25.65%	44.78%	47.40%	65.91%
Black or African American	5.04%	67.83%	48.12%	43.97%	25.26%
American Indian and Alaska Native	0.19%	0.27%	0.21%	0.25%	0.21%
Asian	8.43%	1.43%	2.55%	3.69%	4.91%
Native Hawaiian and Other Pacific Islander	0.02%	0.02%	0.03%	0.04%	0.02%
Other (2+ Races, Some Other Race)	3.27%	4.80%	4.32%	4.66%	3.68%
Ethnicity distribution					
Hispanic or Latino (of any race)	3.27%	4.30%	2.95%	4.51%	3.28%

Source: ThinkHealthSTL, 2022

Community Profile

Demographics

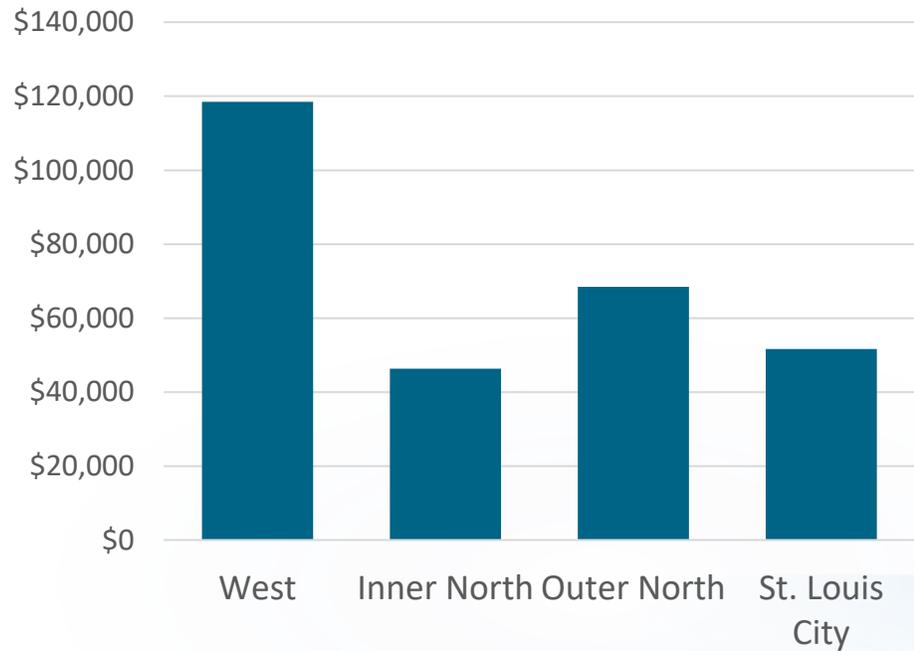
Population by Race



Source: ThinkHealthSTL, 2022

Community Profile

Median Household Income

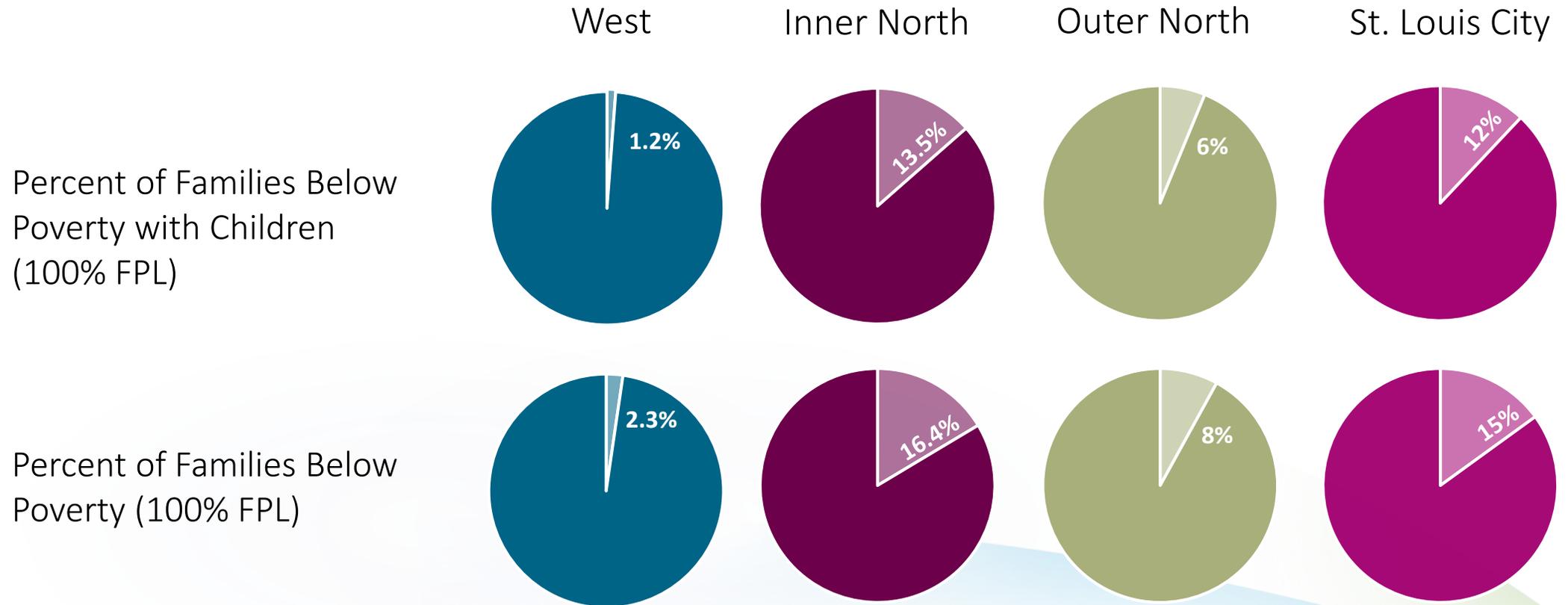


Source: ThinkHealthSTL, 2022



Community Profile

Poverty Statistics



Source: ThinkHealthSTL, 2022

Community Profile

Education

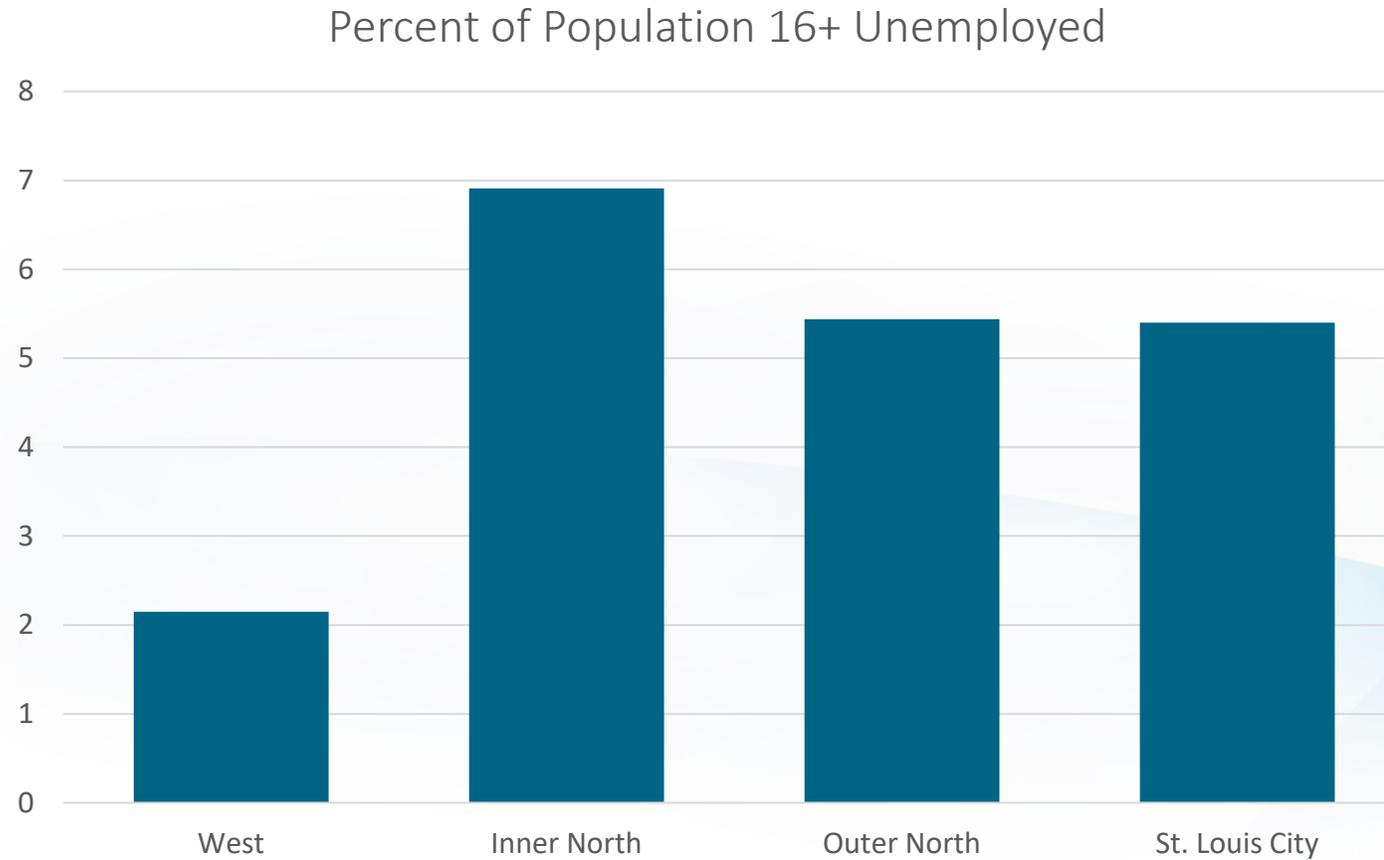
Level	West	Inner North	Outer North	St. Louis City
Less than High School	2.5%	12.4%	12.4%	10.6%
High School Degree	12.3%	34.2%	35.2%	24.5%
Some College or Assoc. Degree	21.3%	35.3%	35.3%	26.6%
Bachelor's Degree	34.9%	10.9%	10.9%	20.6%
Graduate or Professional Degree	29.0%	6.2%	6.2%	17.8%

Source: ThinkHealthSTL, 2022



Community Profile

Employment

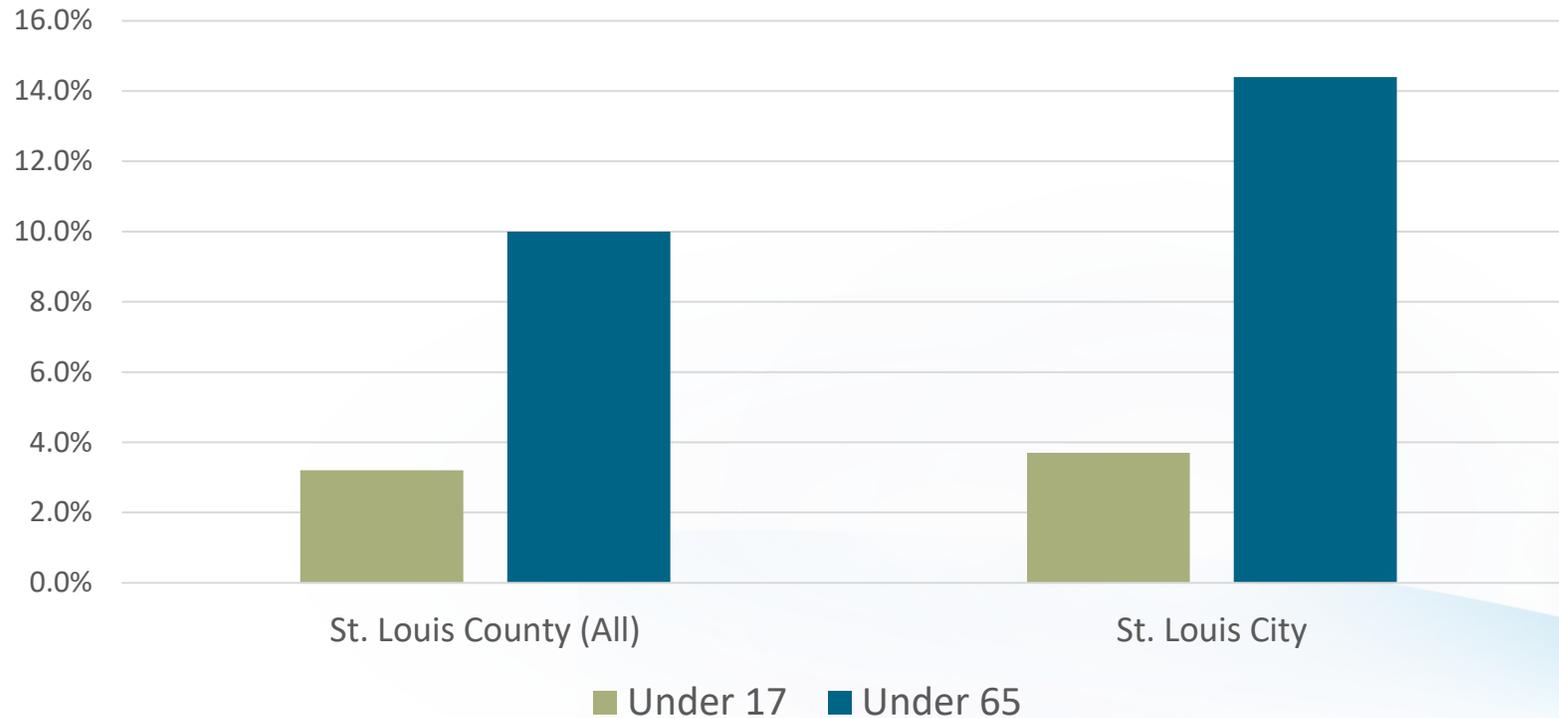


Source: ThinkHealthSTL, 2022

Community Profile

Insurance Coverage

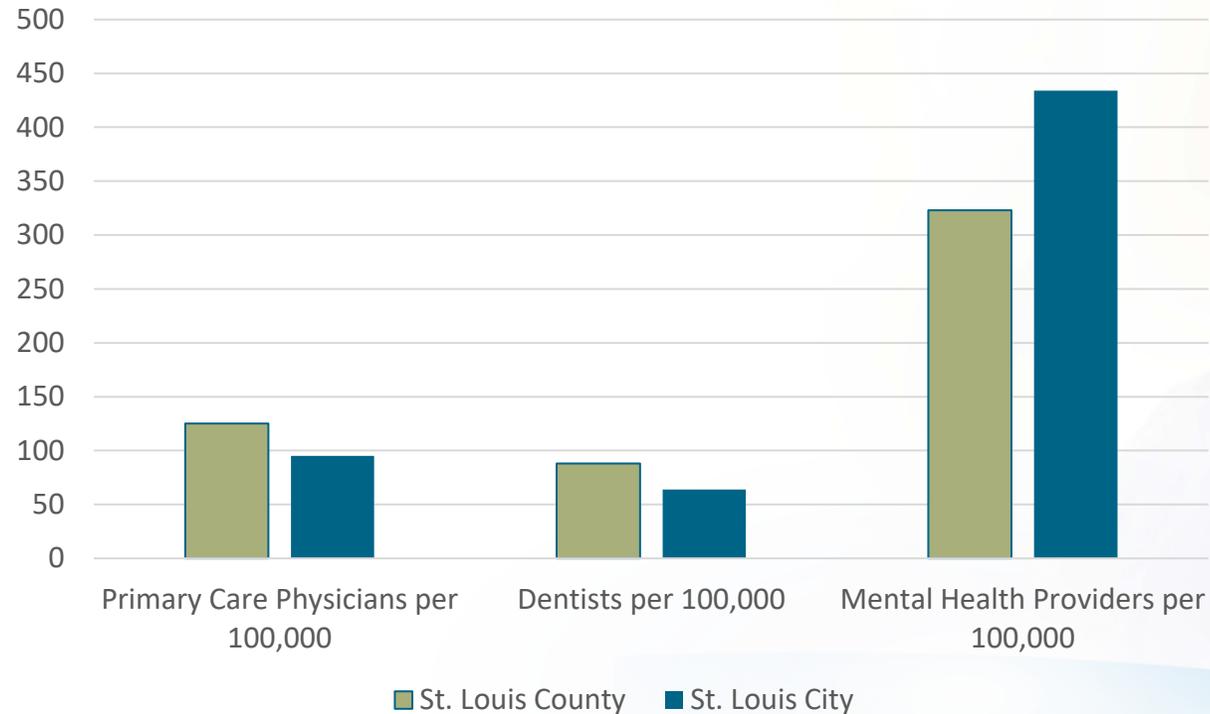
Adult and Child Uninsured Rates



Source: *Small Area Health Insurance Estimates, 2019*

Community Profile

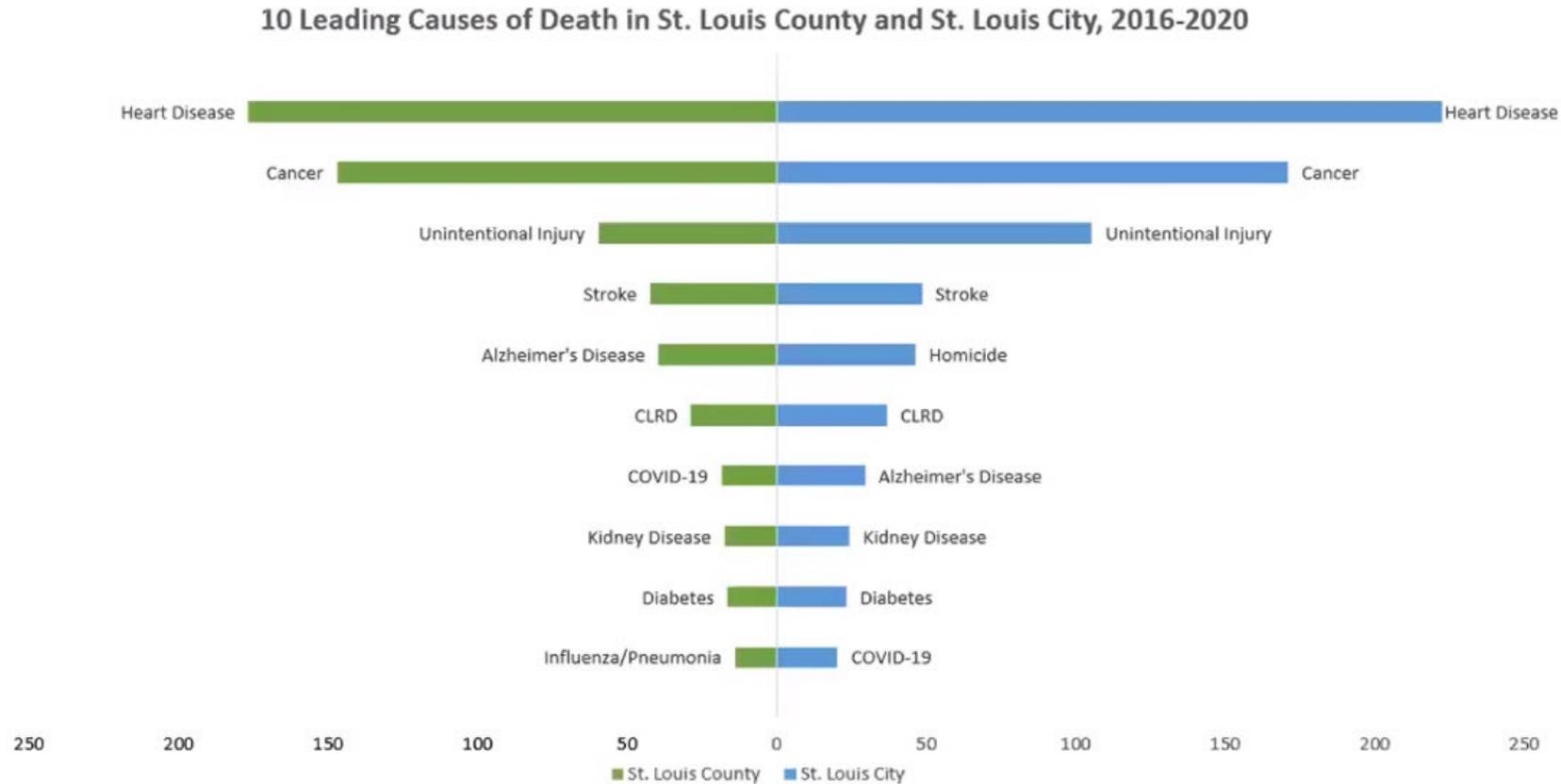
Access to Care



Source: County Health Rankings, 2021.

Community Profile

Leading Causes of Death



Source: St. Louis Partnership for a Healthy Community, 2022 CHA

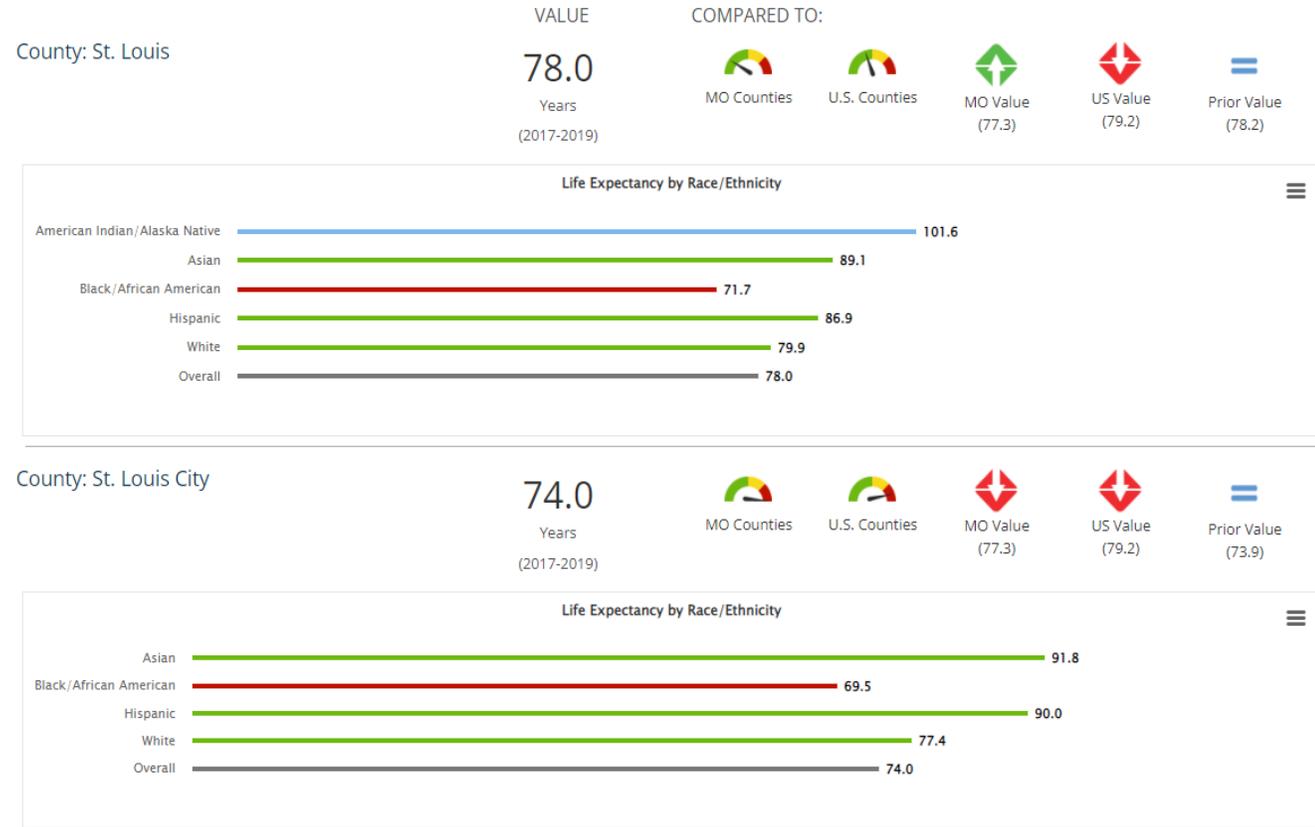
Community Profile

Life Expectancy

Life expectancy at birth varies drastically by ZIP code across the St. Louis region, with considerable disparities across race. Black and African-American St. Louisans live on average 8 years less than white St. Louisans, but in some communities, the disparities are even more stark.

For instance, ZIP codes 63105 (Clayton) and 63106 (JeffVanderLou) are less than 10 miles apart but have an 18 years difference in life expectancy. JeffVanderLou is 95% African American, with 54% of residents living below the poverty line. Clayton, alternatively, is 78% white, with only 7% living below the poverty line.

Life Expectancy by Race (2017-2019), St. Louis County & St. Louis City



Source: St. Louis Partnership for a Healthy Community, 2022 CHA

Community Profile

Equity & Health Disparities

Health disparities according to race, such life expectancy, exist for nearly every health indicator and outcome across the St. Louis region (Appendices A and B, thinkhealthstl.org).

These outcomes are not incidental. St. Louis is the second most segregated hospital market by race in the United States (Lown Hospitals Index, 2022). As emphasized in *Segregation in St. Louis: Dismantling the Divide* (2018), “Place matters. Where people live in St. Louis has been shaped by an extensive history of segregation that was driven by policies at multiple levels of government and practices across multiple sectors of society. The effect of segregation has been to systematically exclude African American families from areas of opportunity that support positive economic, educational, and health outcomes.” (See Appendix C for full *Segregation in St. Louis* report.)

Our Assessment Process

Data Collection

To capture relevant data and community voices for this Community Health Needs Assessment, MHSL collected and analyzed a significant quantity of primary and secondary data. Secondary data was collected primarily through Think Health St. Louis' comprehensive and timely health dashboards, maintained by the St. Louis Partnership for a Healthy Community and powered by Conduent Healthy Communities Institute, as well as through internal Mercy data. Other data resources utilized are listed later in this section. Primary data was collected by means of the community health surveys, one for community members and one for agency stakeholders, which were jointly sponsored by Mercy and our regional hospital partners. Community input was also solicited through stakeholder focus groups, conducted in key neighborhoods within Mercy's service area.

The Community Health Council of Mercy Hospital St. Louis guided the CHNA process. The Community Health Council is accountable for overseeing community health and benefit activities and ensuring these activities meet mission, compliance, and IRS guidelines.

The thoughts and opinions of people within Mercy's service area in the St. Louis region were central to the health needs assessment process. Input from people representing broad interests of the community were solicited through the survey process and be maintaining alignment with regional health efforts led by the St. Louis Partnership for a Healthy Community.

Our Assessment Process

St. Louis Partnership for a Healthy Community

MHSL's community assessment process is inextricably and strategically linked to the collective work of others in our region; it represents one piece of the larger effort towards a healthier St. Louis, led by the St. Louis Partnership for a Healthy Community (STLPHC). The STLPHC is comprised of a broad range of stakeholders representing the wide variety of entities that impact health- it includes both the City of St. Louis Department of Health and the St. Louis County Department of Public Health, area hospital systems, government, academic institutions, agencies/departments, coordinated care organizations, community-based organizations, and business partners in the City of St. Louis and St. Louis County.

See the Appendix A for a comprehensive list of participating organizations.



Our Assessment Process

St. Louis Partnership for a Healthy Community (cont.)

The purpose of the STLPHC is to align the efforts of the participating organizations and the residents of the communities they serve to develop and implement a shared community health assessment and Community Health Improvement Plan (CHIP) across the City of St. Louis and St. Louis County. STLPHC aims to eliminate duplicative efforts, prioritize needs, and enable collaborative efforts to implement and track improvement activities across the region.

This collaborative approach ensures that individuals and agencies are aligned with regional and national priorities and metrics. It enables an effective and sustainable process; strengthens relationships between communities, organizations and government; creates meaningful community health needs assessments; and results in a platform for collaboration around regional health improvement, leveraging collective resources to improve the health and wellbeing of our communities.



Our Assessment Process

COVID-19 Impact

This cycle, the community health assessment process was inevitably impacted by the COVID-19 pandemic. At Mercy and among our key collaborative partners, resources and energy were redirected to essential pandemic response functions, including COVID-19 testing and vaccination, and many organizations experienced fundamental shifts in the workforce and work structure that continue to shape a new normal. Perhaps most impacted were the City of St. Louis Health Department and the St. Louis County Department of Public Health, who were pivotal in pandemic surveillance and response. While these two agencies have been central to the coordination of our area's community assessment in the past, particularly since the formation of the STLPHC in 2014, neither health department had the same capacity to actively engage in the primary data collection process for this cycle. Rather, the coalition of area hospital systems worked together to gather community input, and as appropriate, will continue to both align with the STLPHC's St. Louis Region Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) (2018), and engage with the STLPHC's collective work as it recommences and as existing priorities are reevaluated.

Also impacted by the pandemic were the methods by which our partners collaborated and collected data. All meetings, surveys, and focus groups were conducted online in compliance with social distancing precautions.

Our Assessment Process

St. Louis Regional CHA and CHIP (2018)

STLPHC tailored the Mobilizing for Action through Planning and Partnerships (MAPP) model, a community-driven strategic planning process for improving community health, to conduct the 2018 CHA and CHIP. Beginning in early 2017, partners convened to determine the shared vision and guiding values for the process.

Following the development of the shared vision and guiding principles, the four MAPP assessments were conducted over the course of 2017 and analyzed together to identify overarching priorities and specific programmatic goals. The identified priorities of MHSL's previous CHNA and CHIP were aligned with these goals, and the 2018 CHA continued to serve as a blueprint for the most recent assessment process.



www.thinkhealthstl.org

Our Assessment Process

Hospital Partners

Several regional hospitals and hospital systems committed to work together to solicit input from those who represent the broad interests of the community served by the hospital, those who have special knowledge and expertise in the area of public health and underserved populations, as well as community members who are marginalized and underserved :

- BJC Healthcare
- Mercy Hospital St. Louis
- Mercy Hospital South
- Missouri Baptist Medical Center
- Shriners Hospitals for Children – St. Louis
- SSM Health
- St. Luke’s Hospital
- St. Luke’s Des Peres



Many of these hospitals have been working together since the initial stakeholder assessment, conducted in 2012, followed by a second in 2015.

Our Assessment Process

Community Partners

Other organizations who supported MHSL's needs assessment process include:

- Behavioral Health Network
- St. Louis Integrated Health Network
- St. Louis Regional Health Commission
- Missouri Foundation for Health
- Missouri Hospital Association
- St. Louis City Health Department
- Saint Louis County Department of Public Health
- St. Louis Partnership for a Healthy Community



Our Assessment Process

Needs Assessment Surveys

Mercy conducted two community surveys in conjunction with partner hospital systems including SSM Health, BJC Healthcare, St. Luke's and Shriners' Hospital. Due to pandemic restrictions, online surveys were utilized in lieu of in-person methods. The first was a community-wide survey distributed broadly throughout the St. Louis metropolitan area between April and June 2021. The survey took ten minutes to complete and contained 39 questions about health challenges, access to healthcare, and social determinants of health, including financial status, neighborhood environment and social support networks.

The second, a stakeholder survey, was sent to key leaders of essential community organizations that represent the needs of the community. Both survey tools could be accessed through a unique url or a QR code using a mobile device. (See Appendices D and E for details about the needs assessments surveys for community members and stakeholder agencies.)

BJC HealthCare Mercy Shriners Hospitals for Children - St. Louis SSM Health St. Luke's HOSPITAL St. Luke's Des Peres HOSPITAL

WE WANT YOUR FEEDBACK

Take the Community Health Needs Survey Through June 30, 2021

Your voice counts! Share your opinions and experiences on your health needs and the health of your community. Your input will help the St. Louis area health systems develop action plans to help with a variety of health and social issues.

The survey takes no more than 10 minutes to complete and all responses are anonymous.

Take the survey by visiting surveymonkey.com/r/CHNAstl or scan the code with your smartphone camera.

Our Assessment Process

Needs Assessment Survey - Community

Members of the community were invited to participate in the online survey through a media release, and key targeted outreach efforts were made through community partners to target specific locations and neighborhoods. While the entire metropolitan region, including surrounding counties in Missouri and Illinois, was included in the survey, results were analyzed by region. Within MHS's defined community, 495 individuals responded from North County, 197 from West County, and 377 from St. Louis City.

There were limitations to this community survey. Online distribution, while necessary in this instance, is difficult to access for those without a computer or mobile device, as well as those with low digital literacy. Efforts were made to circulate paper copies of the survey in key community settings like libraries and community centers, but there were still concerns accessibility. While health literacy was top of mind when putting the survey together, it is still impossible to eliminate this as a barrier.

In reviewing survey findings, it was evident that the scope of population reached was limited, and that essential voices of underserved members of our communities were not heard. This limitation is noted as a barrier in our community survey and prompted partner organizations to obtain additional primary data through other means, such as key informant interviews and targeted, smaller focus group sessions.

Our Assessment Process

Needs Assessment Survey – Community *(continued)*

Among the respondents in North County, West County, and St. Louis City, the vast majority were female (83.5%) and white (93.4%) and reported being in very good or good health (46.1% and 29.2%, respectively). Less than 1% of respondents noted that they felt their health was poor. Being a good place to raise a family (72.8%), quality schools and education (67.4%), and access to parks and outdoor spaces (66.5%) were among the top reported community strengths. The top four health challenges reported by the cohort include:

- Overweight/obesity (37.3%)
- Joint or back pain (26.6%)
- High blood pressure (22.5%)
- Other (22.14%)

Nearly a quarter of respondents reported no health challenges. When asked about barriers that prevent people from accessing healthcare, more than half of respondents reported having no barriers at all (55.7%), though others listed scheduling problems (19%), cost or co-pays (16.4%), and difficulty finding doctors (11%). Top challenges were reported as access to affordable housing (43%), racial and ethnic diversity (40.2%), strong community leaders (35.2%), and community safety and crime (32%). (See Appendix D for survey questions and complete survey results.)

Our Assessment Process

Needs Assessment Survey – Stakeholders

The sponsoring hospitals also conducted an online survey for community stakeholders in the summer of 2021, with the focus on public health experts, leaders and those with a special interest in the health needs of the metropolitan St. Louis area. Fourteen stakeholders representing the North St. Louis County region participated in the survey, along with 19 from West St. Louis County and 29 from the City of St. Louis. (See Appendix E) Stakeholders were asked 16 questions about the health needs of their communities and were asked to rank needs on a scale of little to significant concern. Participants also provided feedback on the potential of community partnerships, the barriers to healthcare in their respective communities, and the types of social factors and needs that were making the biggest impact on health. There were questions about the COVID-19 pandemic and its impact on their community, gaps in resources available, health assets, and what zip codes or areas are especially vulnerable or at-risk. As with the community survey, the stakeholder survey had limitations in that it is usually conducted as an in-person, focus group. While participation numbers for the online survey were acceptable, focus groups are typically preferred for our collaborative as they tend to encourage good discussion and provide rich qualitative data that aids in a clear understanding of community needs.

Across Mercy St. Louis' service area, stakeholders identified mental health as the leading area of significant concern. For West County and St. Louis City, drug abuse was also ranked as a top concern by survey respondents, while North County stakeholders noted maternal/infant health and infectious disease, including COVID-19. North County, West County and St. Louis City all identified immunizations and infectious disease (including COVID-19) as an issue with the most potential for agency collaboration, perhaps reflecting the system of cross-sector collaboration in place throughout the pandemic. Mental health was also rated highly in West County and St. Louis City, while North County emphasize collaborative potential around maternal-infant health.

Our Assessment Process

Needs Assessment Survey – Stakeholders *(continued)*

Barriers to accessing healthcare were identified differently in each service area surveyed. North County stakeholders noted transportation and the inability to pay co-pays and deductibles as the most prevalent barriers for their community members, as well as a lack of insurance and lack of mental health services nearby. In West County, scheduling services was listed as the top barrier, along with a lack of nearby mental health services. In St. Louis City, respondents identified lack of insurance coverage and transportation. When asked which populations within their community are most at-risk for healthcare issues, 80% of respondents representing North County identified those who are low-income. Results were similar in St. Louis City, although stakeholders in this community also noted that the homeless and unsheltered populations are also especially at risk. In West County, 60% of respondents selected both low-income populations and older adults as being the most vulnerable. Considering social factors that have historically impacted their communities, respondents from North County identified discrimination, including racism, as the top factor. This is similar to St. Louis City, where stakeholders identified poverty as the most influential historical social factor, followed closely by discrimination, including racism. However, in West County, respondents largely named exposure to drug use and abuse as the most significant factor.

Notably, when asked about the biggest impact the COVID-19 pandemic has had on the community, all three service areas noted impacts on mental health and wellbeing, such as increased symptoms of depression (North County and St. Louis City) and increased feelings of loneliness and social isolation (West County). The economic impact, including loss of household income and overall financial hardship, was also a top concern in St. Louis City. (See Appendix E for details about the needs assessments surveys for community members and stakeholder agencies.)

From the Stakeholder Survey:

“**Mental health** for children and adolescents is a concern for the future, especially after the **pandemic**.

We also need mental health techniques for managing and navigating the **impact** of social media for teens and adolescents.”

North County Stakeholder

From the Stakeholder Survey:

"**Substance abuse** and **mental health** disparities are a real issue. This community is part of a larger, St. Louis community and we all need to play a **significant role** in lifting others in our community."

West County Stakeholder

From the Stakeholder Survey:

“**Generational poverty** has created a sense of **hopelessness** and **isolation**. Investment in neighborhoods that have not received these **investments** in decades is **critical** to break these cycles. It will require **layers** of investment, not just from **hospitals**, but others as well.”

St. Louis City Stakeholder

Our Assessment Process

Stakeholder Focus Group – Ferguson

MHSL conducted a stakeholder focus group with members of the Mercy Clinic Ferguson’s Community Advisory Council. The council consists of important community agencies and leaders who represent the broad interests of the Ferguson community, as well as those who have special knowledge of the underserved populations. (See Appendix F for a full list of focus group participants and a complete summary of focus group findings.)

Participants convened via Webex for a 60-minute discussion of the state of health in the Ferguson community and surrounding North County. Strengths noted by the participants included strong local leadership, grassroots organizations and outreach, an increase in resource availability and strides in justice and police reform. Access to healthy food and fresh produce, violence and public safety, behavioral health, and economic development were listed as community challenges. Mental health and health promotion were identified as two of the most urgent issues facing residents, with access to mental health services also named as a significant concern. Inequitable access to mental health services, dental care, transportation, and technology, including phone and internet access, were described as barriers to health.

Our Assessment Process

Stakeholders Focus Group – Ferguson

Overall Themes:



From a Focus Group Participant:



“Behavioral health is a very significant need in the area. There are not a lot of resources for that. There just **aren’t enough providers** available, or they have **long waitlists** to get in, or there are **insurance issues** sometimes.”

Ferguson Community Representative

Our Assessment Process

Stakeholder Focus Group – Meacham Park

Mercy Hospitals St. Louis and South jointly conducted a stakeholder focus group with members of the Meacham Park neighborhood within Kirkwood, MO. The focus group consisted of attendees who represented the broad interests of the Meacham Park community, as well as those who have special knowledge of underserved populations. (See Appendix G for a full list of focus group invitees, participants and a complete summary of focus group findings.)

Participants convened via Webex for a 60-minute discussion of the state of health in the Meacham Park neighborhood. Community strengths noted by the participants included the presence of churches, connectivity to the police, feelings of being heard, and strong relationships with the Kirkwood School district and other community organizations. Crime, lack of access to healthcare, distrust of people in the neighborhood to share their difficulties, and being a neighborhood in transition were all discussed as community challenges. Access and navigation of health care and crime in the neighborhood were two of the most urgent issues facing residents, with transportation to obtain care as another strong significant concern and on-going barrier to health.

Our Assessment Process

Focus Group: Meacham Park *(continued)*



From a Focus Group Participant:

"...they do not have **health insurance**. They're **unemployed**, have **medical conditions** that have gone on and on and have not been evaluated or treated. As a result, the **ambulance** is called and the only care they receive is the **emergency room**."

Meacham Park Community Representative

Our Assessment Process

Community Health Status Assessment (2022)

In March 2022, the STLPHC, with support of Kulik Strategic Consultants, held a two-day virtual conference in order to present a Community Health Status Assessment (CHSA) update to more than 400 community stakeholders and experts in public health.

The goal of the Community Health Status Assessment (CHSA) was to identify community health and well-being issues using demographic, health, and socioeconomic profiles. Questions answered include: "How healthy are our residents?" and "What does the health status of our community look like?". After each data presentation, attendees were asked to provide feedback, share insights, and identify missing indicators that help tell our region's story. Mercy was an active participant in the CHSA, and data presented over the course of the conference was utilized in better understanding the region's most pressing issues, shaping the central data contained in this year's assessment.

Topics discussed include: demographics and social determinants of health, accidental and intentional injury, behavioral health, communicable diseases, COVID-19, access to care, environmental health, maternal-child-family health, and chronic disease.

See Appendix B for the full CHSA agenda, as well as the nine slide decks from each presentation.

Our Assessment Process

Resources

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

- Cambria N, Fehler P, Purnell JQ, Schmidt B. Segregation in St. Louis: Dismantling the Divide. St Louis, MO: Washington University in St. Louis, 2018.
- County Health Rankings and Roadmaps, 2021: <https://www.countyhealthrankings.org/>
- Healthy People 2030, 2022. <https://health.gov/healthypeople>
- Lown Hospitals Index, 2022: <https://lownhospitalsindex.org/rankings/>
- Missouri Department of Health & Senior Services Data & Statistics, 2022: <https://health.mo.gov/data/>
- St. Louis Partnership for a Healthy Community. Community Health Status Assessment, 2022.
- St. Louis Partnership for a Healthy Community. Think Health St. Louis, 2022: <https://www.thinkhealthstl.org/>
- St. Louis Partnership for a Healthy Community. St. Louis CHA/CHIP Executive Summary (2019-2024), 2018.
- St. Louis Regional Health Commission. Progress Toward a Healthier St. Louis: Access to Care Data Book, 2019.
- U.S. Census Bureau, 2020 Census Results, 2020: <https://www.census.gov/>

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 2022 (see Appendix H). Councilmembers were responsible for prioritizing health needs by reviewing the collected data, evaluating the strengths and resources of the community, and representing the hospital's strategic plan. A preliminary list of nine 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 include:

- Access to Care
- Maternal and Child Health
- Substance Use Disorder
- Health Equity
- Trauma-Informed Care
- Violence
- Housing
- Child Mental Health
- Adult Mental Health (including Maternal Mental Health)

Prioritized Needs

Prioritization Process (cont.)

A nominal group technique was then used to rank the nine priority health needs, according to five criteria:

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

Scores were totaled for all participants. Results of the nominal group technique are included in the adjacent table.

Rank	Identified Health Need	Total Score
1	Access to Care (includes prescriptions and transportation)	188
2	Maternal & Child Health	185
3	Adult Mental Health (including maternal mental health)	181
4	Child Mental Health	179
	Health Equity	179
5	Substance Use Disorder	173
6	Trauma-Informed Care	151
7	Housing	133
8	Violence	130

Prioritized Needs

Prioritization Process (cont.)

Based on the total cumulative scores from the nominal group process, five final priorities were selected for the 2022 CHNA. The Council determined that Adult Mental Health, Child Mental Health, and Substance Use Disorder could be addressed jointly as Behavioral Health. Access to Care and Maternal and Child Health were also selected, along with Health Equity, which will serve as an essential lens to direct efforts across all other needs and partnerships. Finally, Trauma-Informed Care was voted on by the Council as the fifth and final priority for MHSL.

The first four of these needs will be carried over from the 2019 CHNA, while Trauma-Informed Care is a newly identified need. MHSL will maintain current implementation strategies that have demonstrate 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

Mercy Hospital St. Louis' (MHSL) identified priorities continue to align with the three overarching regional priorities identified through the St. Louis Partnership for a Healthy Community:

- Address the social determinants of health as root causes of community health
- Eliminate the disparities in health and promote health and racial equity
- Improve the local public health system to be able to collectively address the needs of the region

Mercy Hospital St. Louis is committed to aligning strategic efforts around the identified priorities the objectives of the STLPHC through participation and engagement in the following action teams:

- Improving Access to Community Health (encompassing behavioral health), led by the Behavioral Health Network of Greater St. Louis and the St. Louis Regional Health Commission
- Maternal, Child, and Family Health, led by Generate Health STL

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. Barrier to access include the high cost of care, lack of health insurance coverage or inadequate insurance coverage, limited availability of services, cultural appropriateness and acceptability of services, and transportation barriers. Those with limited access to 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.

Many people across the St. Louis region face such barriers to obtain the health care services they need. About 1 in 10 adults in St. Louis County, and 1 in 7 adults in St. Louis City, do not have health insurance, and many of those same people are without a consistent primary care provider¹. Not having a doctor overseeing care means that members of our community may not be able to access the health care services and medications that they need in a timely manner. This can often lead to utilizing the local Emergency Department for routine, non-emergent health care needs.

Prioritized Needs

Access to Care (*cont.*)

Access to Care is highly interrelated with social determinants of health (SDOH), which encompass the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.² 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.

Addressing Access to Care, and the social determinants of health that influence access, is a complex and multi-faceted issue. MHSL is committed to strategically addressing SDOH and facilitating access to care along with our community partners in order to ensure more equitable, quality healthcare for all members of the communities we serve, particularly for those who are marginalized. This includes addressing access to behavioral health and maternal and child health services, as well as social needs such as transportation and prescription medications.



Source: HealthyPeople2030

Prioritized Needs

Maternal & Child Health



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 4 times greater rate of pregnancy-associated deaths for Black women than white women in the state of Missouri.⁴ MHSL 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.

Prioritized Needs

Behavioral Health

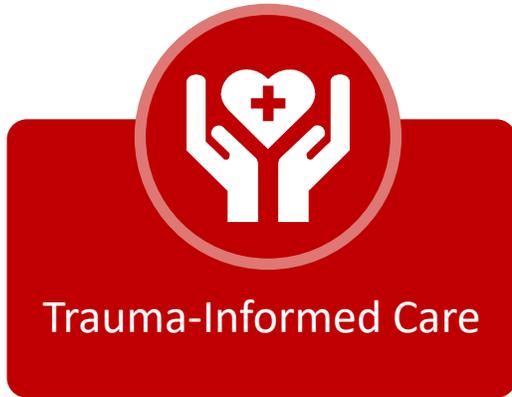


For the purposes of this CHNA, Behavioral Health encompasses MHSL's efforts to address mental health and substance use disorders in the community. Mental health includes our emotional, psychological, and social well-being. While mental illness is not the same as mental health, mental illnesses are among the most common health conditions in the United States; more than 50% of people will be diagnosed with a mental illness or disorder in their lifetime.⁵

Even further, more than 20 million people in the United States have a substance use disorder,⁶ and in June 2018, St. Louis County declared a public health emergency to address rising rates of opioid addiction and overdose in our own region.¹ We have seen evidence that COVID-19 has had a significant impact on the community in terms of behavioral health and substance use, particularly for youth and those who are marginalized. 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

Trauma-Informed Care



Trauma results “from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.” Examples of trauma include experiencing or witnessing violence, abuse, or neglect, having a family member with mental health or substance use disorder, and instability due to poverty, and discrimination.⁷

Experiencing trauma, especially during childhood, significantly increases the risk of serious health problems — including chronic lung, heart, and liver disease — even when correcting for health behaviors such as smoking or substance use.⁷ Trauma-Informed Care recognizes the impact of toxic stress and trauma on the health and well-being of individuals and communities, both our patients and our co-workers, and shifts the focus from “What’s wrong with you?” to “What happened to you?”⁸ Implementing trauma-informed approaches to care can help health care providers care for themselves and engage with their patients more effectively, thereby reducing burnout and improving the quality of care for patients and our community.

Prioritized Needs

Health Equity



Achieving health equity means that everyone in the community has a fair and just opportunity to be as healthy as possible, regardless of their circumstances.⁹ In the St. Louis region, opportunities to be healthy are largely influenced by socioeconomic status, geography, gender, age, and perhaps most significantly, race. In this way, health equity is inextricably linked to all the other priorities identified by MHSL and will serve as the lens through which we implement our programs.

This is in direct alignment with the Vision and Guiding Principles of the St. Louis Partnership for a Healthy Community, which seeks an equitable St. Louis community achieving ultimate health for all and understands that racial equity is an essential component of health equity. In collaboration with our regional partners, MHSL will continue to coordinate the prioritization and allocation of resources to remedy disparities and to achieve equity across the region (see Appendix A).

Prioritized Needs

Needs Not Addressed

Housing

Though MHSL will not directly address housing as a part of the CHNA process, through intentional partnerships with strategic community organizations, MHSL will continue to impact housing needs in the community. MHSL is engaged in the Hospital to Healthy Housing Initiative of the Catholic Charities of St. Louis and supports a Housing Coordinator from the St. Patrick Center to connect unhoused patients who present in the Emergency Department with resources and support. Mercy is also engaged in Project BEACN, and with partner agencies Places for People and the Behavioral Health Network, connects patients with complex care needs with wraparound support, including housing.

Violence

The Violence Prevention Action Team, led by the St. Louis Area Violence Prevention Commission, leads regional efforts to reduce violence, particularly gun-related homicides and nonfatal shooting accidents. While MHSL will not be directly engaged in this work, our commitment to trauma-informed care will support the community in addressing the consequences of interpersonal violence, including gun violence.

Prioritized Needs

References

¹ St. Louis Partnership for a Healthy Community. 2022. Retrieved February 2022, from <http://www.thinkhealthstl.org/>

² Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved March 2022, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

³ American Hospital Association. 2022. *Maternal and Child Health*. Retrieved April 2022, from <https://www.aha.org/advocacy/maternal-and-child-health>

⁴ FLOURISH St. Louis, Generate Health. 2022. Retrieved March 2022, from <https://www.flourishstlouis.org/>

⁵ Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Mental Health and Mental Disorders*. Retrieved March 2022, from <https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders>

⁶ Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Addiction*. Retrieved March 2022, from <https://health.gov/healthypeople/objectives-and-data/browse-objectives/addiction>

⁷ Menschner, C., & Maul, A. (2016, April). *Advancing Trauma-Informed Care: Key Ingredients for Successful Trauma-Informed Care Implementation*. SAMHSA, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

⁸ Alive and Well Communities. 2021. Retrieved May 2022, from <https://www.awcommunities.org/>

⁹ Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017, May 1). *What is Health Equity?* Robert Wood Johnson Foundation. Retrieved May 2022, from <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>

Resources

Mercy Hospital St. Louis collaborates with many local community agencies and organizations that have similar missions and personnel dedicated to improving health and quality of life in our community. These organizations are sources of potentially available resources to address the significant health needs identified in this CHNA:

- St. Louis Partnership for a Healthy Community
- St. Louis County Department of Public Health
- City of St. Louis Health Department
- St. Louis Regional Health Commission
- Integrated Health Network
- Behavioral Health Network
- Places for People
- Generate Health
- FLOURISH St. Louis
- Nurses for Newborns
- Beyond Housing
- Catholic Charities of St. Louis
- Alive and Well Communities
- Operation Food Search
- SSM Health
- BJC Healthcare

Appendices

Appendices are available as a separate, supplemental PDF document.

- Appendix A: St. Louis Region CHA / CHIP – Summary Report (2018)
- Appendix B: CHSA Agenda and Presentations (2022)
- Appendix C: Segregation in St. Louis – Dismantling the Divide Report (2018)
- Appendix D: Community Survey
- Appendix E: Stakeholders Survey
- Appendix F: Ferguson Community Focus Group
- Appendix G: Meacham Park Community Focus Group
- Appendix H: Community Health Council Prioritization





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Appendices

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Appendix A

St. Louis Region Community Health Assessment (CHA)
& Community Health Improvement Plan (CHIP)

Summary Report

August 2018

St. Louis Partnership for a Healthy Community





St. Louis Partnership
for a **Healthy Community**

St. Louis Region

COMMUNITY HEALTH ASSESSMENT



COMMUNITY HEALTH IMPROVEMENT PLAN

August 2018



Saint Louis
COUNTY
PUBLIC HEALTH

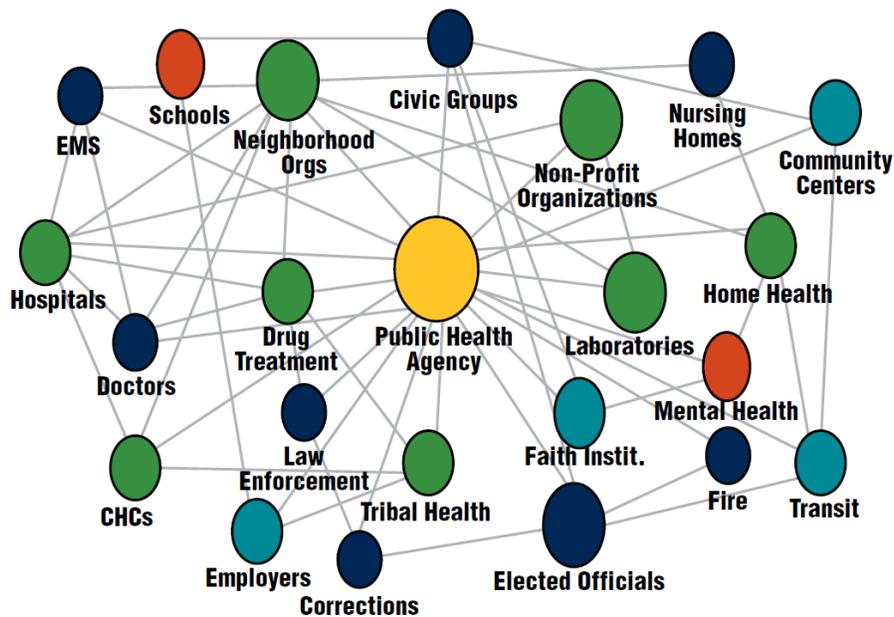


Introduction

St. Louis Partnership for a Healthy Community

St. Louis Partnership for a Healthy Community (STLPHC) is comprised of a broad range of stakeholders from within the public health system and individual advocates who subscribe to a comprehensive definition of health.¹ The public health system includes any organization, entity, or individual that contributes to or impacts the community's health (see Figure 1).²

Figure 1: Generalized Public Health System Diagram (Source: NACCHO)



The membership of STLPHC is intended to represent the wide range of entities that impact health- it includes both the City of St. Louis Department of Health and the St. Louis County Department of Public Health, area hospital systems, government agencies/departments, coordinated care organizations, community-based organizations, academic institutions, and business partners in the City of St. Louis and St. Louis County. See Appendix A for participating organizations.

The purpose of STLPHC is to align the efforts of the participants and the residents of the communities they serve to develop and implement a shared community health assessment (CHA) and Community Health Improvement Plan (CHIP) across the City of St. Louis and St. Louis County. STLPHC aims to eliminate duplicative efforts, prioritize needs, and enable collaborative

¹ According to the World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Source: <http://www.who.int/about/mission/en/>

² Source: <https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html>

efforts to implement and track improvement activities across the region. This collaborative approach enables an effective and sustainable process; strengthens relationships between communities, organizations and government; creates meaningful community health needs assessments; and results in a platform for collaboration around regional health improvement plans and activities, leveraging collective resources to improve the health and wellbeing of our communities. See Figure 2 for a diagram of the STLPHC.

Figure 2: STLPHC Structure



Community Health Advisory Team

In January 2017, STLPHC convened a Community Health Advisory Team (CHAT) comprised of local public health system community leaders, partners, and stakeholders to provide direction and decision-making throughout the Mobilizing for Action through Planning and Partnerships (MAPP) process. The CHAT met regularly throughout 2017 and 2018 to guide the CHA process and to shape the direction of the CHIP and will continue to convene on a semi-annual basis to provide feedback and guidance on the implementation of the CHIP.

Regional Planning and Leadership Group

The Regional Planning and Leadership Group (RPLG) acts as the STLPHC steering committee and is comprised of leadership from both public health departments (City of St. Louis and St. Louis County), hospital systems, regional health organizations, and neutral facilitators. The RPLG is a continuation of the work started with the CHAT, to ensure that effort is sustained from the assessment phase into the into the action planning, implementation, and evaluation phases of the MAPP cycle. RPLG members work to align priorities across organizations, secure resources for implementation, and sustain STLPHC planning, community engagement, and reporting of the CHA/CHIP progress.

Commitment to Addressing Health Disparities

STLPHC and member organizations are committed to a vision and process that can identify and address structural racism, health disparities, and inequities. The 2017-2018 CHA and 2019 CHIP include data on disparities in our region, driven by the vision of identifying and describing factors that impact the health of City of St. Louis and St. Louis County residents, workers, and visitors so that we can address and improve equity in achieving optimal health for all.

CHA/CHIP Framework

STLPHC tailored the Mobilizing for Action through Planning and Partnerships (MAPP) model (see Figure 3) to conduct the CHA and CHIP. MAPP is a community-driven strategic planning process for improving community health. It is an interactive process that helps communities prioritize public health issues and identify resources to address them.

Beginning in early 2017, partners convened to determine the shared vision and guiding values for the process (see next page). Following the development of the shared vision and guiding principles, the four MAPP assessments were conducted over the course of 2017 and analyzed together to identify strategic issues and priorities. Action planning started in late 2017 and continued throughout 2018 with implementation scheduled to begin January 2019.

Vision and Guiding Principles

The CHAT drafted the 2017-18 St. Louis CHA/CHIP vision and guiding principles in January 2017 and fine-tuned the statements at subsequent meetings to the final set depicted in Figure 4. The vision represents an inspirational and aspirational statement for a desired future based on

Figure 3: MAPP Model (NACCHO)



collective action and achievement. The guiding principles represent fundamental values and beliefs that guide day-to-day interactions with each other and the community through the MAPP process. Together, these statements play an important role in the CHA/CHIP process by providing a framework for engagement, decision-making, data collection, and implementation of strategies.

Figure 4: 2017-18 St. Louis CHA/CHIP Vision and Guiding Principles

Our Vision:

St. Louis, an equitable community achieving optimal health for all.

Equity: Racial equity is an essential component of health equity. We prioritize allocation of resources to remedy disparities and to achieve equity.

Respect: We respect everyone in the community, valuing all cultures and recognizing strengths, needs, and aspirations without judgment.

Integrity: We use the highest standards of ethics and professionalism to maintain integrity and build community trust through honesty and commitment.

Data + Results Driven: We are committed to a transparent, data-driven process, including community feedback, actionable data, and evolving priorities, that results in measurable improvements/outcomes.

Community Engagement + Inclusion: Through intentional inclusion, engagement, and empowerment, we foster a culture of equity that respects and values the contributions of every individual toward a healthy community.

Systems level change + regional shared plan: We achieve systemic change and policy solutions locally and within a regionally shared plan to improve population-level health.

Resources: We collaborate regionally, coordinate existing resources, and develop new resources to accomplish healthy outcomes for all.

2017-2018 Community Health Assessment (CHA)

The 2017-2018 St. Louis Community Health Assessment documents the health of City of St. Louis and St. Louis County residents and the strengths and opportunities of the local public health system. The CHA includes data from four different assessments: Community Health Status, Community Themes and Strengths, Forces of Change, and the Local Public Health System (see Figure 5). Together the assessments inform the identification of issues impacting the health of the St. Louis community and assist in the selection of health priorities and improvement strategies. Comprehensive reports for each assessment can be found on STLPHC’s regional dashboard, ThinkHealthSTL.org, and in the appendices of this report.

Figure 5: The Four MAPP Assessments

Assessment	Question
Community Health Status Assessment (CHSA)	What does our data tell us about our health?
Community Themes & Strengths Assessment (CTSA)	What is important to community members and what assets do we have?
Forces of Change Assessment (FOCA)	What is occurring, or might occur, that will affect the community or public health system?
Local Public Health System Assessment (LPHSA)	How are the essential public health services being provided to our community?

Community Health Status Assessment (CHSA)

The Community Health Status Assessment (CHSA) report documents the health status of City of St. Louis and St. Louis County residents. The broad goal of the health status assessment was to analyze community demographics and population health data as well as to identify important health issues affecting the community. A CHSA workgroup (see page 2 of the CHSA report), along with community input, prioritized health indicators using the following criteria:

- Existence of a disparity by race/ethnicity or sex;
- Comparison with the State of Missouri (ability to benchmark);
- Ability to analyze trends over time;
- Severity; and
- Magnitude.

Data came from a wide variety of secondary sources, which are listed in Figure 6.

Figure 6: CHSA Data Sources (Alphabetical Order)

<ul style="list-style-type: none"> American Lung Association: State of the Air Report Assessor’s Office, City of St. Louis Community Commons Community Sanitation Program, City of St. Louis Department of Health County Health Rankings & Roadmaps (CHRR) U.S. Environmental Protection Agency (EPA) Federal Deposit Insurance Corporation (FDIC): National Survey of Unbanked & Underbanked Households Feeding America: Map the Meal Gap Missouri Department of Elementary and Secondary Education MODHSS: Bureau of Health Care Analysis & Data Dissemination MODHSS: Bureau of Vital Statistics MODHSS: Missouri Information for Community Assessment (MICA) Missouri Department of Natural Resources Air Monitoring Stations Nielsen Site Reports Office of the Medical Examiner, City of St. Louis 	<ul style="list-style-type: none"> Prosperity Now: Assets & Opportunity Scorecard Robert Wood Johnson Foundation (RWJF) SAMHSA Buprenorphine Treatment Physician Locator St. Louis Metropolitan Police Department U.S. Census Bureau: American Community Survey (ACS) 5-Year Estimates U.S. Census Bureau: Population Division, Annual Estimates of the Resident Population U.S. Census Bureau: Survey of Income and Program Participation (SIPP) U.S. Department of Agriculture (USDA): FNS SNAP Retailer Locator U.S. Department of Agriculture (USDA): Food Environment Atlas U.S. Department of Housing and Urban Development (HUD) U.S. Department of Labor: Bureau of Labor Statistics University of Wisconsin Public Health Institute
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Key Findings

Social determinants of health and equity³

STLPHC worked to understand why there were differences in health across the St. Louis region by looking at opportunities such as income, housing, and transportation. The percent of families living in poverty in St. Louis County was 7.9% and 21.7% in the City of St. Louis. St. Louis County poverty levels were highest in the Inner and Outer North sub-regions and most zip codes in the City of St. Louis had a medium, high, or very high percent of families living below the poverty line.

When looking at renter- or owner-occupied homes by race in the St. Louis region, 45% of Blacks/African Americans, 75% of Whites/Caucasians, 54% of Asians, and 44% of other races were homeowners. There is a disparity between races when it comes to homeownership. In the St. Louis region, a much higher percentage of homeowners and renters in the lowest income brackets were spending 30% or more of their yearly income on housing costs. Substandard

³ All data sources in this section are cited in the full CHSA report, which can be found in Appendix C.

housing is defined by having one or more severe conditions related to plumbing, kitchen facilities, overcrowding, and housing costs. The City of St. Louis had 41.5% and St. Louis County had 30% of homes with one or more substandard housing conditions.

The percentage of City of St. Louis and St. Louis County residents using public transportation as their primary means of commute to work was 9.43% and 2.48%, respectively. The northeastern St. Louis region had the highest percentage of residents using public transit.

Mortality⁴

Measuring how many people die each year and why they died is one of the most important means for assessing the health of the community and the local public health system.

- The top two Leading Cause of Death (LCOD) for City of St. Louis, St. Louis County, and the United States (2010 to 2014 average) were heart disease and cancer. The third LCOD in the City of St. Louis was chronic lower respiratory disease (which includes asthma and chronic obstructed pulmonary disease), and stroke was the third LCOD for St. Louis County. Unintentional injury was the fourth LCOD for St. Louis County and the fifth LCOD for the City of St. Louis.
- The three leading causes of death among ages 1-19 years old were: Accidents (unintentional injury), suicides, and homicides. A racial disparity exists in both the city and county, as the rate of death among black children was significantly higher than the rate of death for white children.
- The leading cause of death among children ages 15-19 in the City of St. Louis was homicide and the leading cause of death of this group in St. Louis County was unintentional injuries.
- While much of the US has steadily decreased infant mortality rates for years, infant mortality rates in both the City of St. Louis and St. Louis County combined, continue to remain higher than the state average and national average.
- From 2010-2014 in the St. Louis region there was a 13% decrease in heart disease mortality in Whites/Caucasians compared to a 7.1% increase in Blacks/African Americans and a 20% decrease in diabetes mortality in Whites/Caucasians and a 4.6 % decrease in Blacks/African Americans.
- The population with “high” and “very high” poverty levels had the highest rates of heart disease, diabetes, and cancer mortality in St. Louis County on average (years 2010 and 2014) when compared across all poverty levels.
- The City of St. Louis’ homicide rate was seven times higher than Missouri’s rate and St. Louis County’s homicide rate was almost double that of Missouri.

⁴ All data sources in this section are cited in the full CHSA report, which can be found in Appendix C.

- From 2010 to 2016 there was a 228.5% increase in opiate-related deaths in the City of St. Louis and a 22.9% increase in St. Louis County.

Additional data and information on social and economic conditions, the environment, clinical care, and health behaviors are discussed in depth in the full CHSA report. Data are organized around Demographics; Opportunity Measures; Access to and Linkage with Clinical Care; Environmental Health; Chronic Disease and Injury Prevention; Communicable Disease, and Maternal, Child and Family Health. Additional regional health status data can be found on STLPHC's data dashboard ThinkHealthSTL.org.

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) report documents the community's perspective on the characteristics of a healthy community; the barriers and issues impacting quality of life and health in the St. Louis region; strengths and assets to support health; and ideas to address some of the most important issues impacting the health and wellness of the community. The CHAT identified several groups of individuals as priorities for listening sessions due to their potential understanding and experiences related to health inequities. Organizers specifically sought out participants who identify with, or interact with, populations such as racial or ethnic minorities, limited English speakers, low-income communities, individuals with physical and intellectual disabilities, individuals with mental health or substance use disorders, and seniors. Further, in many listening sessions, participants were asked to identify population groups that were most vulnerable and experiencing the greatest inequities.

Fourteen listening sessions, two surveys, and twelve focus groups were conducted over a period of four months in 2017 with residents throughout the region. To better understand the barriers and needs of frequently overlooked populations, organizers used surveys and discussions with key stakeholders who frequently provide services to these populations in addition to listening to the populations themselves.

Key Findings

Through the listening sessions, surveys and focus groups, residents identified key themes related to what a healthy community should look like, current St. Louis conditions that impact health as barriers or facilitators, and ideas for improving the health of the community. Key themes were identified across the responses and summarized on the following page and in the full CTSA report.

The most frequently cited descriptions of a **healthy community** included factors such as:

- Positive relationships with neighbors and fellow community members
- Welcoming, kind, and supportive community
- Feeling safe inside and outside of the home
- Lack of violent crime, guns, and drugs
- Clean, safe, and well-maintained neighborhoods
- Quality, safe, and affordable housing
- Access to open, green space for recreation and exercise
- Access to healthcare, including behavioral health services
- Residents engage in regular physical activity

Listening session participants discussed several issues impacting health, with the **biggest issues** facing the St. Louis region as:

- Lack of jobs and training opportunities
- Poverty and low income is a barrier to home ownership, services, resources
- Racism and residential segregation
- Inequitable distribution of resources and lack of resources
- High rates of violent crime, gun violence, and drug activity makes the community feel unsafe
- Lack of safe and affordable spaces for young people to learn, socialize, stay physically active
- Easy access to substances (alcohol, tobacco, prescriptions, illicit drugs), heavy substance use

When asked about the **strengths and assets** of the St. Louis region that support health, participants identified factors such as:

- Abundance of museums and cultural institutions
- Good schools (though quality varies across the region)
- Recreation and entertainment for children, adults, and families
- Strong neighborhood associations and other community-based organizations
- Region is diverse and multi-cultural
- Plentiful parks and green space (though safety is a concern)
- Relatively low cost of living compared to other urban areas

Additional data and information on community strengths and assets, barriers and gaps to healthy living, and strategies to improve health and wellbeing are discussed in depth in the full CTSA report and on the ThinkHealthSTL.org dashboard.

Forces of Change Assessment (FOCA)

The Forces of Change Assessment (FOCA) identifies trends or factors that are influencing, or may influence, the health and quality of life of the community and the effectiveness of the local public health system. The FOCA was completed by CHAT members and focused on two key questions:

- What is occurring, or might occur, that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

Key Findings

Threats and opportunities emerged across five key areas (see Figure 7). The participants recognized the uncertainty and instability associated with potential changes to federal policy. There was particular concern regarding the repeal and/or replacement of the Affordable Care Act (ACA) and the impact it will have on regulations, funding for public health, and access to care. Another theme was lack of funding for programs due to budget cuts at federal, state, and local levels. The group pointed to reduced tax revenue due to population loss, shifts in political priorities, macroeconomic trends, and inequitable allocation as the drivers behind loss of funding for critical programs and services. Violent crime was a common theme across categories, including gun violence and violence directed towards communities of color. Violence is not only a threat to residents' safety but also affects access to opportunity and investment. Social justice surfaced as a cross-cutting theme, in relation to economic inequity (e.g. the impact of tax abatements), citizen-law enforcement relations, and environmental inequity. Finally, population shifts and urban renewal influence tax revenue, economic development, and social cohesion. Additional data and information on trends, factors, and events identified during the assessment are discussed in depth in the full FOCA report and on the ThinkHealthSTL.org dashboard.

Figure 7: FOCA Key Findings



Local Public Health System Assessment (LPHSA)

The Local Public Health System Assessment (LPHSA) report documents the strengths, weaknesses, and opportunities related to how essential public health services are being provided to our community. Hosted by STLPHC, 96 multi-sector partners participated on May 22, 2017 in a full-day of dialogue and discussion. Participants representing a broad spectrum of the local public health system used a standardized tool⁵ to review the optimal level of performance for the 10 Essential Public Health Services (EPHSs) and scored how well the St. Louis local public health system collectively performs the services. Through the scoring and discussion, participants identified local strengths, gaps, and opportunities for quality improvement.

Key Findings

Overall, participants described the St. Louis local public health system's performance as "moderate" on a scale from no activity to optimal. EPHS 2, *Diagnose and investigate health problems and health hazards in the community* was described as the highest performing essential public health service by participants. EPHS 4, *Mobilize community partnerships to identify and solve health problems* was described as the lowest performing essential public health service by participants. From the discussion, participants identified eight strategic areas that the local public health system should collectively address to improve the function and effectiveness of the system (Figure 8).

Figure 8: LPHSA Key Findings



⁵ The LPHSA uses the National Public Health Performance Standards (NPHPS) to assess capacity and performance of local public health systems and local public health governing bodies. This framework can help identify areas for system improvement, strengthen state and local partnerships, and ensure that a strong system is in place for providing the 10 essential public health services. Source: <https://www.cdc.gov/stltpublichealth/nphps/index.html>

Participants in the LPHSA identified the following strengths of the local public health system:

- Assessment and Data Collection: LPHS organizations conduct many assessments and collect a great deal of data for data-driven decision making.
- Community Engagement and Communication: LPHS partners engage community members and stakeholders, and regularly gather input from community members. Community partnerships between research and practice are strong. Risk communication and emergency preparedness communication is well coordinated at the organizational level.
- Partnership and Collaboration: LPHS organizations partner and collaborate in many ways, including data collection and sharing, health promotion and education, policy development, service provision, and research. The increased city and county collaboration is notable and there is momentum for increased collaboration across sectors outside of what is considered traditional public health.
- System-wide Workforce Development: The LPHS has knowledgeable public health staff, good leadership, and high potential for the existing talent in the region.
- Policy: The LPHS has demonstrated willingness to take on policy reforms and has had some recent successes.
- Resources: Academic institutions are an important source of funding, expertise, research, and training for the LPHS.

Additional data and information on the strengths, weaknesses, and opportunities associated with each EPHS area are discussed in depth in the full LPHSA report and on the [ThinkHealthSTL.org](https://thinkhealthstl.org) dashboard.

Community Health Assessment: Overall Key Findings

While each assessment touched on many themes and issues that affect health and quality of life in the St. Louis region, the CHAT extracted key findings from each assessment, as described in the prior sections. Key findings that surfaced across two or more assessments are plotted in Figure 9. Key findings that surfaced in three or more assessments are highlighted in green.

Figure 9: MAPP Assessment Key Findings

	CHSA	CTSA	LPHSA	FOCA
Access to Care/ Social Services			X	X
Behavioral Health	X	X	X	
Child/Adolescent Development	X	X		
Chronic Disease Prevalence	X			X
Employment/ Workforce Needs		X	X	
Funding/ Resource Distribution		X	X	X
Health Equity	X	X	X	X
Housing Quality/ Burden	X			X
Policy			X	X
Poverty/ Economic Mobility	X	X		X
Transportation	X		X	
Violence/ Community Safety	X	X		X

Topics that surfaced in three or more MAPP assessments are detailed below, with the data source in parentheses.

Health Equity

The rate of death among Black/African American children is significantly higher than the rate of death among White/Caucasian children. From 2010-2014, in the St. Louis region there was a 13% decrease in heart disease mortality in Whites/Caucasians compared to a 7.1% increase in diabetes mortality in Blacks/African Americans and a 20% decrease in diabetes mortality in Whites/Caucasians and a 4.6 % decrease in Blacks/African Americans (CHSA). Listening session participants observed racism and residential segregation (CTSA). The assessment data lack disaggregation beyond a few variables such as age and race, which can inhibit the ability to assess smaller populations that may experience health disparities. Inclusion of marginalized populations is often a one-time event rather than a systematic process. Lack of trust from marginalized groups is a barrier to engagement in many EPHSs including assessment, constituency development, policy development, service provision, evaluation, and research, among other areas (LPHSA). The legacy of structural racism produced patterns of segregation, disinvestment, and injustice that have proven difficult to reverse (FOCA).

Poverty/ Economic Mobility

The percent of families living in poverty in St. Louis County was 7.9% and 21.7% in the City of St. Louis. St. Louis County poverty levels were highest in the Inner and Outer North sub-regions and most zip codes in the City of St. Louis had a medium, high, or very high percent of families living below the poverty line (CHSA). Poverty and low income are barriers to home ownership, services, and resources (CTSA). Reduced access to higher education, higher interest rates for communities of color, and lack of tax abatements for low-income areas of the City may reduce economic mobility (FOCA).

Violence and Community Safety

Unintentional injury was the fourth leading cause of death (LCOD) for St. Louis County and the fifth LCOD for the City of St. Louis. The City of St. Louis homicide rate was seven times higher than Missouri's rate and St. Louis County's homicide rate was almost double that of Missouri (CHSA). High rates of violent crime, gun violence, and drug activity makes the community feel unsafe (CTSA). Violence disproportionately affects communities of color and is not only a threat to residents' safety but also affects access to opportunity and investment in the community. The participants also noted greater incidence of violence against the Muslim community and other immigrant groups (FOCA).

Behavioral Health

From 2010 and 2016 there was a 228.5% increase in opiate-related deaths in the City of St. Louis and a 22.9% increase in St. Louis County (CHSA). Listening session participants reported easy access to substances (alcohol, tobacco, prescriptions, illicit drugs), heavy substance use, and difficulty accessing available, integrated, and affordable care (CTSA). The LPHS has gaps in access to care due to lack of behavioral health services (LPHSA).

Funding and Resource Distribution

Listening session participants observed inequitable distribution of resources and lack of resources (CTSA). When there is a budget crisis, public health is often the first area to be cut. Dependence on grant funding rather than consistently being part of the normal budget process threatens the sustainability of the public health organizations. The assets and resources that do exist in the LPHS are not well documented or coordinated (LPHSA). Participants reported a lack of funding for critical programs and services due to budget cuts at federal, state, and local levels (FOCA).

Community Assets and Resources

A community asset can be a person, physical structure or place, community service, or institution. The MAPP framework emphasizes the identification of assets and resources to give

a more complete picture of the community, rather than simply focusing on deficits. This enables the community to act from a position of strength and leverage its own assets for solutions, especially when external resources (e.g. state or federal money) may not be available.⁶ The STLPHC gathered information about community assets and resources from three sources: the CHAT, the LPHSA, and the CTSA. CHAT members identified regional assets and resources in three separate meetings, January 17, June 19, and December 11, 2017. A selection of their findings is provided in Figure 10 and Figure 11. Participants in the LPHSA identified the strengths of the local public health system (see page 13) and participants in the CTSA identified many strengths and assets that support health in the St. Louis region (see page 10).

Figure 10: Assets and Resources Identified by the CHAT (January 2017)

PARTNERSHIP & COLLABORATION	<ul style="list-style-type: none"> Connections with community partners Collaboration across St. Louis region Accountable care community network Neighborhood stabilization team Collaboration with universities Relationships with other local health departments and businesses Relationships with HIV/AIDS agencies Unified Health Command and emergency response planning coalition City and county government working together
CIVIC ENGAGEMENT	<ul style="list-style-type: none"> Growing number of young people committed to making a difference Involved community members, organizing and civic engagement People want to be involved and make community better Diversity of population
BUILT ENVIRONMENT	<ul style="list-style-type: none"> Public transit/infrastructure Parks and access to green space Place-making efforts Community gardening International housing standards that city adopted in code
HEALTH CARE	<ul style="list-style-type: none"> Public health clinics and pediatric clinics Free EKG program for adults at St. Louis University Health care institutions Community health workers Gateway to Better Health (safety net program)

⁶ “Section 8: Identifying Community Assets and Resources.” The Community Toolbox. <https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main>

DATA	<ul style="list-style-type: none"> Ability to analyze data and make data-driven decisions Progress Toward Building a Healthier St. Louis: Access to Care Data Book 2017 BJC CHNA Report is available online For the Sake of All: A report on the health and well-being of African Americans in St. Louis and why it matters for everyone
OTHER SERVICES	<ul style="list-style-type: none"> Legal counsel team Citizen Service Bureau (City of St. Louis) Recreation centers (YMCA) STLcondoms.com Music therapy program Philanthropic resources and United Way
WORKFORCE	<ul style="list-style-type: none"> Health department employees and partners Passionate and culturally competent workforce High level of professionalism All the different city and county departments/employees Law enforcement reform with a focus on mental health issues
HEALTH EQUITY APPROACH	<ul style="list-style-type: none"> Public health approach Being outcome driven Coming together to address social determinants of health Inclusiveness Willing to put health as priority Recommendations from the Ferguson Commission Recognize need for human development

Figure 11: Existing Coalitions or Initiatives Working on Issues Identified in CHA (June 2017)

24:1 Initiative	HEAL/Healthy Living Coalition
Behavioral Health Network	Incarnate Word Foundation
Beyond Housing	Large hospitals
Clark-Fox Family Foundation	Missouri Foundation for Health
Community Action Agencies	Promise Zone
Community Development Administration	Regional Health Commission
Continuum of Care	School based health initiatives
Deaconess Foundation	St. Louis University
Emergency Planning	St. Louis Community Foundation
Food Policy Coalition	St. Louis Economic Development Partnership
Gateway Center for Giving	St. Louis Metro Police Department
Generate Health	United Way
Geographic collective impact groups	Violence Prevention Collaborative
Healthy Schools, Healthy Communities	

Opportunities for the Community to Review and Contribute to the CHA

During the assessment period, the CHAT, representing over 52 multi-sector organizations across the region, and the community at large were provided with preliminary assessment findings and opportunities to review and contribute to the assessment. CHAT members were provided assessment updates at monthly meetings from January 2017 through September 2017 and will continue to receive updates on the CHA/CHIP through semi-annual meetings beginning December 2017. CHAT members provided extensive feedback during the monthly meetings and through periodic surveys and worksheets between meetings. The ThinkHealthSTL.org website was launched in February 2017 and included a description of the MAPP process and updates on the CHSA. The CHSA indicators were hyperlinked to available data on other pages of the website. In addition, the ThinkHealthSTL.org website was linked on partners' websites and social media sites as a regional data dashboard and a place to receive updates on plans and progress. STLPHC receives and responds to emails directly from the ThinkHealthSTL.org website "Contact Us" form and a CHAandCHIP.dph@stlouisco.com email address. Interested residents and organizations have contacted STLPHC representatives to get involved in the CHA/CHIP and to comment on information they have read.

2019 Community Health Improvement Plan (CHIP)

The 2017-2018 CHA described the health of the population, identified areas for health improvement, named contributing factors that impact health outcomes, and documented community assets and resources that can be mobilized to improve population health in the St. Louis region. The CHA informed the identification of strategic issues impacting the health of the St. Louis community and assisted in the selection of health priorities and improvement strategies. STLPHC developed a regional Community Health Improvement Plan (CHIP) to frame a collaborative approach to addressing the priorities and goals of our community.

Prioritization Process

Based on the CHA findings, STLPHC developed a set of regional priority health issues with input from the RPLG, CHAT, and the general community. At the August 2017 CHAT meeting, members reviewed the CHA assessment data, identified potential strategic issues that the region should work on collectively for the next three to five years, and then participated in a consensus building workshop to arrive at three to five priorities for the CHIP. The CHAT members considered the following prioritization criteria:

- A strategic issue will surface in at least **3 of the 4 assessments as a need**.
- Focusing on this issue will help achieve our **vision**.
- The **consequences** of not addressing this issue are severe.
- This issue requires a **multi-sector, multi-faceted** approach.
- This issue is a **root cause for multiple health/system issues**.
- We can **leverage opportunities, strengths and assets**.

The September 2017 CHAT meeting was used to narrow down the priorities and determine how to organize for the CHIP.

CHIP Priorities and Goals

The final CHIP structure is depicted in Figure 12, with three priorities and five goals. The goals represent the strategic issues that the CHIP will address over the next five years. The three priorities underpin all of the CHIP work, explicitly recognizing the need to address the social determinants of health, promote health and racial equity, and support regional infrastructure in all of the CHIP goals. The priorities were identified as a commitment and intentional approach to improve public health outcomes while also recognizing limited infrastructure and the need to strengthen multi-sector (i.e., community development, transportation) collaboration in the local public health system to address social and structural determinants of health.

Figure 12: 2019 CHIP Priorities and Goals



STLPHC identified community coalitions to lead Action Teams for each of the five goals (see Figure 13) and invited additional community organizations to join the teams. The Action Teams will have designated members that will report to the CHAT and RPLG on implementation progress and can seek assistance from both advisory bodies for CHIP planning and implementation needs.

Figure 13: CHIP Action Teams



CHIP Action Planning

At the December 2017 CHAT meeting, members began preliminary planning by discussing how member organizations are currently addressing the issue, gaps in the region, potential strategies and member organization roles to address gaps. It was important for the CHAT to identify the existing initiatives and coalitions working in each goal area in order to reduce duplicative work and to leverage existing assets and resources in the community for greater sustainability. CHAT members also explored how working on each goal may advance the local public health system’s development in data, policy and community engagement. Finally, members explored the role of the business community and other potential new public health partners in addressing the goals. More detail can be found in Appendix F “Chip Priority Planning Launch.”

Action Teams convened in January 2018 to adopt the CHIP Action Team Charter, solidify the action planning process with consideration of current coalition plans, adapt planning templates/tools, and adopt a timeline for completion of draft action plans by August 2018. Over the course of five months, each Action Team developed an Action Plan with measurable objectives, improvement strategies, and activities with time-framed targets. The plans indicate which individuals and organizations have accepted responsibility for implementing the

strategies and outline policy changes that are needed to accomplish health objectives. Where possible, teams considered both national and state health improvement priorities to maximize alignment across jurisdictions. Action Teams presented posters with high level overviews of the action plans at the May 2018 CHAT Open House. The final Action Plans are located in Appendix G.

Community Participation in CHIP

The CHIP planning process included participation by a wide range of community partners representing various sectors of the community. Community partners and community members involved in the CHA process were invited to continue participating in CHIP planning and implementation. Each Action Team is co-chaired by community coalition leaders and team membership is comprised of RPLG and CHAT representatives as well as a variety of community organization representatives. See Appendix A for participating organizations. CHIP updates will be available via the ThinkHealthSTL.org website and community members can continue to share feedback through the “Contact Us” form and a CHAandCHIP.dph@stlouisco.com email address.

The May 2018 CHAT meeting was hosted as an open house for CHAT members, RPLG members, and organizers and participants from community listening sessions to learn about the CHA/CHIP and provide feedback on assessment findings, CHIP priorities, and preliminary action plans. The CHAT met regularly throughout 2017 and 2018 to guide the CHA process and to shape the direction of the CHIP and will continue to convene on a semi-annual basis to provide feedback and guidance on the implementation of the CHIP. The full assessment report can be found at <http://www.thinkhealthstl.org/>.

Appendix B

Community Health Status Assessment March 2022
St. Louis Partnership for a Healthy Community

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2022 COMMUNITY HEALTH STATUS ASSESSMENT

The Community Health Status Assessment (CHSA) identifies community health and well-being issues using demographic, health, and socioeconomic profiles. **Questions answered include:** "How healthy are our residents?" and "What does the health status of our community look like?".

You will be asked to provide input into what data is used to make decisions about the priority indicators that impact the St. Louis region and where there are disparities in access to, or receipt of, services to move the needle on those indicators.

DAY ONE: March 30th from 9:00 am to 1:00 pm

9:00 am - 9:45 am - Directors Welcome, Demographic & Social Determinants of Health - Current population demographics help determine the types of health and social services needed by communities. Social Determinants of Health are the conditions in which people are born, live, work, play and pray. Economic and social insecurity are associated with poor health, poverty, unemployment, and lack of educational achievement. These affect access to care and a community's ability to engage in healthy behaviors. Without a network of support and a safe community, families cannot thrive. Ensuring access to social and economic resources provides a foundation for a healthy community.

10:00 am - 10:30 am - Accidental & Intentional Injury - Accidents or intentional injuries are a leading cause of death. These include falls, drownings, motor vehicle accidents, and crime—assaults, rapes, murder, and property crime.

10:45 am - 11:15 am - Behavioral Health - Mental health status or substance use disorders are indicators of social issues experienced by an individual or a community. Mental health disorders have a serious impact on physical health and are associated with the progression and outcomes of many chronic diseases, including diabetes, heart disease, and cancer.

11:30 am - 12:00 pm - Communicable Diseases - A review of communicable diseases reported to the Department of Health includes sexually transmitted infections, hepatitis, and influenza. HIV is also a major cause of illness and in some cases, death. This is also a 'winning battle' according to the CDC given prevention.

12:15 pm - 12:45 pm - COVID-19 - A review of the impact of the COVID-19 pandemic with the percent of fully vaccinated, confirmed cases, death by age-race/ethnicity-City and County impact will be presented. The ability to be mobile during the pandemic is also reviewed. The impact of COVID has touched all lives with a disproportionate impact on people of color.

DAY TWO: March 31st from 9:00 am to 1:00 pm

9:00 am - 9:45 am - Directors Welcome, Access to Care - A lack of access to care presents significant barriers to good health. Rates of sickness, death, and emergency hospitalizations can be reduced if residents access preventive care including health screenings, routine tests, and vaccinations. Prevention indicators call attention to a lack of access and/or knowledge regarding health issues and inform program interventions. The supply of workforce (physicians, nurses, other clinicians) and their relationship with their patients (cultural, language, and lifestyle similarity) are negatively impacted by lack of health insurance, financial hardship, transportation barriers, cultural competency, residence, and coverage limitations.

10:00 - 10:30 am - Environmental Health - A community's health is affected by where people live. A safe, clean environment provides access to healthy food, recreation, and hygienic places where people can maintain and improve their health. This includes many important climate factors such as clean air, water, sanitary living conditions, and safe and affordable housing. Access to the Internet and healthy food are also environmental factors in community health.

10:45 am - 11:15 am - Maternal-Child-Family Health - These indicators point to the likelihood of maternal and infant health risks with a focus on disparities. Lack of access to preventive, prenatal, and postnatal care can result in high infant and maternal mortality rates. Insufficient provider outreach, social barriers, or structural racism adversely impact infant and mother complications and even death.

11:30 am - 12:15 pm - Chronic Diseases, Closing Remarks - A review of chronic diseases is a measure of the illness and death (morbidity and mortality) due to chronic disease. Certain diseases relate to lifestyle choices or Social Determinants such as obesity and diabetes or smoking and heart disease. Reducing or managing these diseases can prevent illness and death.

DEMOGRAPHICS AND SOCIOECONOMIC

COMMUNITY HEALTH STATUS ASSESSMENT

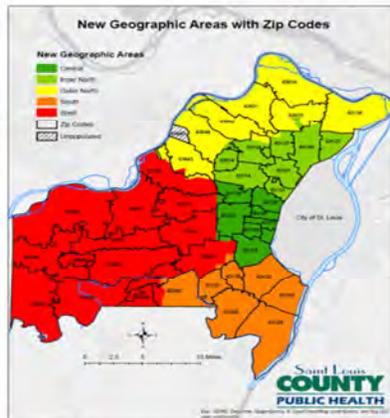
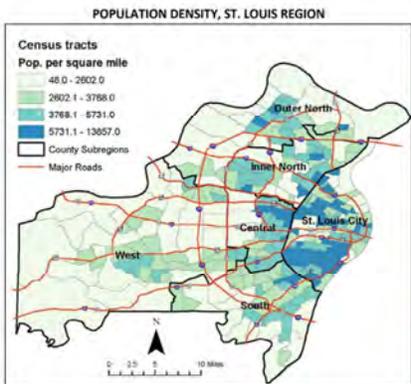
TRACY KULIK & MARCOS ALCORN

MARCH 30, 2022

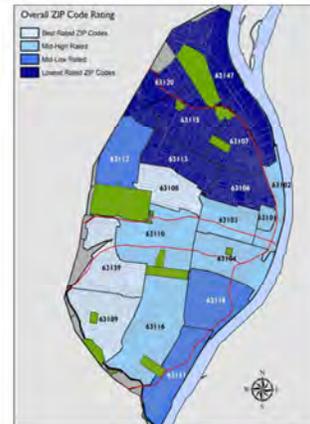


GEOGRAPHIC AREA

In 2012, the St. Louis County Department of Public Health designated new geographic areas within St. Louis County and aligned them with the Department of Planning's five-year Strategic Plan.



5 regions with 42 zip codes



18 zip codes

Demographics

A PROFILE OF THE CITY AND COUNTY OF SAINT LOUIS AND THE REGION
REGARDING CHARACTERISTICS OF THE POPULATION

Overview



	Total Population	Median Household Income	Bachelor's Degree or Higher	Total Housing Units	No Health Care Insurance
St. Louis City	301,578	\$43,896	36.33%	176,729	10.8%
St. Louis County	1,004,125	\$67,420	43.65%	440,960	6.1%

- **St. Louis City** - A total of 308,174 people live in the 61.74 square mile area for a population density of 4,991.9 in the City of St. Louis, according to the U.S. Census Bureau American Community Survey for the 5-year estimated timeframe of 2015-2019.
- **St. Louis County** - A total of 996,919 people live in the 507.43 square mile for a population density of 1,964.66 in St. Louis County, according to the U.S. Census Bureau American Community Survey 5-year estimate for 2015-2019.

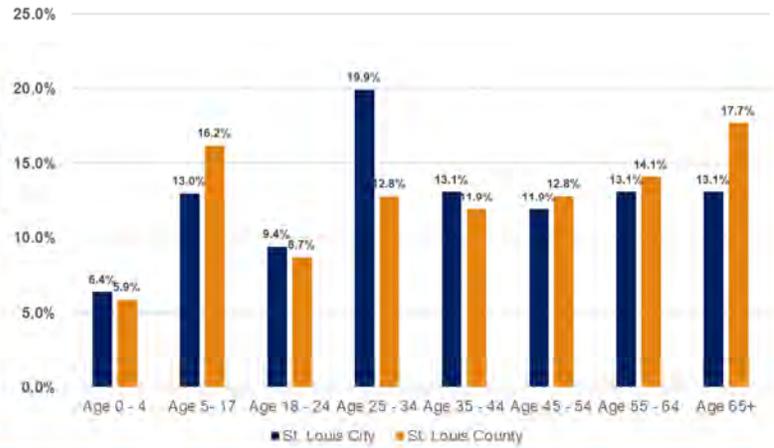
Demographics – Sex & Age



Female

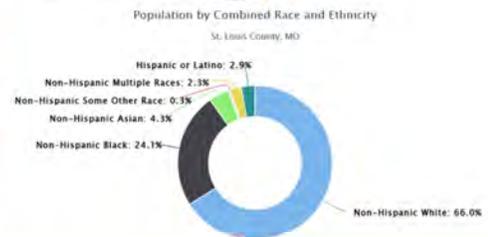
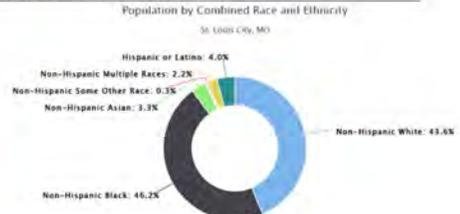
Male

St. Louis City	51.6%	48.4%
St. Louis County	52.7%	47.4%



Demographics – Race & Ethnicity

	St. Louis City	St. Louis County
White	46.5%	67.9%
African American	46.4%	24.2%
Asian	3.4%	4.3%
Native American or Alaska Native	0.3%	0.2%
Native Hawaiian or Pacific Islander	0.1%	0.04%
Other Race	1.0	0.9%
Multiple Races	2.4%	2.5%
Hispanic or Latino	4.0%	2.9%



Demographics - Languages

9.9%

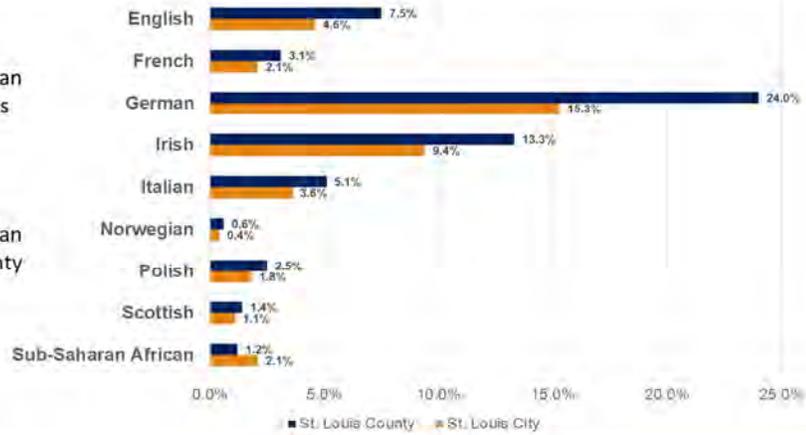
Speak a language other than English at home in St. Louis City

10.0%

Speak a language other than English at in St. Louis County

6.6%

Speak a language other than English in Missouri



Socioeconomics

A STATISTICAL PROFILE OF THE SOCIAL DETERMINANTS THAT DESCRIBE HOW PEOPLE ARE BORN, LIVE, LEARN, WORK, PLAY, WORSHIP AND AGE THAT AFFECT A WIDE RANGE OF HEALTH FACTORS AND QUALITY OF LIFE AND HEALTH OUTCOMES.

Financial Security - Poverty

\$43,896

Median Household income
in St. Louis City

0.50

Income Inequality - GINI
Index Value in St. Louis City

21.8%

% of Persons in Poverty in
St. Louis City

35.9%

% of Children (under 18) in
Poverty in St. Louis City

\$67,420

Median Household income
in St. Louis County

0.49

Income Inequality - GINI Index
Value in St. Louis County

9.7%

% of Persons in Poverty in
St. Louis County

13.8%

% of Children (under 18) in
Poverty in St. Louis County

\$55,461

Median Household income
in Missouri

0.46

Income Inequality - GINI
Index Value in Missouri

13.7%

% of Persons in Poverty in
Missouri

18.7%

% of Children (under 18) in
Poverty in Missouri

9

- This coefficient is a **measure of statistical dispersion intended to represent the income inequality or the wealth inequality within a nation or a social group.**
- A value of 0 indicates perfect equality (where everybody has the same wealth/income) and 1 indicates perfect inequality (that is, where one person owns all the wealth in a country).
- Practically, the value falls between 0 and 1 for most countries. In countries with high inequality, the value would be close to 1.
- A value below 0.4 is considered acceptable.

Uninsured - Disabled

10.8%

Adult Population Uninsured
in St. Louis City

5.0%

Uninsured Children in
St. Louis City

5.0%

% Population with Disabilities
in St. Louis City

6.1%

Adult Population Uninsured
in St. Louis County

3.1%

Uninsured Children in
St. Louis County

12.0%

% Population with Disabilities
in St. Louis County

9.4%

Adult Population Uninsured
in Missouri

5.6%

Uninsured Children in
Missouri

14.6%

% Population with Disabilities
in Missouri

Affordable Housing



45%

Renter Occupied Households
in St. Louis City

27%

Renter Occupied Households
in St. Louis County

26%

Renter Occupied Households
in Missouri

Percentage of Households where
Housing Costs Exceed 30% of
Income



● St. Louis City (36.07%)
● Missouri (25.53%)
● United States (30.85%)

Percentage of Households where
Housing Costs Exceed 30% of
Income



● St. Louis (27.17%)
● Missouri (25.53%)
● United States (30.85%)

3.9%

Eviction Rate in St. Louis City

4.1%

Eviction Rate in St. Louis County

2.9%

Eviction Rate in Missouri

HUD Definition: Cost Burden is when 30% or more of a household income goes to housing costs.

Transportation



27,929

Households with no motor vehicle in St. Louis City

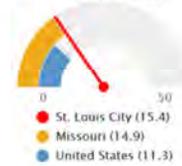
7.5%

Carpool in St. Louis City

8.8%

Public Transportation in St. Louis City

Motor Vehicle Crash Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



27,119

Households with no motor vehicle in St. Louis County

6.8%

Carpool in St. Louis County

2.3%

Public Transportation in St. Louis County

Motor Vehicle Crash Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



165,906

Households with no motor vehicle in Missouri

8.6%

Carpool in Missouri

1.3%

Public Transportation in Missouri

THANK YOU!





ahaslides.com/CHSADAYONE

DEMOGRAPHICS AND SOCIOECONOMIC

The purpose of today's meeting is to identify measures and indicators are reflective of Demographics and Socioeconomic in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

TRACY KULIK
MARCOS ALCORN

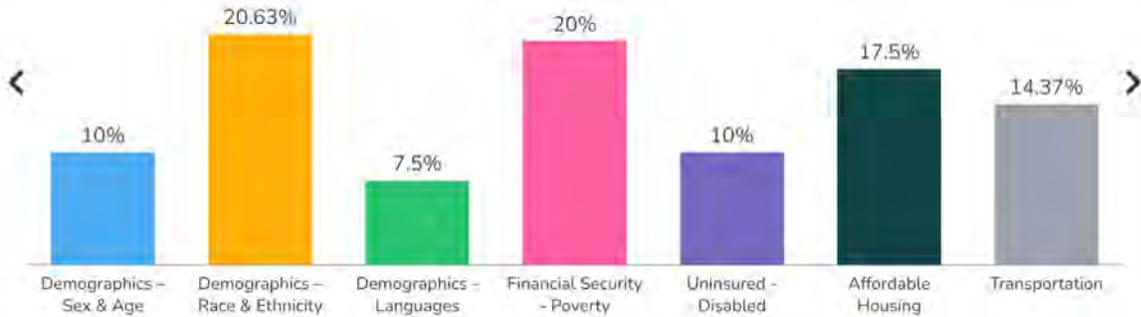




To join, go to: ahaslides.com/CHSADAYONE

AhaSlides

Select the indicators which effectively tell the story of Demographics and Socioeconomic in our community



Menu

25 4 2 4 37 0

How does the data reflect your experience? How do they differ from your experience?

I think the data reflects my experience pretty accurately.

Race matters in STL, which was captured in the data

Unsurprising based on personal & professional experience

Affordable housing is lacking and it's a huge problem for the region.

The data overall reflect my perceptions of what is happening in the city and county.

No surprises in data

It accurately reflects my experience.

The data shows race matters and can get you different forms of treatment.

The race and ethnicity definitely reflect my lived experiences as a Black person locally and nationally.

Data clearly and accurately reflect my experience, particularly race, poverty and affordable housing.

It is matching with what I have experienced in the past six years in Saint Louis region. Deeper dive by stratification is needed.

This data reflects the racial disparities we observe across a variety of health indicators

Housing is a huge issue.



How does the data reflect your experience? How do they differ from your experience?

- huge problem for the region.
- what is happening in the city and county.
- It accurately reflects my experience.
- The data shows race matters and can get you different forms of treatment.
- Data clearly and accurately reflect my experience, particularly race, poverty and affordable housing.
- It is matching with what I have experienced in the past six years in Saint Louis region. Deeper dive by stratification is needed.
- Housing is a huge issue
- This data reflects the racial disparities we observe across a variety of health indicators
- What I expected mostly. I would have liked to see additional racial and ethnic
- The data show the stark inequities in our region and who is most impacted by them.
- It's not surprising that poverty and affordable housing are seen as important aspects when telling the narrative

How does the data reflect your experience? How do they differ from your experience?

Community is a huge issue

What I expected mostly, I would have liked to see additional racial and ethnic categories and languages spoken broken out.

As a tenant organizer affordable housing is always a concern.

Data confirms my experience, consistent with degree of community disinvestment.

The data show the stark inequities in our region and who is most impacted by them.

Racial differences drive all of the other indicators.

Housing is critical

Overall reflective, but missing some nuance/details, which is to be expected when trying to summarize in one slide.

It's not surprising that poverty and affordable housing are seen as important aspects when telling the narrative

Racism and poverty needs to be addressed

Food security data is does not reflect accurate in regard to North St. Louis County

Decrease ability for parents to keep their

Page 1 of 2 ▶

Menu

👍 25 🍷 4 😬 2 🙄 4 🙋 42 👤 0

How does the data reflect your experience? How do they differ from your experience?

Inequality is a huge issue.

What I expected mostly, I would have liked to see additional racial and ethnic categories and languages spoken broken out.

As a tenant organizer affordable housing is always a concern.

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Page 1 of 2

Menu

👍 25 🍷 4 😬 2 😞 4 🗳️ 42 👤 0

How does the data reflect your experience? How do they differ from your experience?

Overall reflective, but missing some nuance/details, which is to be expected when trying to summarize in one slide. Would recommend a more detailed look at income beyond poverty. Many residents have incomes above FPL, but just barely. Important to reflect this; percentages of income that is not enough to meet basic needs will be a much higher % than currently presented.

County

Decrease ability for parents to keep their children safe by purchasing car seats, safe sleep environments, and other safety items. Financial insecurities and racial disparities.

Data is rarely reflective of my experience. The answers provided are always limited

It hits right on. We could not have planned our approaches to challenges any better if

Data confirms my experience, consistent with degree of community disinvestment.

The data are clear and not surprising

differences between City and County are highly important in understanding health

Data drive policy funding and programs

I think there is disparity among St. Louis county.

How does the data reflect your experience? How do they differ from your experience?

Data drive policy funding and programs

Currently presented.

The answers provided are always limited

I think there is disparity among St. Louis county.

It hits right on. We could not have planned our approaches to challenges any better if we had tried. We have a disconnect between resources and challenges. The threat to health experienced by one demographic group is transferred in numerous ways to the entire region. However, we seem to ignore the challenges when we don't live with them every day. We can and must do better. Thanks.

Page 1 of 2

 Menu

 25  4  2  4  42  0

What indicators do you feel are missing? Please share data sources.

More on inequity. Lord the Gini index. CDC social vulnerability

Need geocoded map on food insecurity.

Food security by zip code. Think Health STL only shows by county or city.

Would like to know more about the experiences of the disability community. Not sure where to find the data.

Access to computer/smartphone/internet

Data gathered from Nonprofits working on the ground

Education levels attained.

Education rates

gender identity

Deeper dive into ethnicity, languages spoken, poverty level and housing availability

Data on residents who are houseless/homeless

Education level, may obtain data from schools and colleges or board of education.

Access to quality education

life expectancy by zip code, all-cause

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Menu

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What indicators do you feel are missing? Please share data sources.

schools and colleges in order to education.

Access to quality education

life expectancy by zip code, all-cause mortality rates

You need to look more closely at the aging population. The last CHIP did not include issues that impact older adults. Currently the Mo Senior Report is looking to update its report to focus on SDOH by County. Please contact MU Health Center for Policy who oversees the report.

Disaggregated County Data (in current data)

Access to healthcare in general and health literacy. Not sure where or how to collect such data, other than directly talking to community itself.

Pediatric data is missing.

I think there are a lot of other factors that could be considered: mental health, crime and safety, school attendance and graduation rates, employment.

Disability regardless of insurance, ACS.

Access to affordable medical care

More options/responses/answers from

Page 1 of 2

Menu

25 4 2 4 36 0



What indicators do you feel are missing? Please share data sources.

^

Access to affordable medical care.

graduation rates, employment.

More options/responses/answers from areas not considered controlled areas such as homeless areas, under the table pay jobs, etc

sexual orientation, gender identity and expression

More on housing affordability and evictions. Continue work started by affordable housing coalition.

Poverty rates by race

Poverty rates by census tract

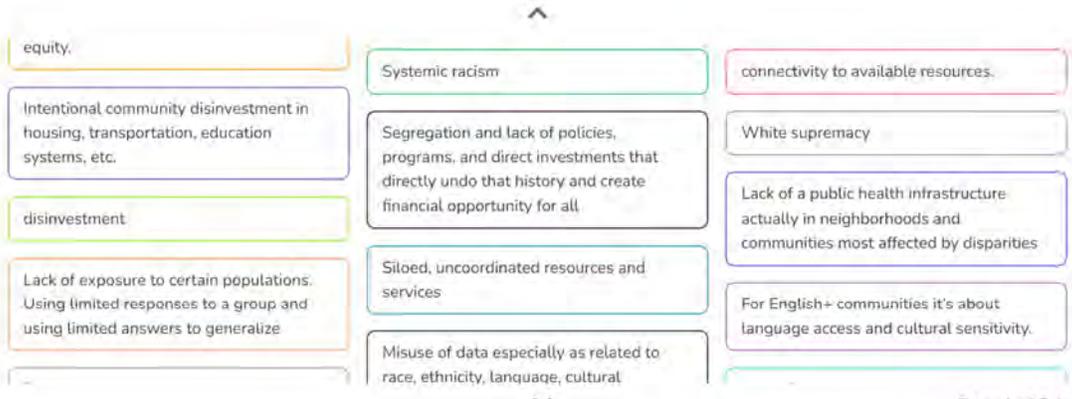
Second for life expectancy by zipcode.

Food access, educational attainment, access to physical activity, financial opportunity, employment

Look beyond poverty rates. More breakdown related to income. Economic Security Index could be helpful.

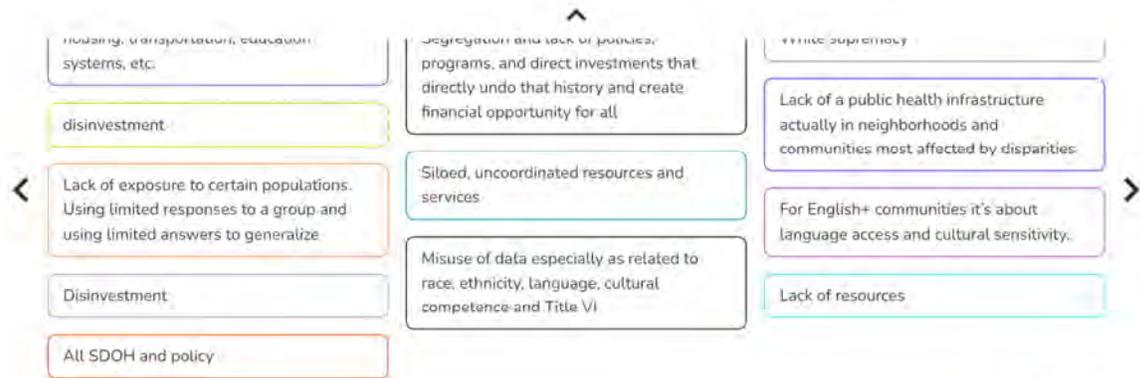
Mental health, substance abuse

What are the underlying causes and external factors that affect the disparities in this category?





What are the underlying causes and external factors that affect the disparities in this category?



Questions

Tracy Kulik, Project Lead
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Marcos Alcorn, Project Manager
malcorn@kulikstrategic.com

Intentional and Unintentional Injury

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY ECHO WANG, ABIGAIL ANDRESEN & CLAYTON ADAMS
MARCH 30, 2022
10:00 – 10:30 A.M.



Good morning everyone! My name is Clayton Adams. I'm an epidemiologist with Saint Louis County Department of Public Health. Thank you for joining us on day 1 of the Community Health Status Assessment, which is part of the joint city and county Community Health Assessment process. The data presentation you'll see today was compiled by the City of Saint Louis Department of Health and the St. Louis County Department of Public Health with the assistance of our consultants from Kulik Strategic Advisors.

In this session, we will be discussing Unintentional and Intentional Injury, as well as indicators and risk factors that contribute to Injury. Afterwards, we'll have an interactive activity where you will have the opportunity to rank measures and provide feedback. Now, let's get started.

Indicators for Unintentional and Intentional Injuries:

These injuries are a leading cause of death. These include falls, drowning, motor vehicle accidents, gun violence and crime.

Intentional Injury

- Homicide
- Firearm-related Mortality
- Crime
- Emergency Room Visits - Intentional Self-Harm
- Suicide

Unintentional Injury

- Leading Causes of Death
- Emergency Room Visits - Substance Use
- Overdose Mortality
- Opioid Overdose Mortality
- Alcohol Impaired Driving Mortality

2

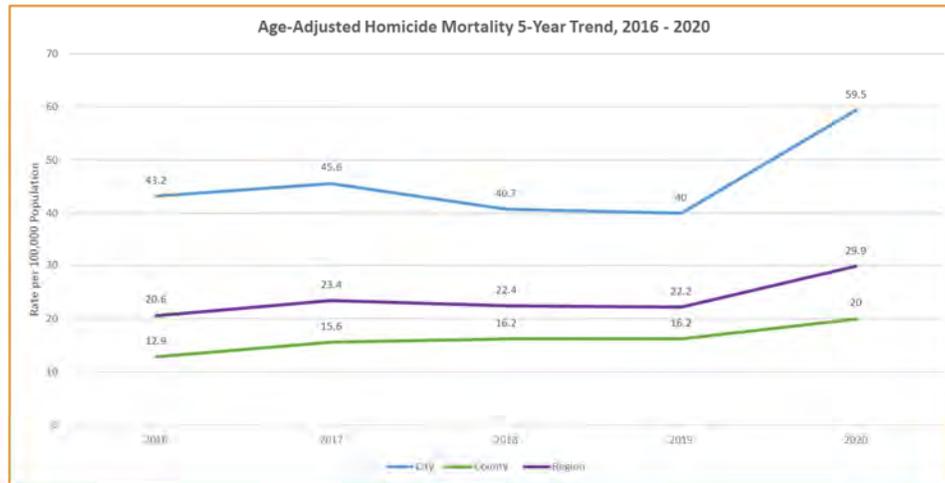
On this slide, you see that we'll be covering two main topics for injury, intentional and unintentional injury. Regional Hospital and vital records data utilized in this presentation were provided by MO DHSS. When we conducted the analysis for this presentation, we looked at past 5-year trends in addition to stratifying data by race, sex, and poverty level.

Intentional Injury

3

Throughout the next few slides we will examine indicators related to Intentional Injury

Homicide

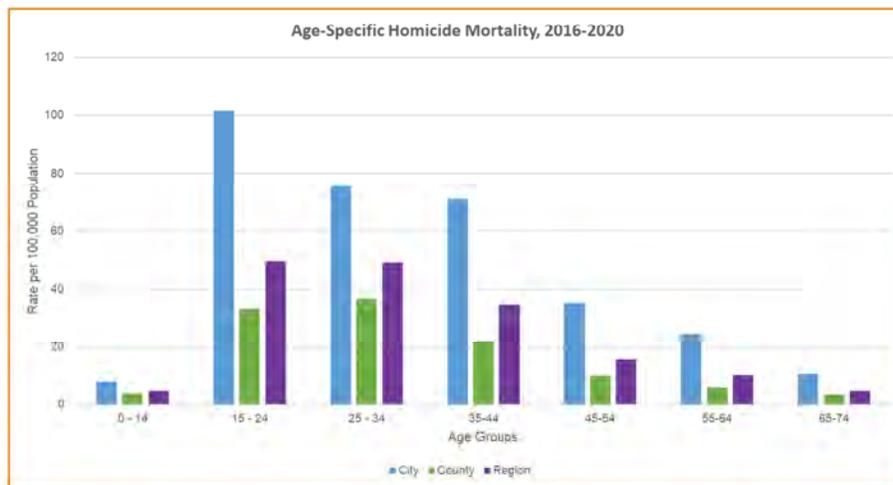


4

This first indicator we will look at is Homicide Mortality. Here we see an increase in Homicide Mortality rates across the 5-year period. With the highest rates occurring in the most recent year of data 2020.

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Homicide

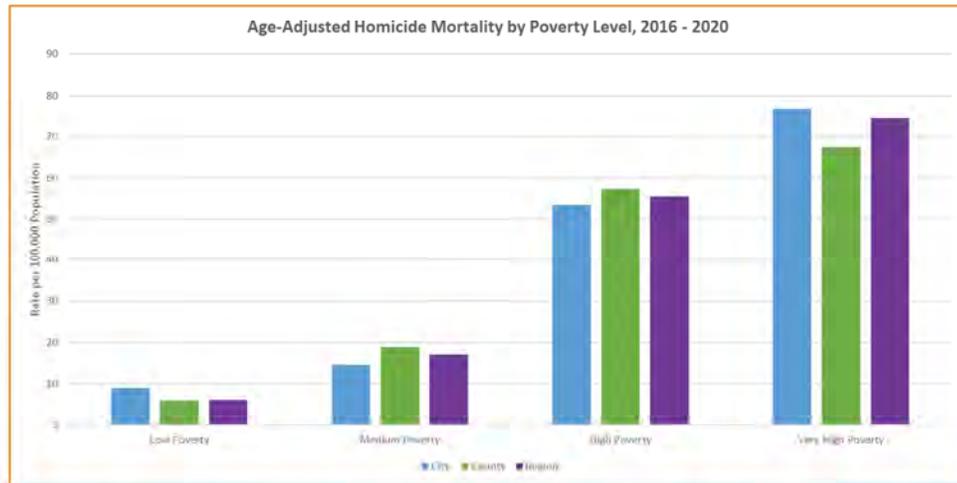


5

When we examine age-specific homicide mortality rates, we can clearly see that in St. Louis City rates are highest in the 15-24 age group then 25-34 and 35-44 age groups. The trend is slightly different in St. Louis County with the highest rates involving the 25-34 age group followed by 15-24 and 35-44 age groups.

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

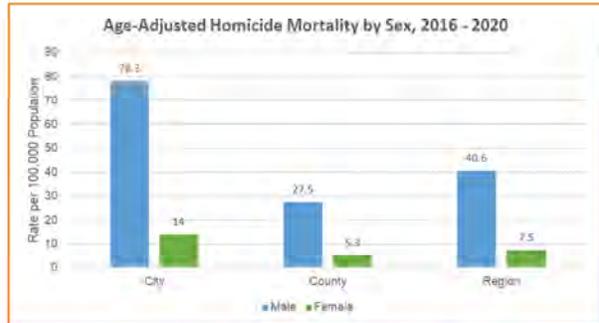
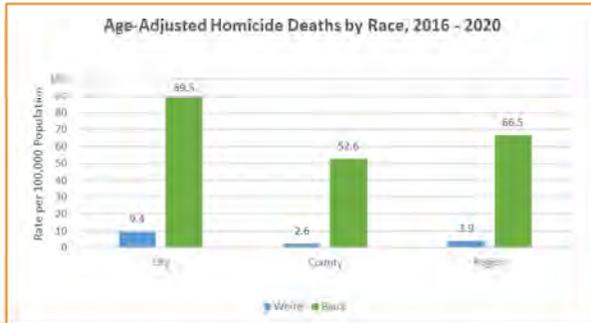
Homicide



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

The homicide mortality rate increases across each of the increasing levels of poverty. The rates are significantly higher in the High Poverty Group and Very High Poverty Group. Rates are consistent across the City County and Region within each poverty level.

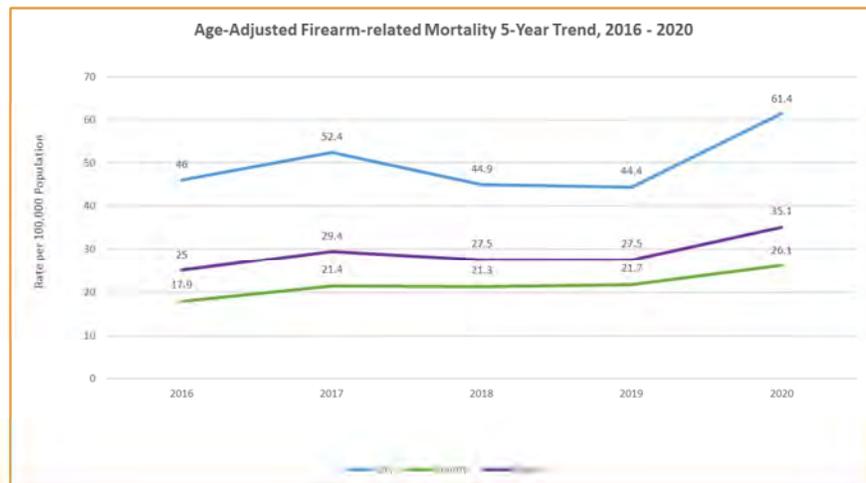
Homicide



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Looking at Homicide rates by Race, we can observe the disproportionate impact that homicide has Black residents compared to White residents. When we examine rates by Sex we see that Males have much higher rates of homicide mortality compared to Females.

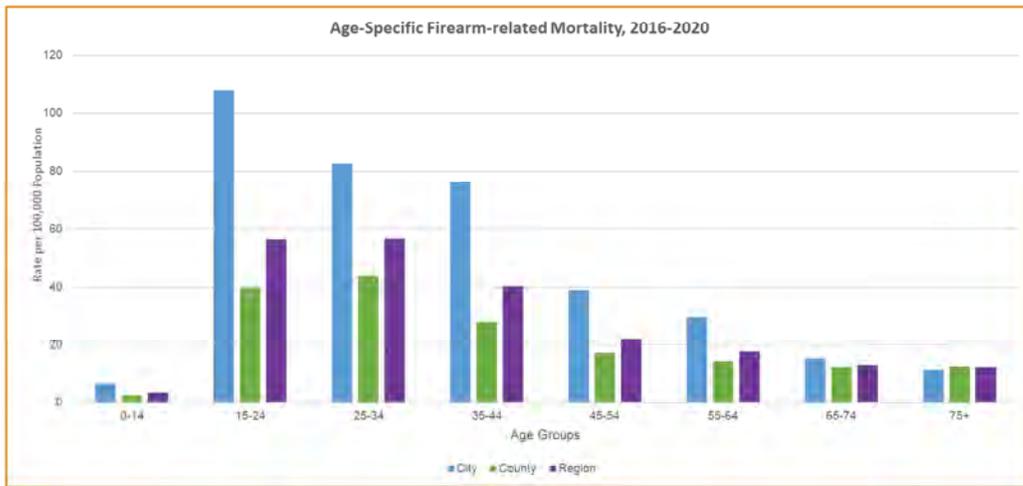
Firearm-related Mortality



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Next we look at firearm-related mortality which includes intentional and accidental deaths involving firearms. In the City, County, and combined region we see a general increasing trend in Rates across the 5-year period. With the highest rates for an individual year all coming in 2020.

Firearm-related Mortality

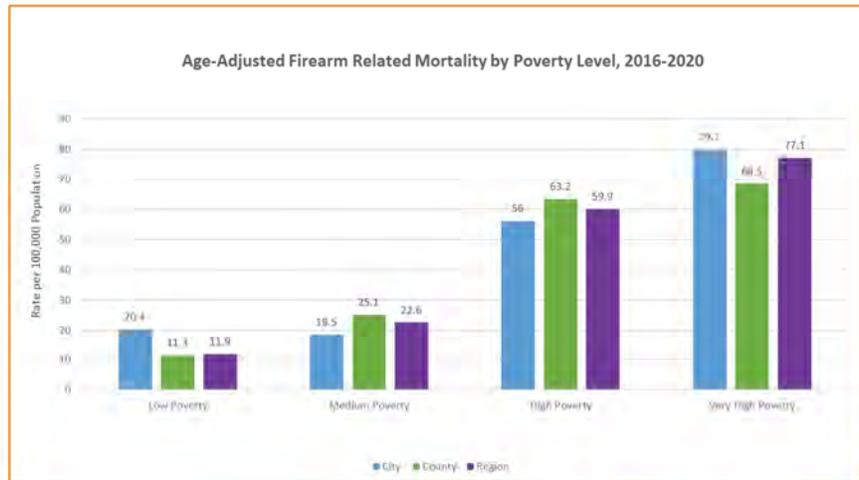


9

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Similar to the age-specific trends in homicide mortality, we observe that in St. Louis City 15-24 yr olds have the highest rate of fire-arm related mortality. In St. Louis County and the Region combined 25-34 yr olds are observed to have the highest rates.

Firearm-related Mortality

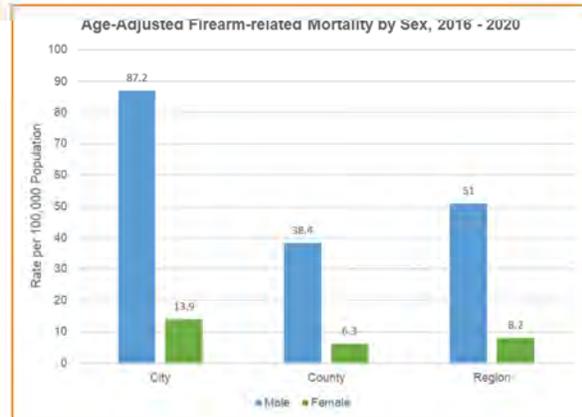
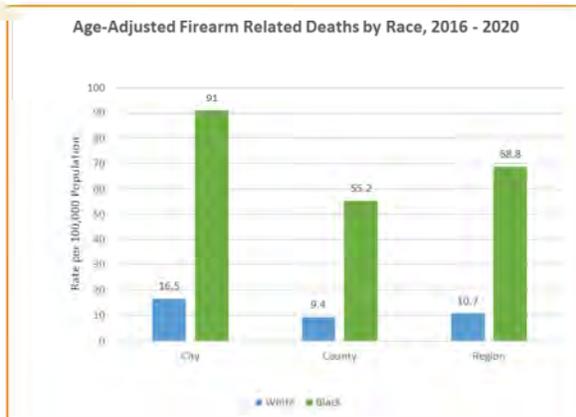


10

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

In this next visual we see that Firearm-related mortality increases with increasing poverty level. With the highest rates of firearm-related mortality occurring in the Very High Poverty and High Poverty groups.

Firearm-related Mortality

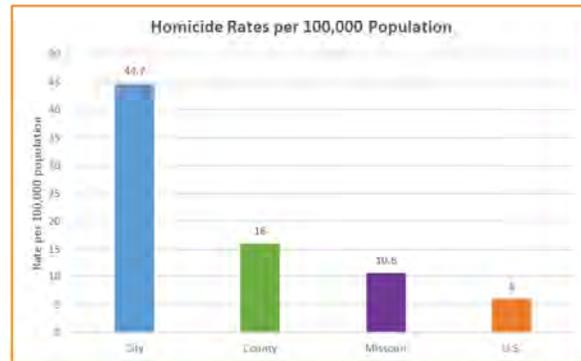
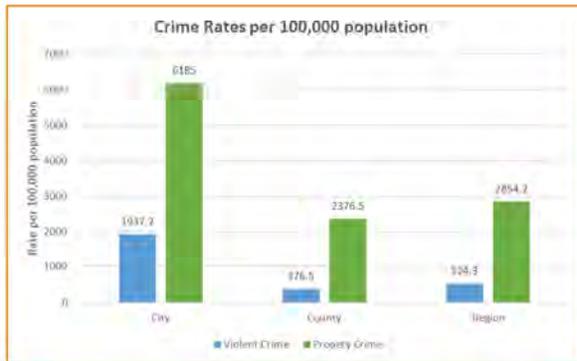


11

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

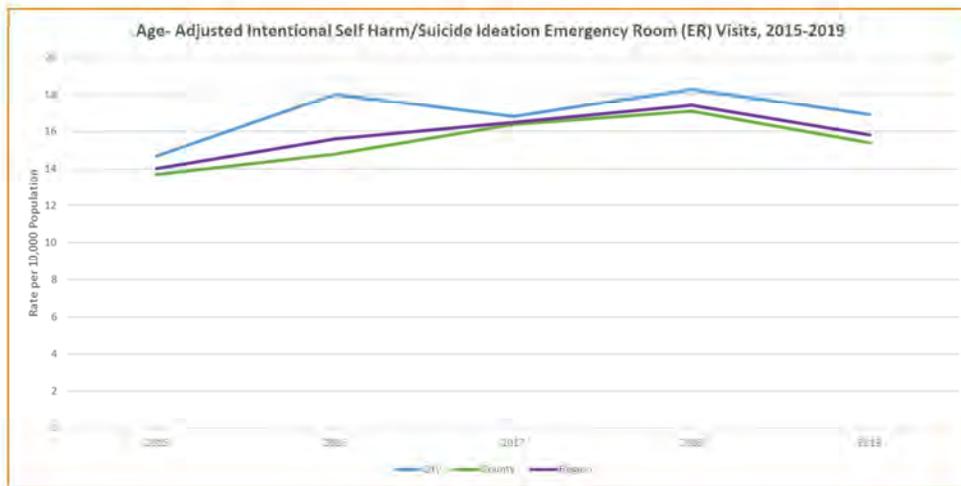
Age-adjusted rates of firearm-related mortality are higher in both Black and White Residents compared to homicide mortality rates. With Black residents across each of the 3 geographic regions being disproportionately impacted. We can also observe that rates are higher for males compared to females.

Crime



On this slide, we see that the rates for homicide and violent and property crime were highest in the city, with a ratio of violent crime to property crime in the city of 1:3.2 and in the county of 1:8.7.

Emergency Room Visits – Intentional Self-harm

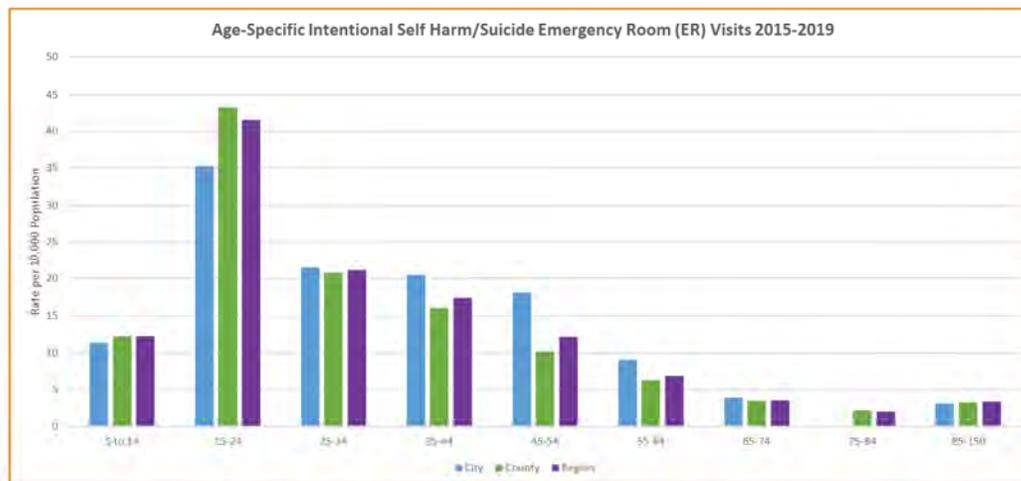


13

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

For the next few slides, we will be looking at suicide (i.e., intentional self-harm) related indicators and risk factors. As we can see in the first figure, ER visit rates due to intentional self-harm have increased overall in the region over this 5-year timeframe, with a spike in visits in 2018 followed by a minor drop in 2019.

Emergency Room Visits – Intentional Self-harm



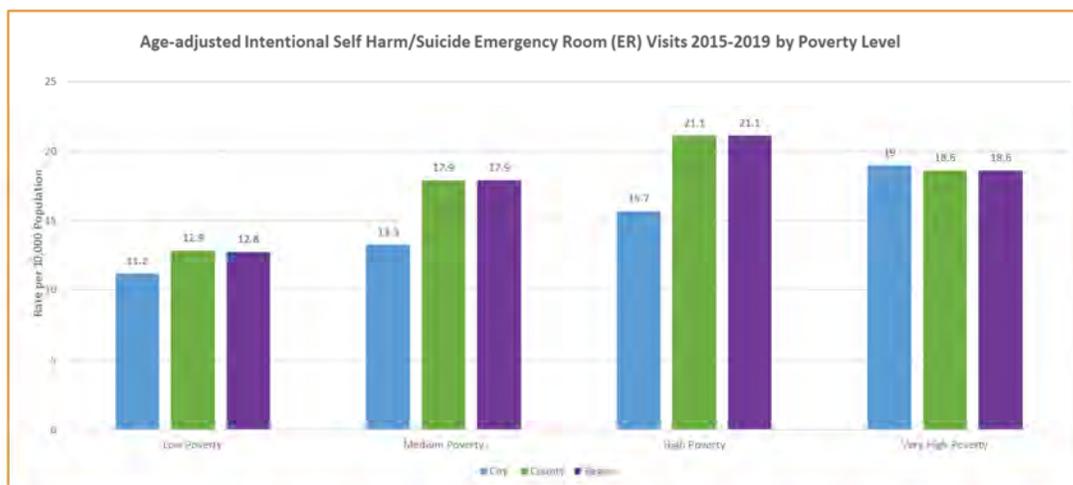
14

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

*City data suppressed for 75-84

On this slide, we see that the 15 -24 age group had the highest rates of ER visits for intentional self-harm in the region, with a relative incremental decrease in rate for each subsequent cohort less than 85 years.

Emergency Room Visits – Intentional Self-harm

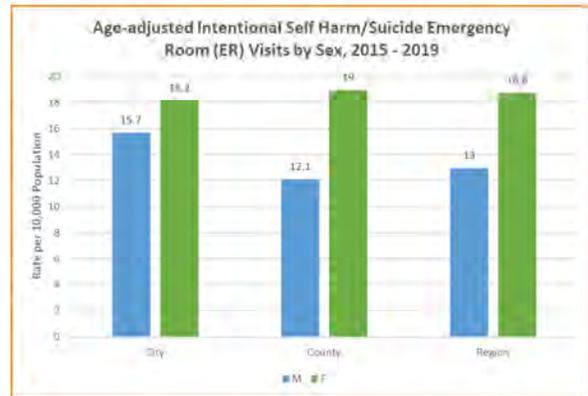
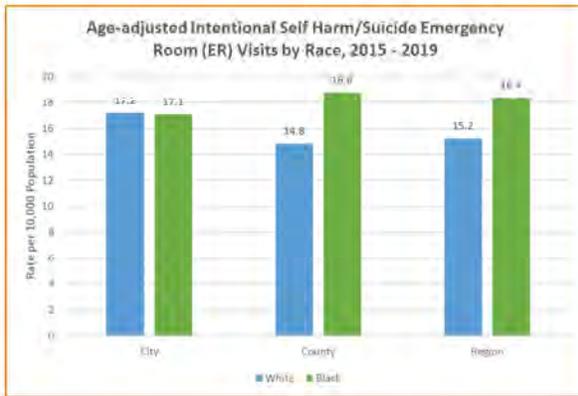


15

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

Poverty level showed a positive association with ER visits for intentional self-harm in the city, with the highest rates occurring in neighborhoods labeled 'very high poverty,' while the highest rates in the county occurred in those labeled 'high poverty.' As an aggregate, individuals from high poverty neighborhoods in the region had the highest rates during this 5-year timeframe.

Emergency Room Visits – Intentional Self-harm

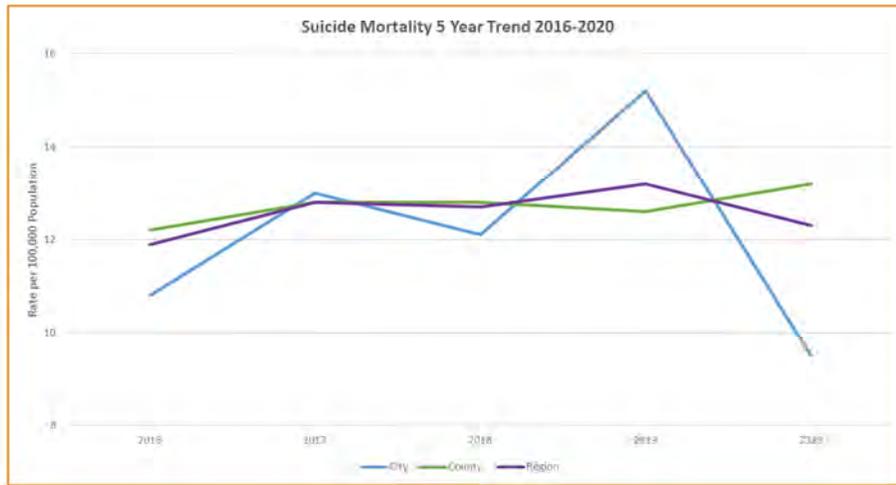


16

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

In the county, rates of ER visits for intentional self-harm were higher among black residents compared to white residents, but the same trend did not hold true in the city. Meanwhile, female's visits to the ER for intentional self-harm were more common than males in both the city and the county.

Suicide

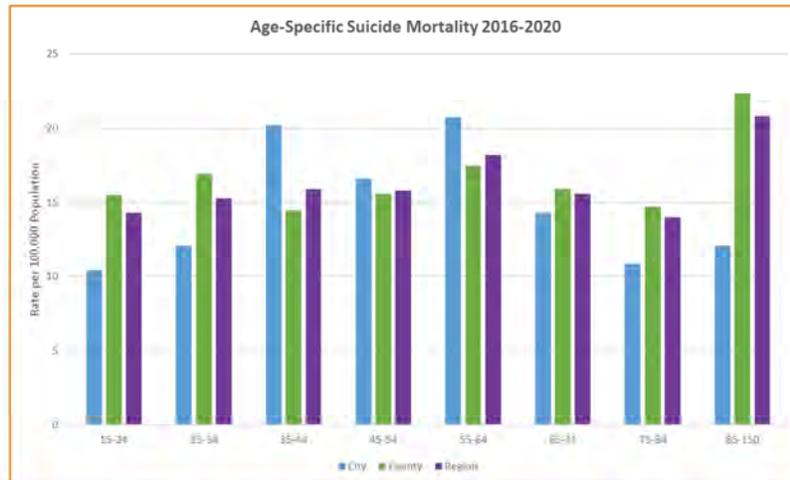


17

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

The rate of suicide mortality overall has gone up in the region over the last five years, but 2020 gave way to rate of 12.3 per 100,000 population, a 7% decrease from 2019. This decrease is largely attributable to the stark drop in suicide mortality rate in the city in 2020 from 2019.

Suicide

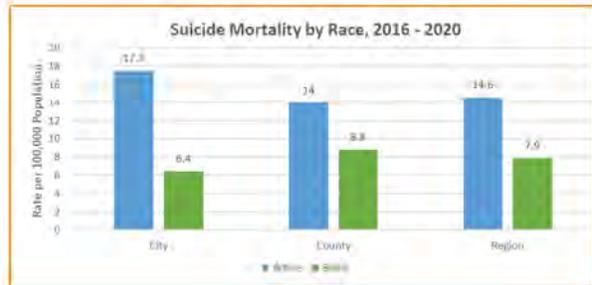
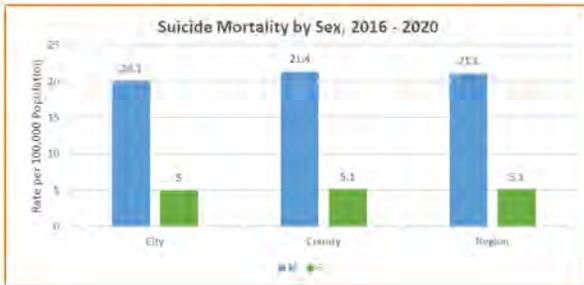


18

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

On this slide, we see that suicide mortality rate in the city was highest among the 55-64 age group, while the county rate was highest among age group 85 years and older.

Suicide



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Stratifying by race and sex, we see that across the region, suicide mortality rates among males and whites were higher compared to their female and black counterparts, respectively.

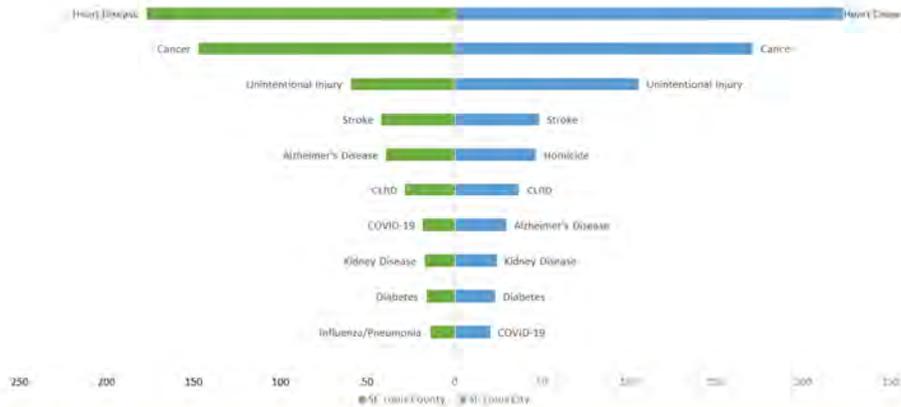
Unintentional Injury

20

Now we will take a look at a few indicators related to Unintentional Injury. As you will see on the next slide, Unintentional Injury was the 3rd leading cause of death in the City and County between 2016 and 2020.

Leading Causes of Death

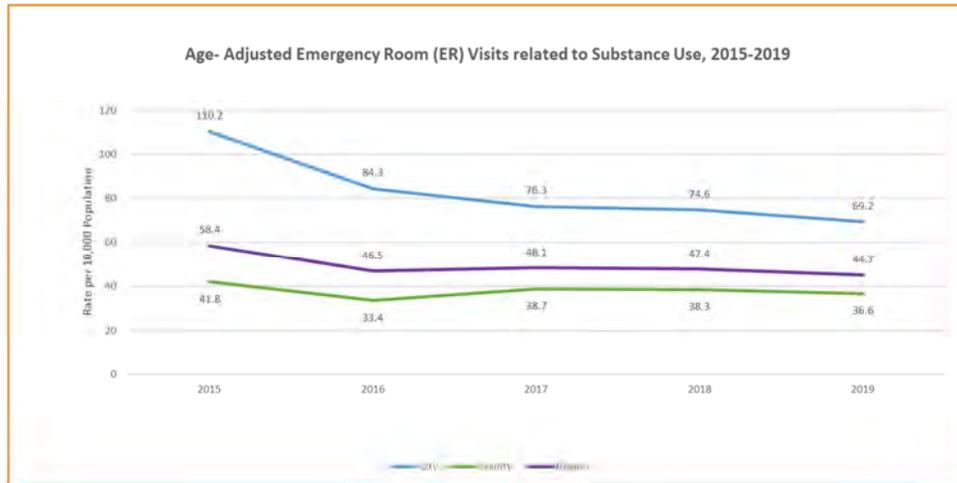
10 Leading Causes of Death in St. Louis County and St. Louis City, 2016-2020



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Here you can see displayed the top 10 leading cause of death in St. Louis City, in Blue, and St. Louis County, in Green, over the 5-year period. Heart Disease, Cancer, Unintentional Injury and Stroke were the top 4 leading causes of death across both City and County then we begin to see some differences. COVID-19 is in the Top 10 for both, after only being in the data for 1 of the 5 years, underlining the impact that it has had on the region in that time.

Emergency Room Visits – Substance Use

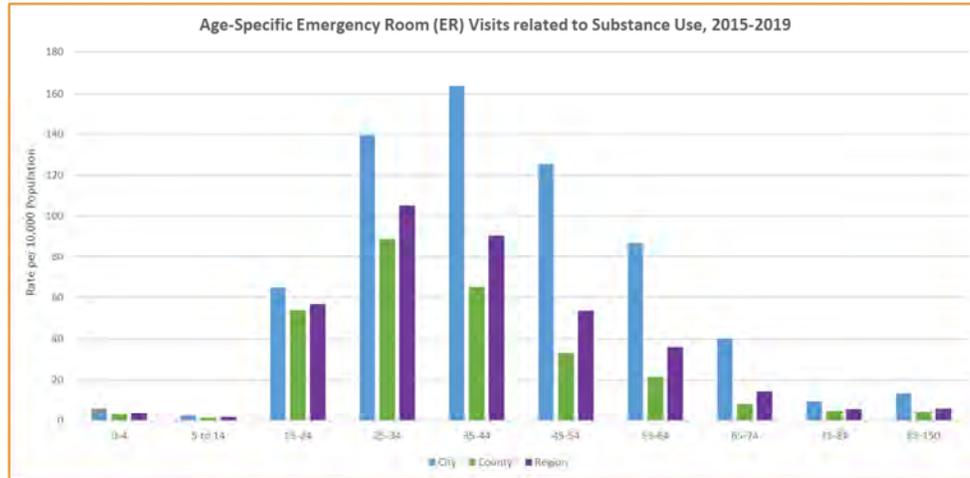


22

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

Important reminder, over the next few slides we will be looking at the trends in Emergency Room Visits and figures will display rates per 10,000 Population. As we take a look at the 5-year trend, from 2015 – 2019, in emergency room visits related to substance use we see a downward trend in St. Louis City and consistent rates across the County and Region.

Emergency Room Visits – Substance Use

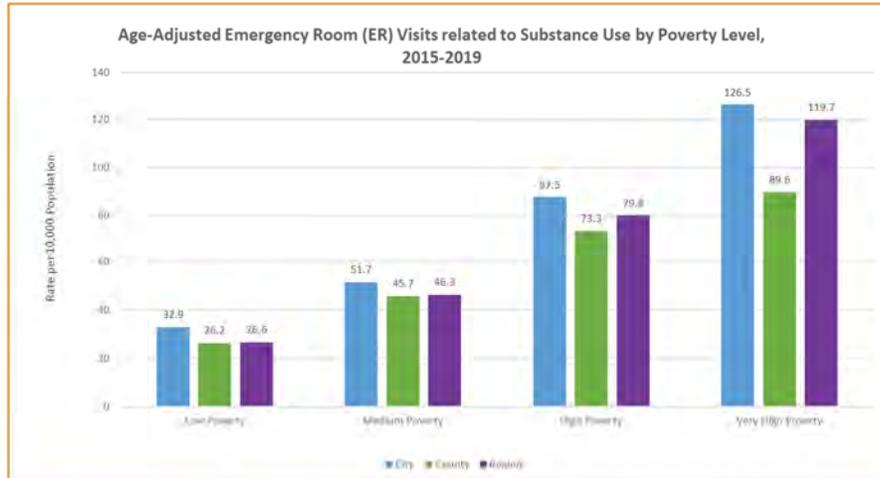


23

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

When we look at the visits related to substance use by age-specific rates in St. Louis City the rate is highest in the 35-44 age group followed by the 25-34 and 45-54 age groups. In St. Louis County the rate is highest in the 25-34 group followed by the 35-44 and 15-24 age groups.

Emergency Room Visits – Substance Use

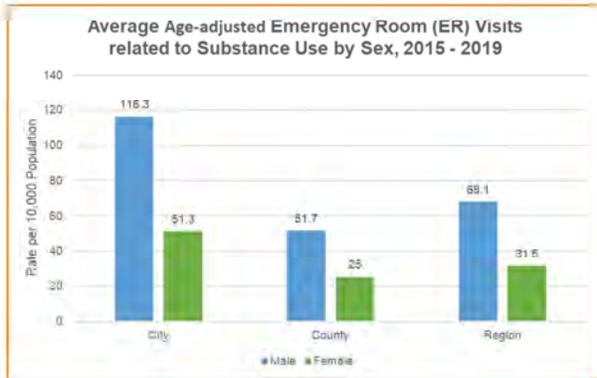
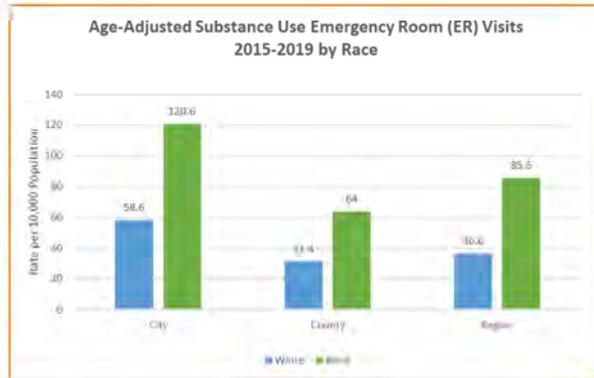


24

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

When we examine substance use related ER visits by poverty-level we see increased rates as the level of poverty increases across both the City and County. We also see that rates are consistent across the City and County for low poverty and medium poverty residents. Rates for high poverty and very high poverty residents in St. Louis City and the Region begin to separate from the County.

Emergency Room Visits – Substance Use

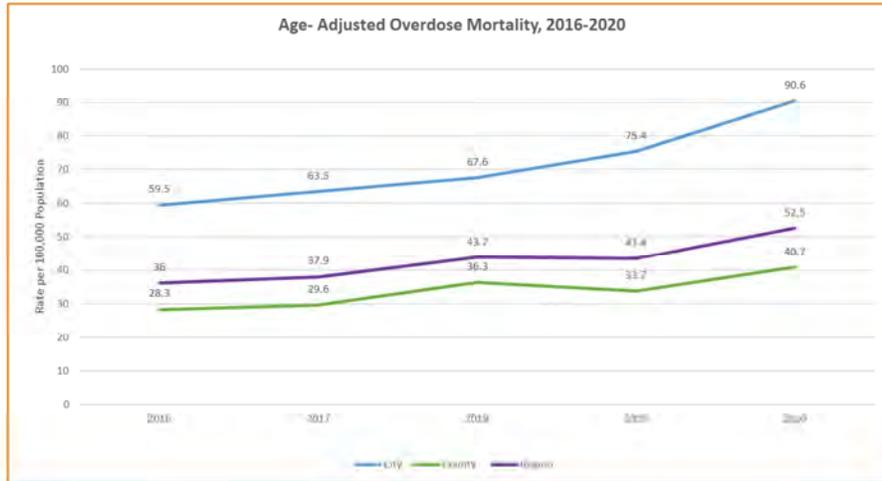


25

Data Source: MO DHSS Patient Abstract System Emergency Room Data, 2015-2019.

Rates of ER visits related to Substance Use are higher in Males than Females throughout the region. When we look at the trend by Race we can see that rates for Black Residents are higher than White Residents.

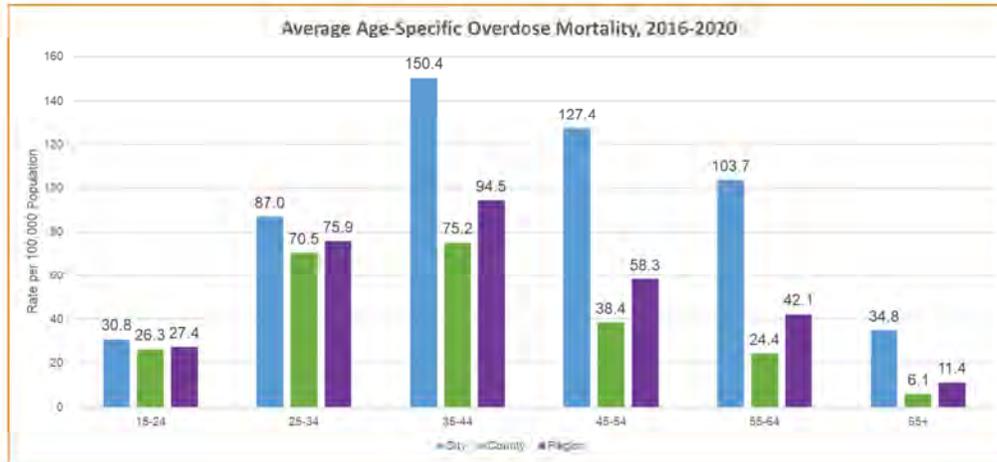
Overdose Mortality



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Now we will transition into looking at Substance Use indicators that involve mortality data. Rates over the next few indicators are displayed per 100,000 population. Here we see the 5-year trend between 2016 and 2020, for St. Louis City, County, and the combined region. The rate increases across all 3 geographic areas with the highest single-year rate in each occurring in 2020.

Overdose Mortality

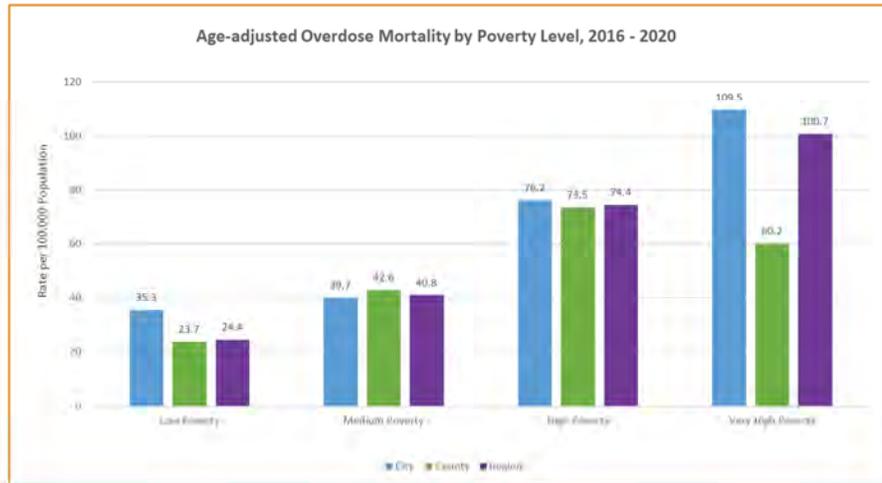


27

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

When we look at age-specific overdose mortality by age group we can see that in all geographic areas the 35-44 age group has the highest rate. In St. Louis County the 25-34 and 45-54 age groups have the next highest rates. In St. Louis City, the next highest rates occur in slightly older age groups compared to the County 45-54 and 55-64 respectively.

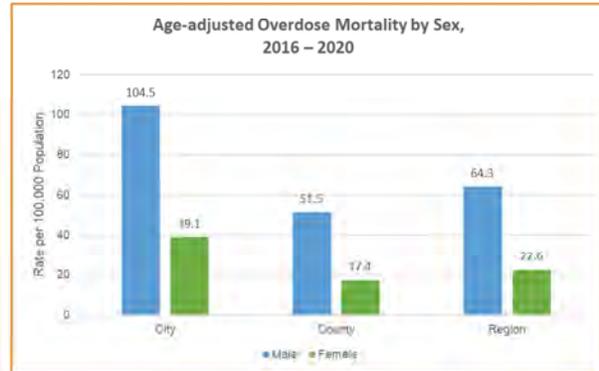
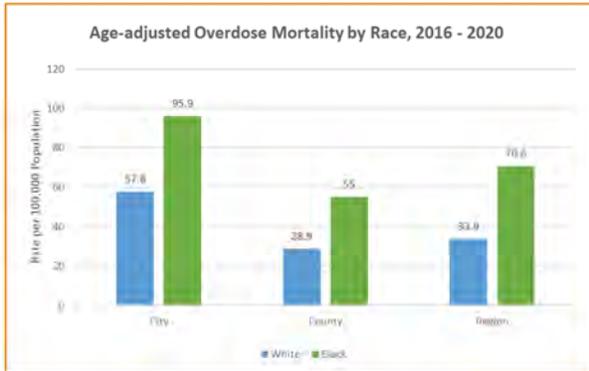
Overdose Mortality



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Overdose Mortality Rates increase with increasing poverty level of residents. Mortality rates are consistent across the 3 geographic areas for each of the poverty levels except Very High poverty where the Mortality rates in the City and region are observed to be higher than for St. Louis County. Additionally, the rate for Very High Poverty residents is lower than the rate for High Poverty residents in the County.

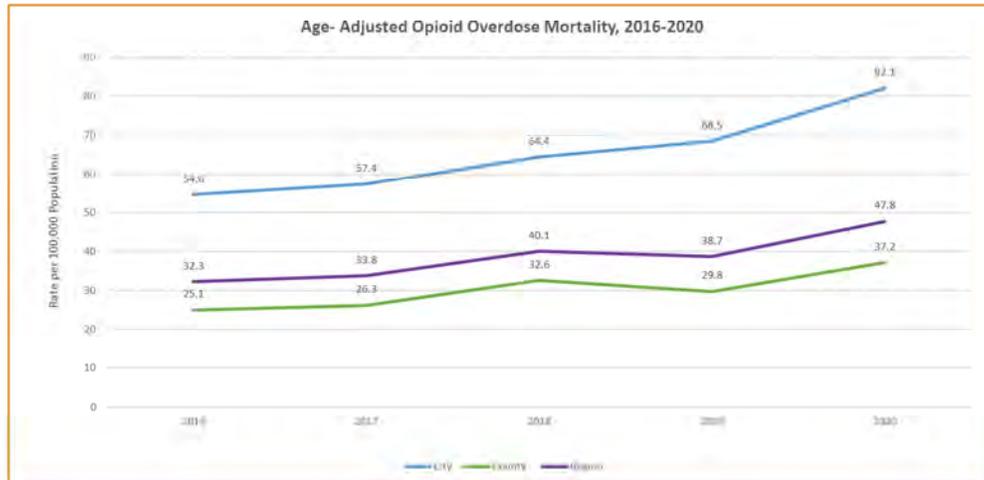
Overdose Mortality



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

Examining overdose mortality by Sex we observe the trend that Males overdose at higher rates than Females. When we look at the indicator by Race we see that Mortality Rates are higher for Black residents across the City, County, and Region.

Opioid Overdose Mortality

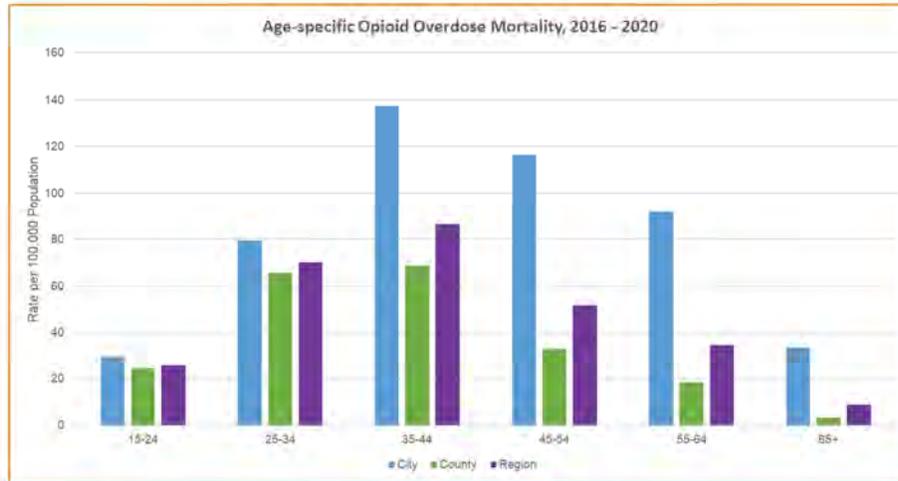


30

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

This next indicator specifically focuses on Overdose Mortality involving opioids. Similar to what we saw in overdose as a whole, the 5-year trend is increasing across St. Louis City, County, and Region. With the highest rates of Opioid Overdose occurring in 2020.

Opioid Overdose Mortality

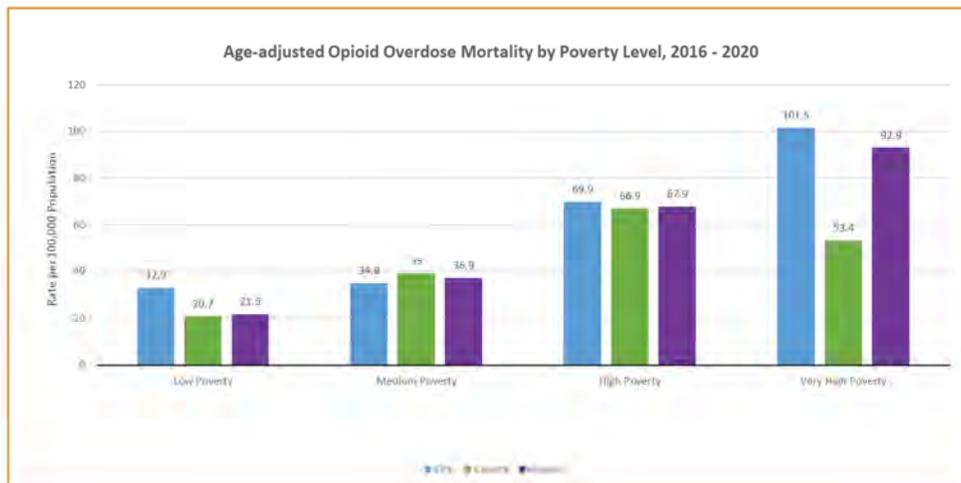


31

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

In St. Louis City, age-specific Mortality rates for Opioid Overdose were highest in the 35-44 age group followed by 45-54 and 55-64. In St. Louis County and the combined Region the rates were highest in the 35- 44 age group as well, followed by 25-34 and 45-54.

Opioid Overdose Mortality

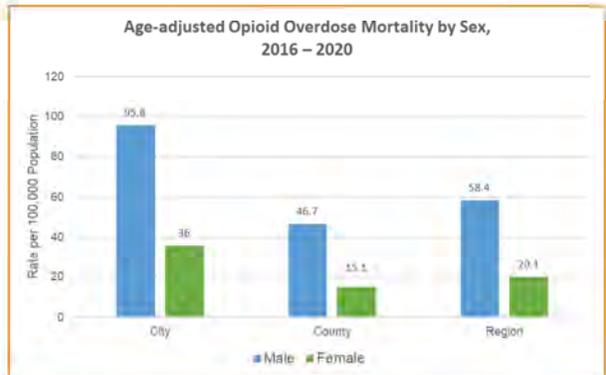
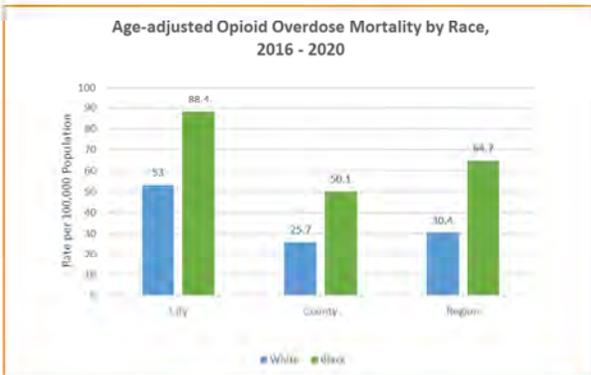


32

Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

When we look at Opioid Overdose Mortality by Poverty level we again see the general trend that rates increase across the increasing Poverty level of residents. We additionally see the same trend, as in overall overdose mortality, that rates are consistent across the 3 geographic areas until we look at rates for Very High Poverty Residents.

Opioid Overdose Mortality



Data Source: MO DHSS Bureau of Vital Records Data, 2016 – 2020.

As we saw with overall Substance Use Mortality, Opioid Mortality Rates were higher for Males compared to Females. And higher for Black Residents compared to White Residents.

Alcohol Impaired Driving Mortality



34

Source(s):

US Department of Transportation, National Highway Traffic Safety Administration, 2015-2019.

Fatality Analysis Reporting System, National Highway Traffic Safety Administration, 2016-2020.

Next we take a look at the percentage of Fatal crashes that involved Alcohol Impaired Drivers. Any driver with a BAC of $>.08$ was considered impaired. This data comes from the Fatality Analysis Reporting System. Due to similar percentages in the data, this visual may be hard to interpret upon first look. But some general trends we see are an increasing trend with the percentage of impaired drivers in and individual year being highest in 2020 for each geographic area. The visual on the left with 2018 data is utilized to be able to compare the region to the state and broader country.

Thank You!





ahaslides.com/CHSADAYONE

INTENTIONAL AND UNINTENTIONAL INJURY

The purpose of today's meeting is to identify measures and indicators are reflective of Intentional and Unintentional Injury in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

ECHO WANG
ABIGAIL ANDRESEN
CLAYTON ADAMS



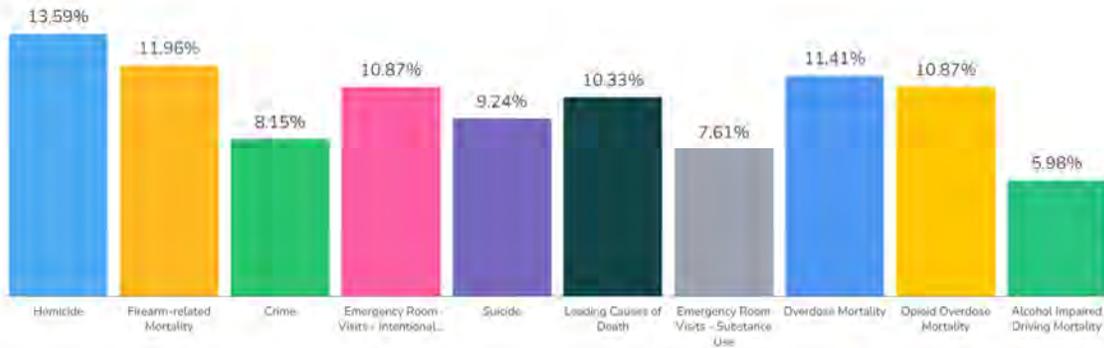
Menu

25 4 2 4 0

To join, go to: ahaslides.com/CHSADAYONE

AhaSlides

Select the indicators which effectively tell the story of Intentional and Unintentional Injury in our community



Menu

25 4 2 4 32 0

How does the data reflect your experience? How do they differ from your experience?

County law enforcement data reported as suspect

More current data would be helpful to see the impact of covid

Captures it

mental health and substance use are two of the biggest concerns reported by community members - particularly in lieu of the pandemic's impact

The data is incomplete (specifically for homicides) and doesn't account for the intersectionality.

State gun laws need to change

Gun violence and homicides are major cause of intentional injury. Substance overdose due to jobloss and other stressors in increasing as well.

Crime- tired of them breaking into cars

Crime data & rates should be displayed spatially to see disparities

Data not inclusive of all pediatric unintentional injuries & fatalities. This data does not support funding opportunities in order to obtain funding for safety

Data reflects my experience specifically; high rate of youth victims/perpetrators of gun violence, self-harm among adolescents, and 78% of overdose

The data is very reflective of the populations that community organizations serve. Gun violence against children!

How does the data reflect your experience? How do they differ from your experience?

Crime: view of them breaking into cars

Ability to see disparities

Data not inclusive of all pediatric unintentional injuries & fatalities. This data does not support funding opportunities in order to obtain funding for safety resources, ie car seats

Data reflects my experience specifically, high rate of youth victims/perpetrators of gun violence, self-harm among adolescents, and 78% of overdose fatalities among Blacks across the state occurred in St. Louis area

The data is very reflective of the populations that community organizations serve. Gun violence against children!

Would include pedestrian and biker injuries.

The data is divided by City and County, but fails to outline the movement of people in the region.

More state and national comparisons.

Substances seen in opioid overdoses.

Agree with more data on chronic

Other unintentional injury risk area for pediatric population: (Infant safe sleep,

Need to have indicators of upstream factors of violence

Menu

25 4 2 4 20 0



How does the data reflect your experience? How do they differ from your experience?

unintentional injuries & fatalities. The data does not support funding opportunities in order to obtain funding for safety resources, ie car seats

high level of youth victimization (victims of gun violence, self-harm among adolescents, and 78% of overdose fatalities among Blacks across the state occurred in St. Louis area

policy, law) protection against children

Would include pedestrian and biker injuries.

The data is divided by City and County, but fails to outline the movement of people in the region.

More state and national comparisons.

Substances seen in opioid overdoses.

Agree with more data on chronic conditions

Other unintentional injury risk area for pediatric population. (Infant safe sleep, drownings, poison prevention, distracted/drowsy driving)

Need to have indicators of upstream factors of violence

access to healthcare and mental health services

Menu

25 4 2 4 20 0

What indicators do you feel are missing? Please share data sources.

Gender identity	Correlate non-alcoholic driving deaths to alcohol involved. High crash rate	Pedestrian and biker injury data (not sure source, but Trailnet routinely reports).
automobile death due to not helmet or seatbelt	intimate partner violence	Here's a link to UCR data by agency in Missouri: https://crime-data-explorer.fr.cloud.gov/explorer/state/missouri/crime
Disability status	more analysis of chronic conditions by income, age, etc	Non-alcohol related vehicle crashes. Over 700 people have died in the county/city since 2017 by a traffic crash
Census trends as regional dynamics change	Domestic violence rates	Drug related homicide/crime
Falls data	Motor vehicle accidents. DMV is the data source.	

Menu

 25  4  2  4  20  0

What indicators do you feel are missing? Please share data sources.

^

Census trends as regional dynamics change	income, age, etc	
Falls data	Domestic violence rates	Non-alcohol related vehicle crashes. Over 700 people have died in the county/city since 2017 by a traffic crash
Would be good to include data from last CHA report to show longer trends.	Motor vehicle accidents, DMV is the data source.	Drug related homicide/crime
City and County are a movement of people back and forth	More granular data for zip codes	Work related injury
	All unintentional pediatric injuries	Gun availability

Menu

25 4 2 4 20 0

What are the underlying causes and external factors that affect the disparities in this category?

unemployment	Poverty	Hopelessness
Access to healthcare - Factors that affect emergency dept use vs. other sources for health-related assistance.	Income, access to care/mental health services,	Lack of access to mental and behavioral health services
employment	Disinvestment in neighborhoods, and vacancy left un-addressed	A regional men's health program
Lack of safety resources; poverty, low health education literacy levels, access to healthcare	Access to treatment (i.e., MAT treatment for opioid use)	Yes, I think that the lack of geographic data misses some of the intersectionality of causes.
Lack of investment and intentional	Lack of mental health services	Poverty and lack of access to resources, even when they are free.

What are the underlying causes and external factors that affect the disparities in this category?



What are the underlying causes and external factors that affect the disparities in this category?



Questions

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Behavioral Health

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY ECHO WANG, ABIGAIL ANDRESEN AND CLAYTON ADAMS
MARCH 30, 2022
10:45 – 11:15 A.M.



Intro- Good morning everyone! My name is Abigail Andresen. I'm an epidemiologist with the City of St. Louis Department of health. Thank you for joining us on day 1 of the Community Health Status Assessment, which is part of the joint city and county Community Health Assessment process. The data presentation you'll see today was analyzed and prepared by the City of Saint Louis Department of Health and the St. Louis County Department of Public Health with the assistance of our consultants from Kulik Strategic Advisors. In this session, we'll be discussing various behavioral health indicators and risk factors for these indicators. Afterwards, we'll have time for a Q & A about data and analysis methods with myself and Echo Wang. We also have an interactive activity where you will have the opportunity to rank measures and provide additional insight. Now, let's get started. The cross cutting themes discussed in this category overlap with several indicators in the previous injury and accidental injury category.

Indicators for Behavioral Health:

Mental health status or substance misuse are indicators of social issues experienced by an individual or community.

Mental Health

- Poor or Fair Mental Health Days (self-reported)
- Emergency Room Visits - Mental Disorders
- Emergency Room Visits - Intentional Self-harm

Substance use

- Emergency Room Visits - Substance Use
- Emergency Room Visits- Alcohol Use
- Overdose Mortality
- Opioid Overdose Mortality

2

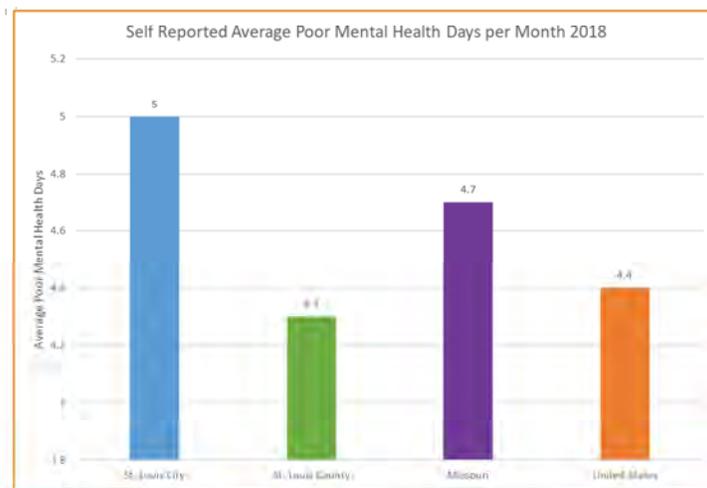
Slide 2- On this slide, you see that we'll be covering two main topics for behavioral health, mental health and substance use. Hospital data and vital records for the St. Louis region were received from DHSS. The analyses looked at past 5-year trends in addition to stratifying data by race, sex, age and poverty level.

Mental Health

3

Slide 3 – First, let's take a look at mental health.

Poor or Fair Mental Health Days



4

Source:

<https://www.countyhealthrankings.org/app/missouri/2021/measure/outcomes/42/data>

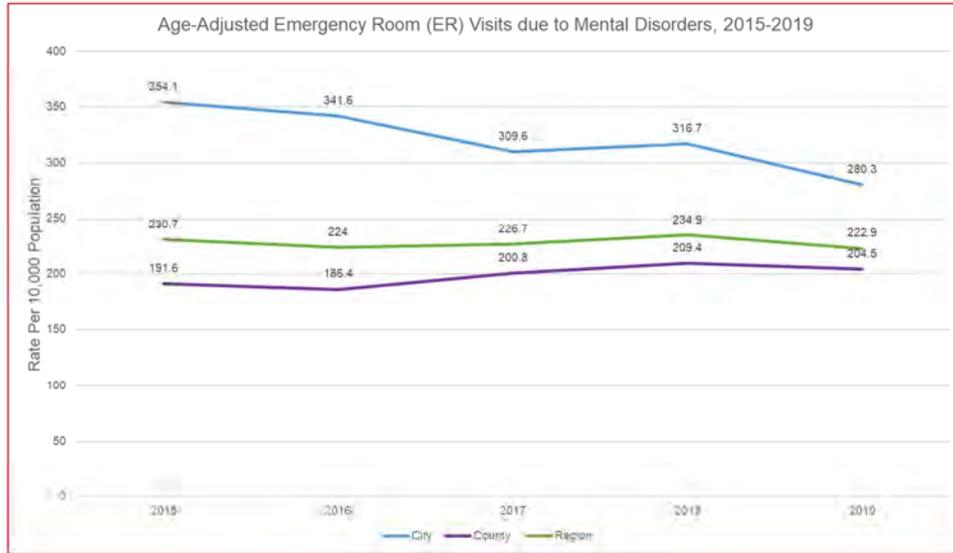
Slide 4 – This graph uses data collected by BRFSS, a nationally distributed survey instrument, and it shows how our region compares with the state and country in regard to average poor mental health days per month in 2018. As we can see, the city has the highest self reported mental health days.

Emergency Room (ER) Visits due to Mental Disorder

5

Slide 5 – For these next few slides, we'll be looking at emergency room visits due to mental disorders.

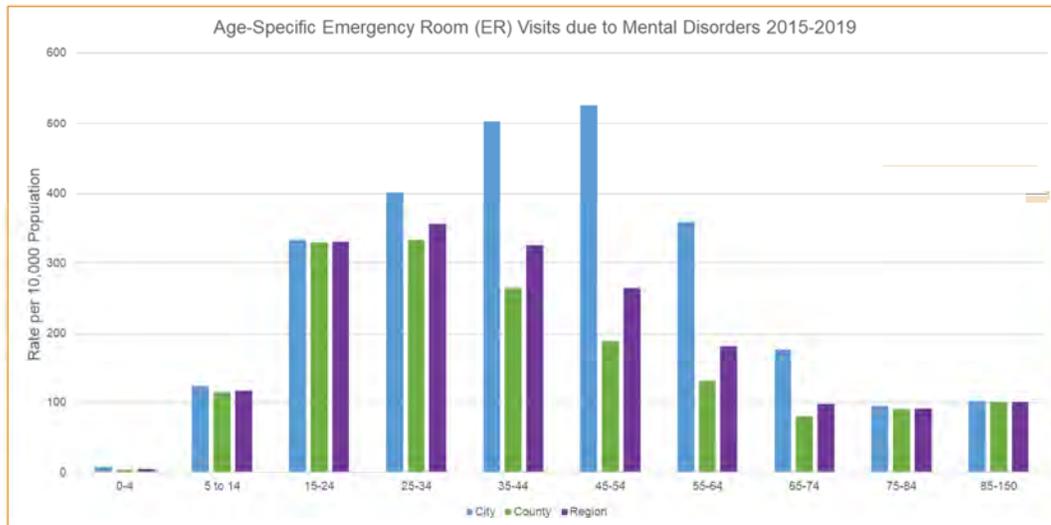
Emergency Room Visits – Mental Disorders



Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 6 - While the region as a whole had remained relatively stable from 2015-2019, this figure indicates that the city and county are experiencing opposite trends: with the exception of 2018, the city has trended downward every year during this timeframe, while the county's mental disorder-related ER visit rates increased.

Emergency Room Visits – Mental Disorders

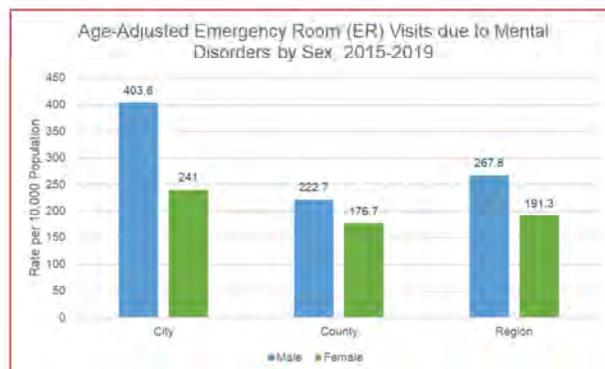
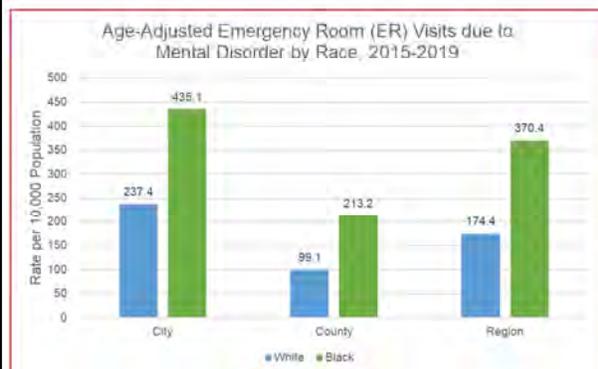


7

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 7 – This figure shows the average rate of ER visits due to mental disorders by age group. In the city, the highest rates over the past 5 years were seen in the 45-54 year cohort, while the 25-34 year-old cohort had the highest rates.

Emergency Room Visits – Mental Disorders

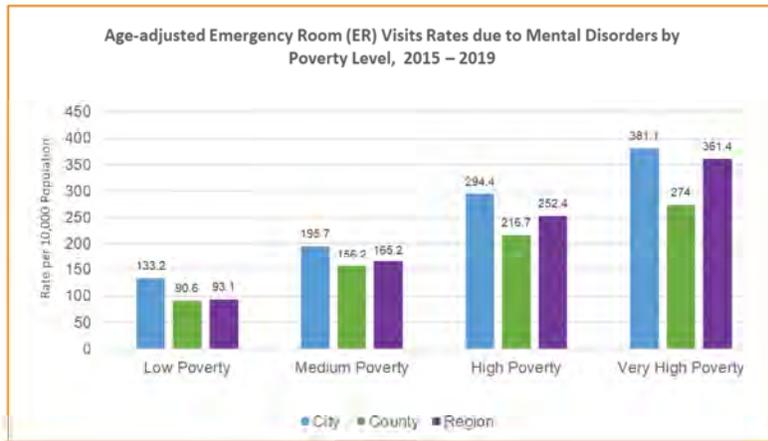


8

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 8 – In this slide, we can see the disparities that exist between race and sex. African Americans and men in the region were both considerably more likely to visit an emergency room for a mental disorder than Caucasians and females. Notably, we see that blacks in the county had visited an ER more than twice as often as their white counterparts.

Emergency Room Visits – Mental Disorders



Source: Missouri DHSS, Patient Abstract System Emergency Room Data

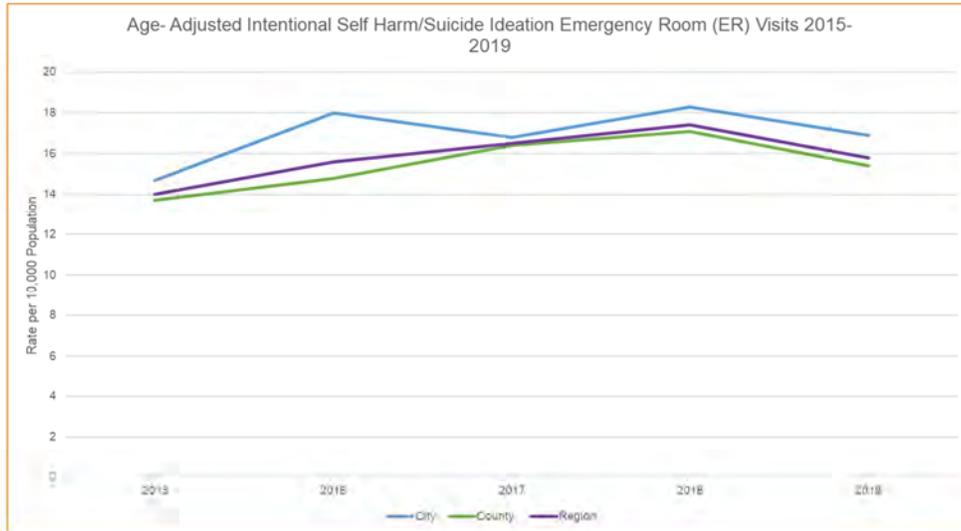
Slide 9 – Slide 9 reveals a clear positive association between poverty level and mental disorder-related ER visits for both the city and county.

Emergency Room Visits – Intentional Self-harm

10

Slide 10 – For the next few slides, we'll be looking at suicide related indicators and risk factors.

Emergency Room Visits – Intentional Self-harm

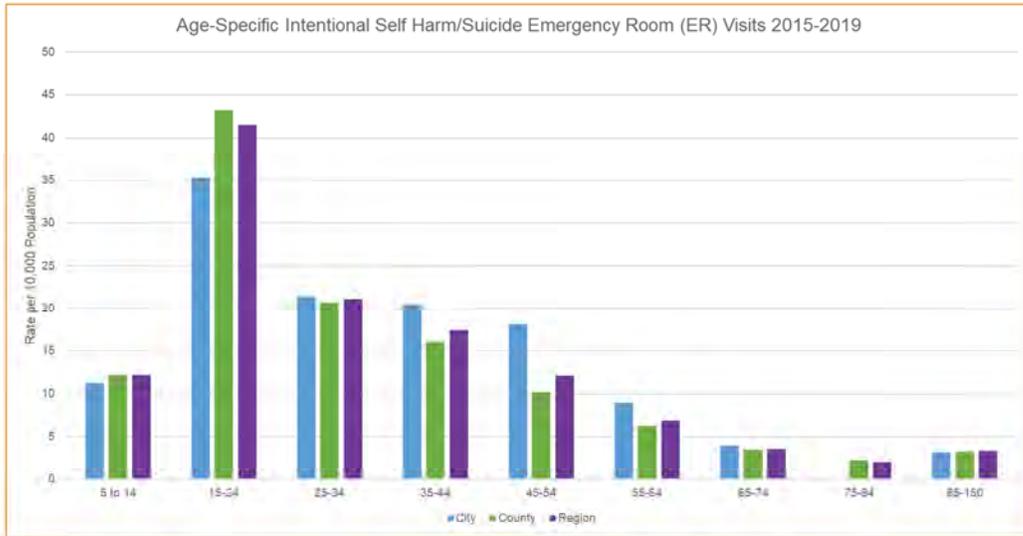


11

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 11 - As we can see in the first figure, ER visit rates due to intentional self-harm have increased overall in the region over the course of this 5-year timeframe, with a spike in visits in 2018 followed by a minor drop in 2019.

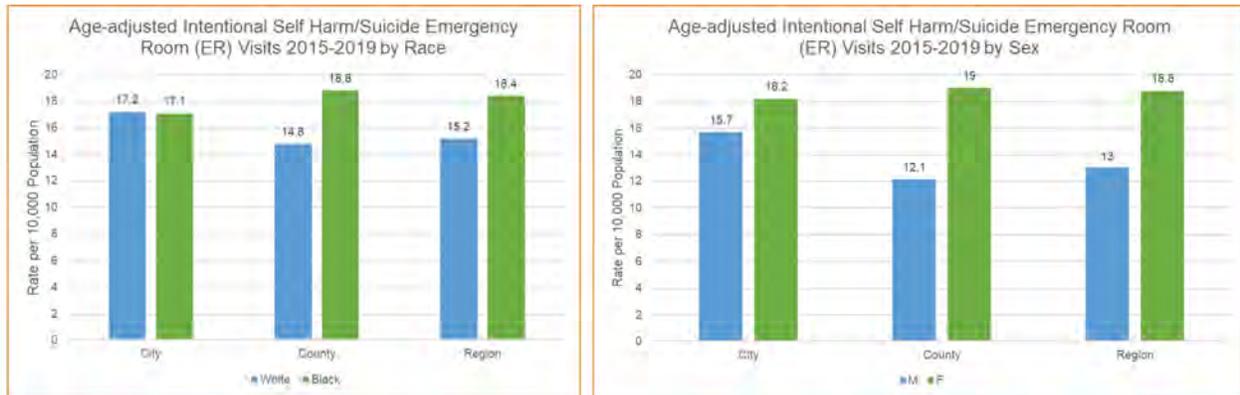
Emergency Room Visits – Intentional Self-harm



Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 12 – On this slide, we see that the 15 -24 year cohort had the highest rates of ER visits for intentional self-harm in the region, with a relative incremental decrease in rate for each subsequent cohort less than 85 years.

Emergency Room Visits – Intentional Self-harm

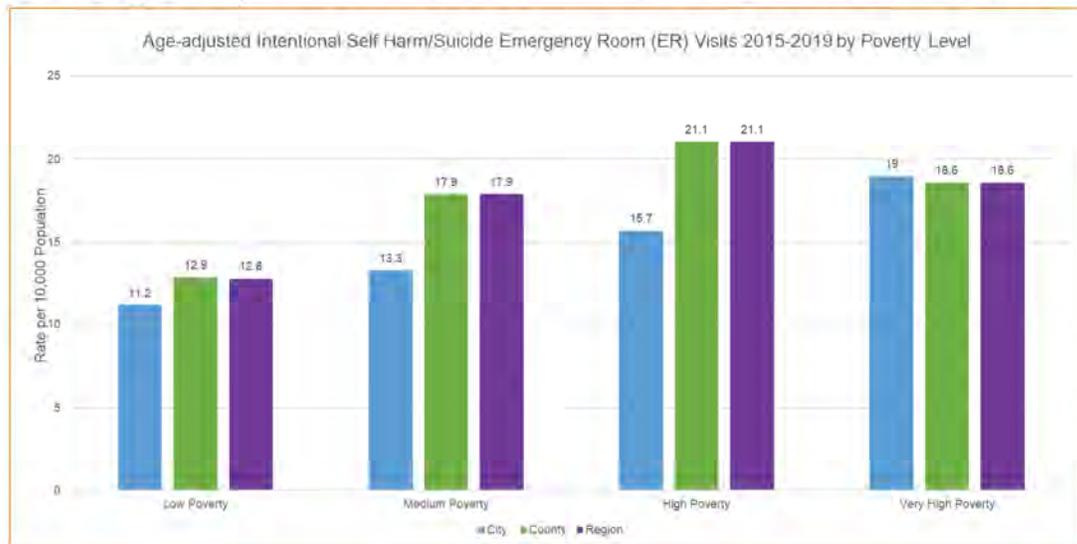


13

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 13 – In the county, rates of ER visits for intentional self-harm were higher among blacks compared to whites in the county, but not the city. Meanwhile, female visits to the ER for intentional self-harm were more common than males in both the city and the county.

Emergency Room Visits – Intentional Self-harm



14

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

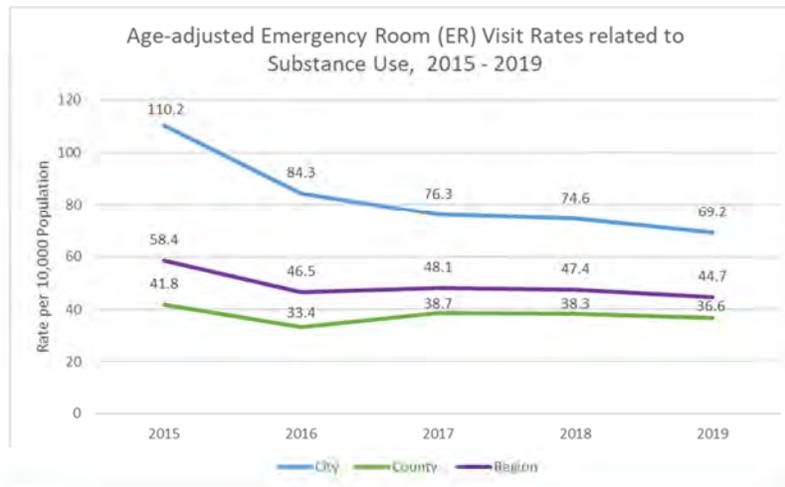
Slide 14 – Poverty level showed a positive association with ER visits for intentional self-harm in the city, with the highest rates occurring in neighborhoods labeled ‘very high poverty,’ while the highest rates in the county occurred in those labeled ‘high poverty.’ As an aggregate, individuals from high poverty neighborhoods in the region had the highest rates during this 5-year timeframe.

Emergency Room Visits – Substance Use

15

Slide 15 - Now we will take a look at various Substance Use trends across the City, County, and Region. A few trends to note that we see consistently across the Substance Use indicators and across the City, County and Region; rates for males are higher than females, rates for Black Residents are higher than White Residents and rates are higher for residents in the high and very high poverty groups compared to the low and medium poverty residents.

Emergency Room Visits – Substance Use



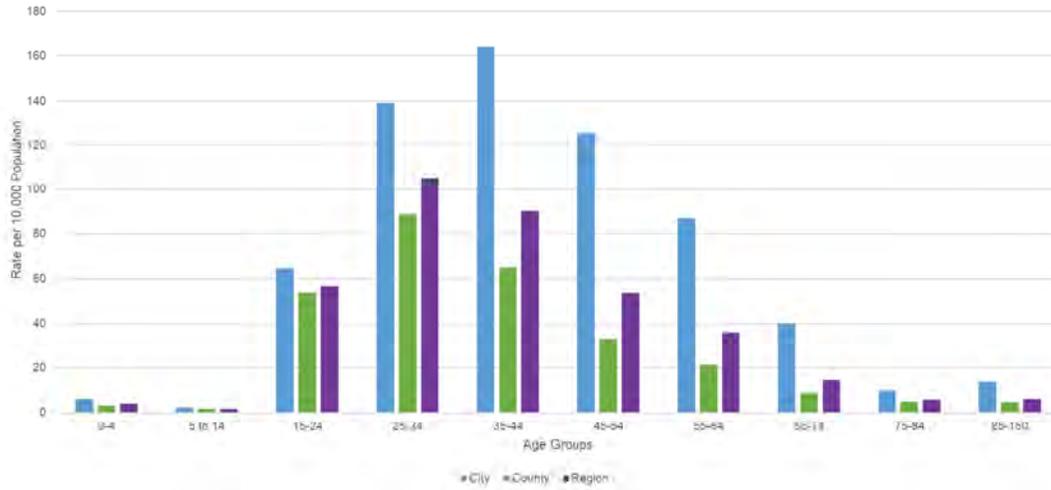
16

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 16 (Age-specific ER 5-year trend) – Important reminder, over the next few slides we will be looking at the trends in Emergency Room Visits and figures will display rates per 10,000 Population. As we take a look at the 5-year trend, from 2015 – 2019, in emergency room visits related to substance use we see a downward trend in St. Louis City and consistent rates across the County and Region.

Emergency Room Visits – Substance Use

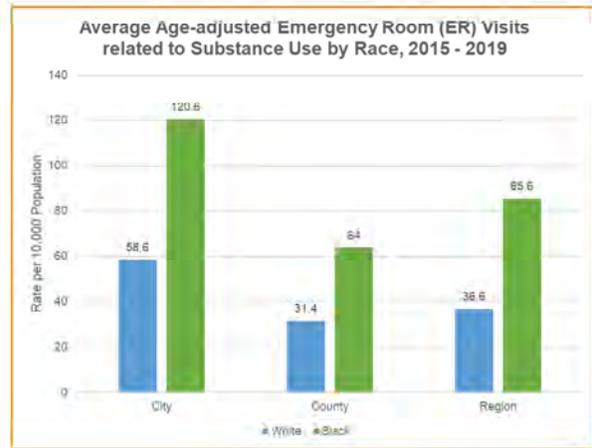
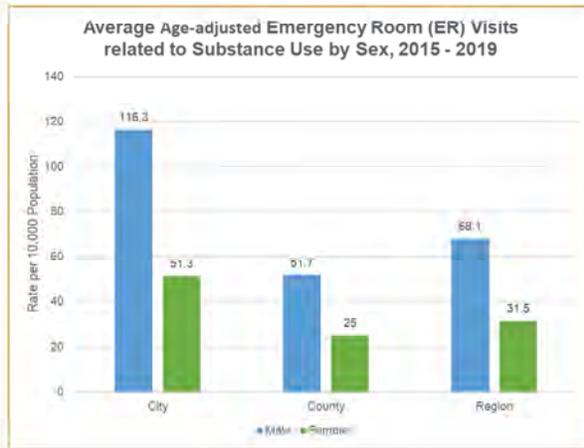
Age-Specific Substance Misuse Emergency Room (ER) Visits 2015-2019



Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 17 – A few of the general trends that we see when we look at the visits related to substance use by age-specific rates are that in St. Louis City the rate is highest in the 35-44 age group. In St. Louis County the rate is highest in the 25-34 group.

Emergency Room Visits – Substance Use

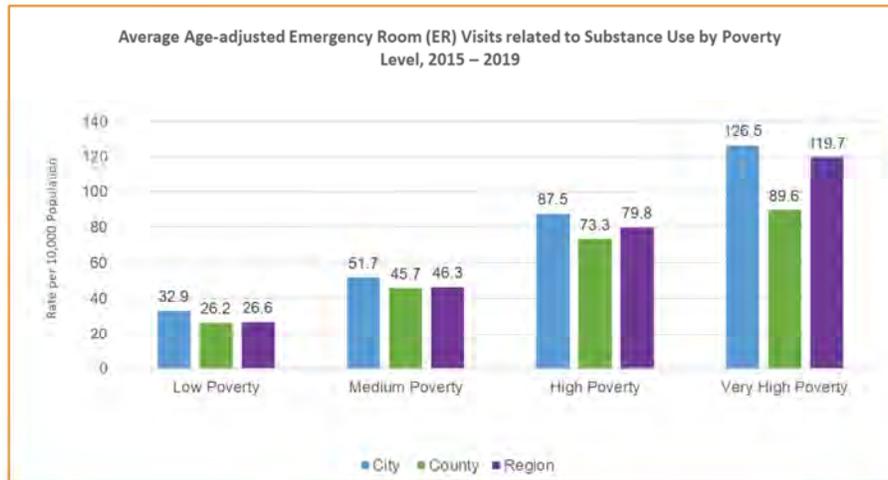


18

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 18 – Rates of ER visits related to Substance Use are higher in Males than Females throughout the region. When we look at the trend by Race we can see that rates for Black Residents are higher than White Residents.

Emergency Room Visits – Substance Use



19

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

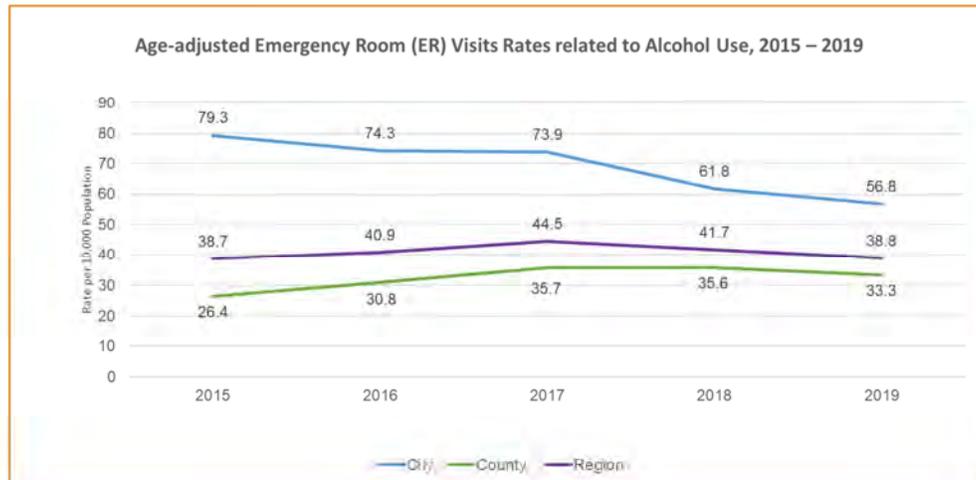
Slide 19 – When we examine substance use related ER visits by poverty-level we see increased rates as the level of poverty increases across both the City and County. We also see that rates are consistent across the City and County for low poverty and medium poverty residents. Rates for high poverty and very high poverty residents in St. Louis City and the Region begin to separate from the County.

Emergency Room Visits – Alcohol Use

20

Slide 20 - The next indicator we will examine is Emergency Room Visits related to Alcohol Use.

Emergency Room Visits – Alcohol Use

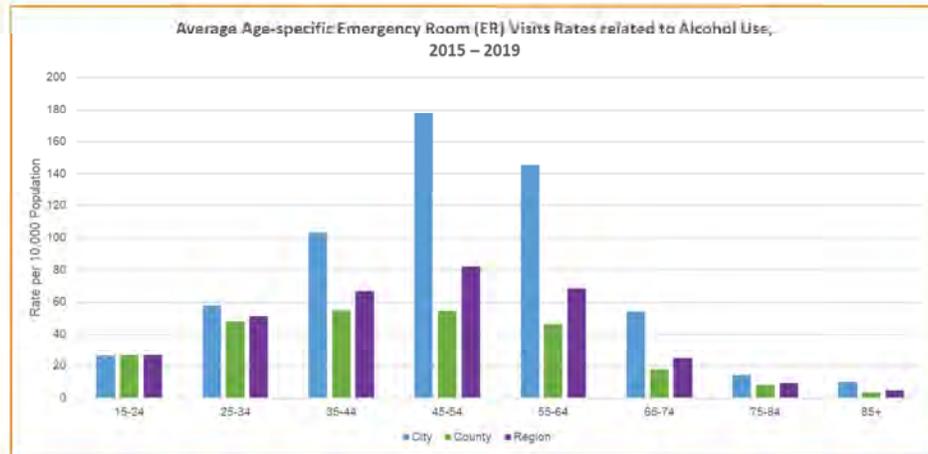


21

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 21- In the 5-year trend we see the rates overall increase in St. Louis County while the rate decreases in St. Louis City and remains steady across the combined region. Looking at the 3 most recent years of this data, 2017-2019 we see a slight decrease across all 3 areas.

Emergency Room Visits – Alcohol Use

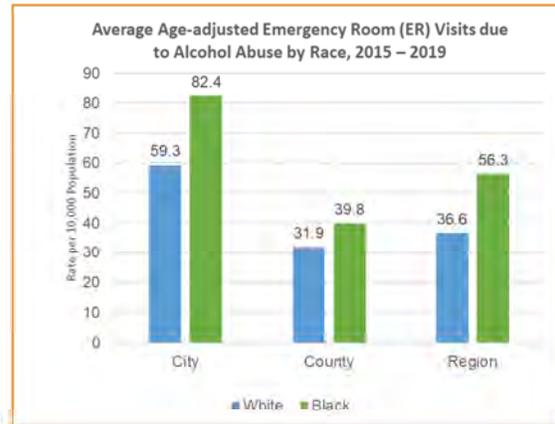
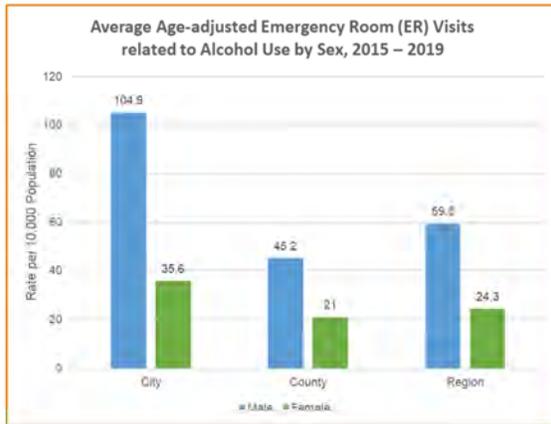


23

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 22 - Age-specific rates for ER visits related to Alcohol use are highest in the 45-54 age groups across the City, County and Region. ER visits related to alcohol use trend towards the older age groups compared to substance use related visits.

Emergency Room Visits – Alcohol Use

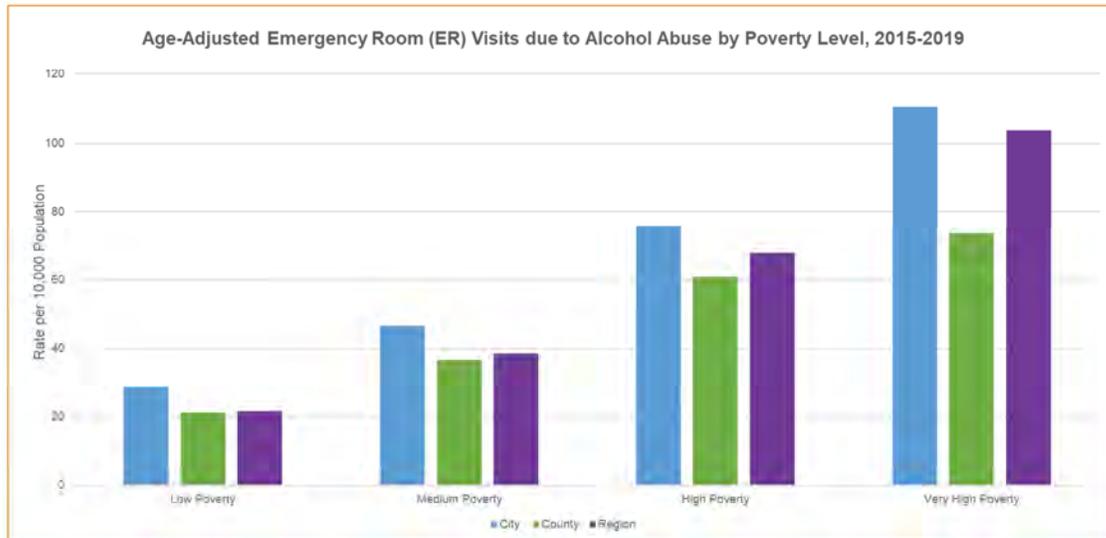


23

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

Slide 23 – Similar to the trends seen in substance use related visits we see that rates for Males are highest and Black residents.

Emergency Room Visits – Alcohol Use



24

Source: Missouri DHSS, Patient Abstract System Emergency Room Data

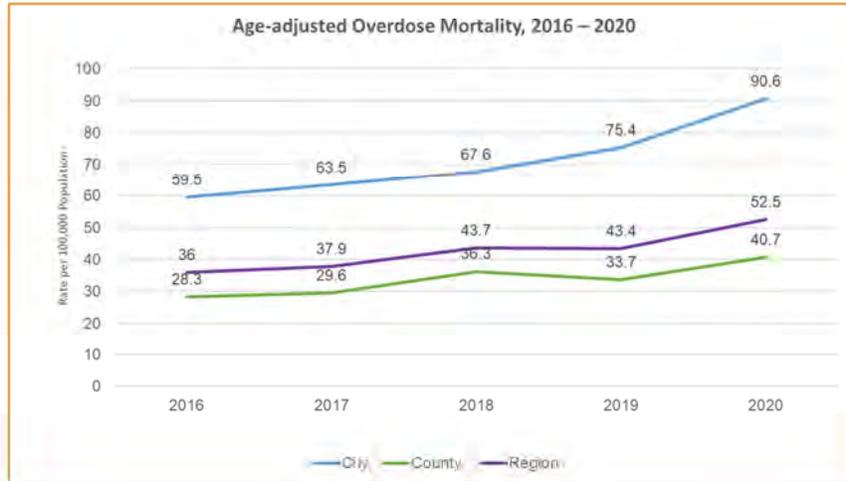
Slide 24 – Rates for alcohol use related visits increase significantly as Resident’s poverty level increases. With the highest rates being experienced by Very-High Poverty and High Poverty residents.

Overdose Mortality

25

Slide 25 - Now we will transition into looking at Substance Use indicators that involve mortality data. Rates over the next few indicators are displayed per 100,000 population.

Overdose Mortality

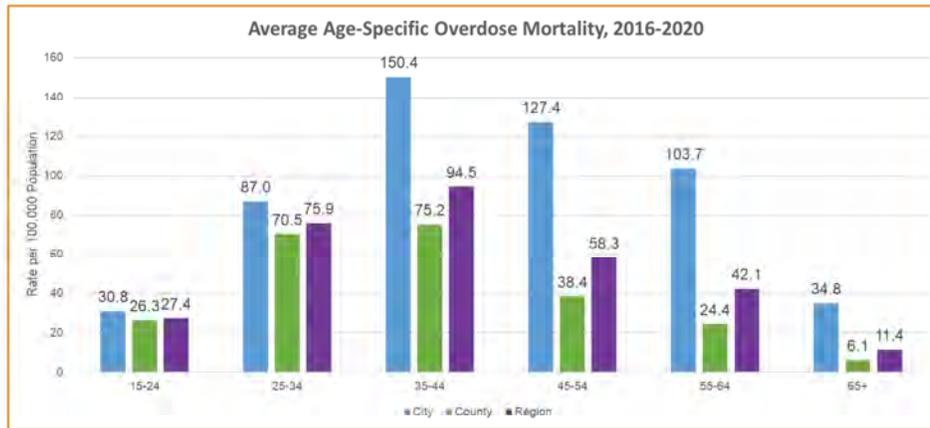


25

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 26 - Here we see the 5-year trend between 2016 and 2020, for St. Louis City, County, and the combined region. The rate increases across all 3 geographic areas with the highest single-year rate in each occurring in 2020.

Overdose Mortality

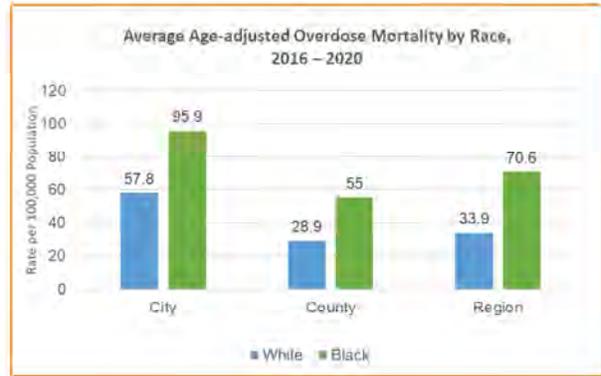
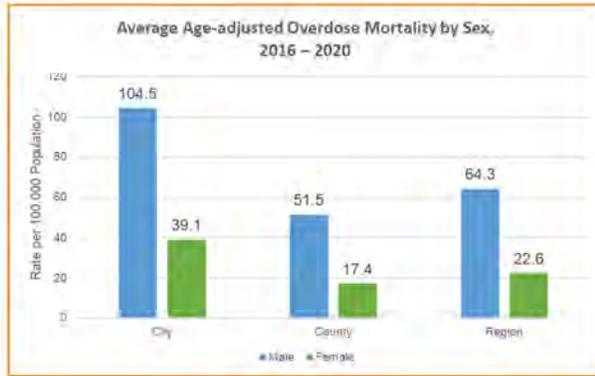


27

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 27 – When we look at age-specific overdose mortality by age group we can see that in all geographic areas the 35-44 age group has the highest rate. In St. Louis County the 25-34 and 45-54 age groups have the next highest rates. In St. Louis City, the next highest rates occur in slightly older age groups compared to the County 45-54 and 55-64 respectively.

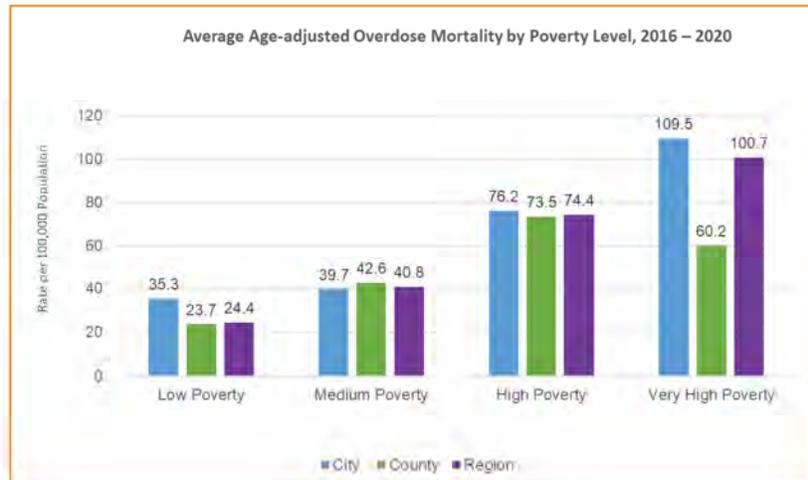
Overdose Mortality



Source: Missouri DHSS, Bureau of Vital Statistics

Slide 28 - Examining overdose mortality by Sex we observe the trend that Males overdose at higher rates than Females. When we look at the indicator by Race we see that Mortality Rates are higher for Black residents across the City, County, and Region.

Overdose Mortality



23

Source: Missouri DHSS, Bureau of Vital Statistics

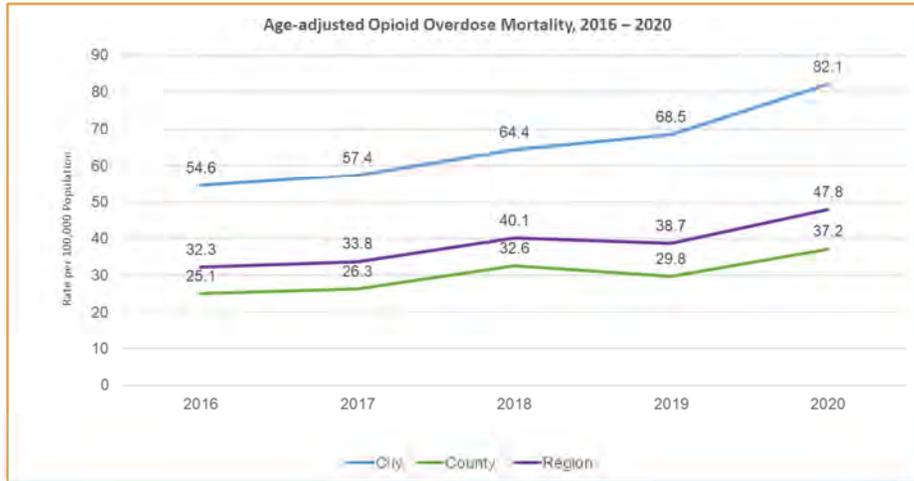
Slide 29 – Overdose Mortality Rates increase with increasing poverty level of residents. Mortality rates are consistent across the 3 geographic areas for each of the poverty levels except Very High poverty where the Mortality rates in the City and region are observed to be higher than for St. Louis County.

Opioid Overdose Mortality

30

Slide 30 – This next indicator focuses on Overdose Mortality involving opioids.

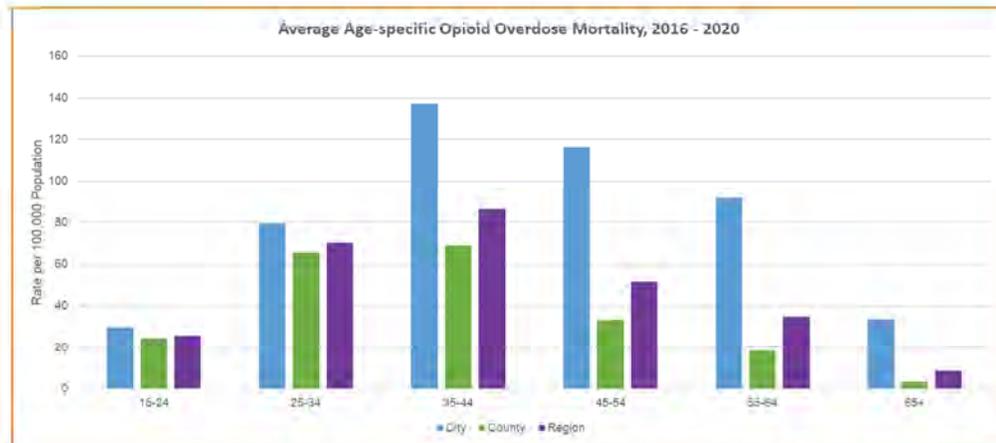
Opioid Overdose Mortality



Source: Missouri DHSS, Bureau of Vital Statistics

Slide 31 - Similar to what we saw in overdose as a whole, the 5-year trend is increasing across St. Louis City, County, and Region. With the highest rates of Opioid Overdose occurring in 2020.

Opioid Overdose Mortality

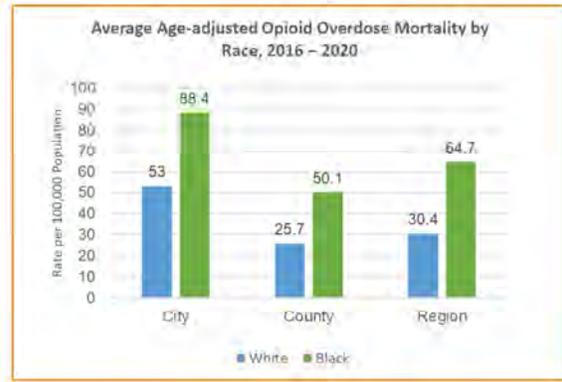
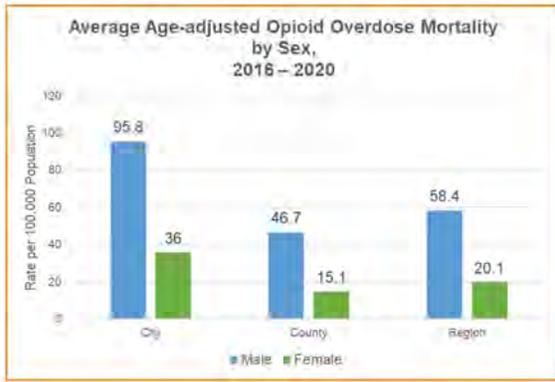


32

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 32 – In St. Louis City age-specific Mortality rates for Opioid Overdose were highest in the 35-44 age group followed by 45-54 and 55-64. In St. Louis County and the combined Region the rates were highest in the 35- 44 age group as well, followed by 25-34 and 45-54.

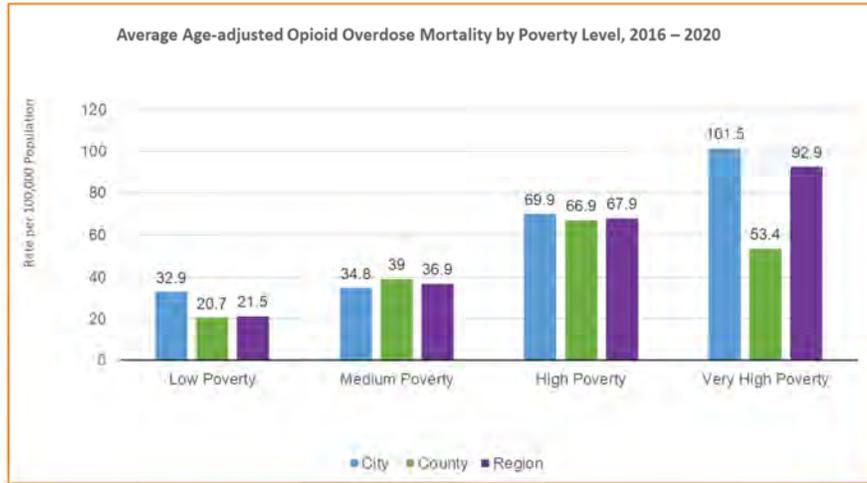
Opioid Overdose Mortality



Source: Missouri DHSS, Bureau of Vital Statistics

Slide 33 - As we saw with overall Substance Use Mortality, Opioid Mortality Rates were higher for Males compared to Females. And higher for Black Residents compared to White Residents.

Opioid Overdose Mortality



34

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 34 – When we look at Opioid Overdose Mortality by Poverty level we again see the general trend that rates increase across the increasing Poverty level of residents. We additionally see the same trend, as in overall overdose mortality, that rates are consistent across the 3 geographic areas until we look at rates for Very High Poverty Residents.

Thank You!



References

- <https://www.countyhealthrankings.org/app/missouri/2021/measure/outcomes/42/data>
- MODHSS, Vital Records
- MODHSS, Patient Abstract System Emergency Room Data



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BEHAVIORAL HEALTH

The purpose of today's meeting is to identify measures and indicators are reflective of Behavioral Health in the St. Louis Community. As we move through these assessments, Priorities will be developed for action at a later meeting.

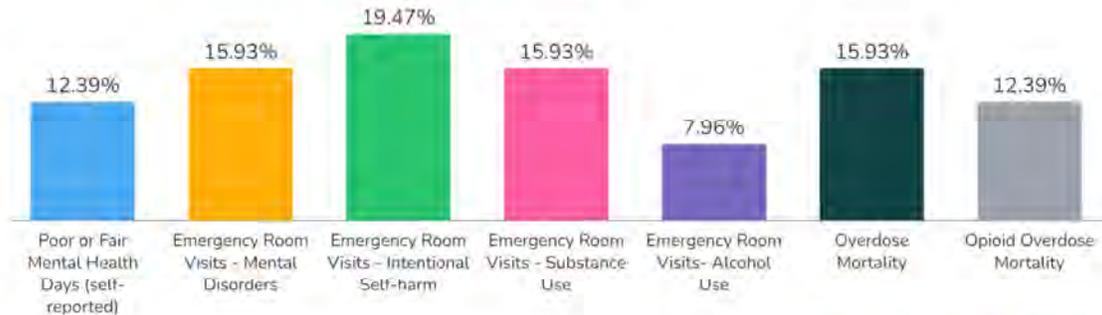
ECHO WANG
ABIGAIL ANDRESEN
CLAYTON ADAMS



Menu

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Select the indicators which effectively tell the story of Behavioral Health in our community



Menu

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How does the data reflect your experience? How do they differ from your experience?

Slides were a little fast. Hard to interpret.

Fri Questions; is high poverty for substance use an artifact of high ER USE?

It depends on where you live

Data fairly represents my experience

Mental health crises don't always end up in the ED. It would be good to combine police data and the Cops and Clinicians data with what was presented.

We have seen some higher income zip codes with increased rate of substance abuse when compared to benchmarks

Most of the data seems to be capturing the extremes and there's not really any indicator showing those who are receiving help before landing in the ED

They confirm my experience.

Concern about youth mental health issues in schools

there aren't enough providers, beds or resources for folks in the region who need behavioral health support. access and navigation can be challenging.

Other mental and cognitive health data would be helpful, particularly beyond ED data.

Overall accurate, but since the data are

Its similar to my experience. I feel there is

How does the data reflect your experience? How do they differ from your experience?

Help before turning in the CD

Concern about youth mental health issues in schools

Overall accurate, but since the data are lagging they do not accurately represent the tremendous impact COVID has had on behavioral health outcomes, particularly regarding overdose deaths, ER visits, the extreme shortage of BH services, and the ongoing boarding of BH patients in ERs

there aren't enough providers, beds or resources for folks in the region who need behavioral health support. access and navigation can be challenging.

Its similar to my experience. I feel there is larger populations who do not take help and have no support systems, so data may be under-reported.

Reporting from psychiatry clinics/Hospitals.

Other mental and cognitive health data would be helpful, particularly beyond ED data.

Nothing about PMADs in this data

High ED utilizers vs. "appropriate" use of crisis services

Menu

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What indicators do you feel are missing? Please share data sources.

More on depression, anxiety	Overall ED USE, detail by type of substance	Cognitive health - dementia
Visits to and referrals from school counselors	Maps by zip code would be nice	data re repeat ER visits due to BH needs
The proportion of 911 calls routed to mental health professionals rather than police officers might be nice	Data from school counselors	Psychiatric hospitalization, other people of color data, LGBT Q status
High ED users vs. "appropriate" use of crisis services	More breakdown of race and ethnicity. Understand smaller samples, but need to see representation as much as possible.	UNMET requests for psychiatric services
	Non ED visit data	Something that speaks to the availability and quality of behavioral health resources

What indicators do you feel are missing? Please share data sources.

Trauma, racism, accessibility of care

Language barriers

Poor positive parenting skills

Individual and community trauma caused by historical discrimination, poverty, and disinvestment. Not enough focus on prevention and early intervention for young children



Page 2 of 2

Menu

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What are the underlying causes and external factors that affect the disparities in this category?

trauma	Mental health stigma	systemic racism
Poverty	employment	Availability, accessibility, and capacity of MH/SU services.
From comment, inaccurate data on race, ethnic	Coordination between crisis and stabilizing services	socioeconomic status
undiagnosed mental health issues at earlier ages.	Poverty, mental health stigma, racism	lack of access to timely, culturally relevant behavioral health services/supports, especially where people live
Social support and connectedness to community	Culturally and linguistically relevant services	Low income
	Cultural differences for immigrants.	

Menu

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What are the underlying causes and external factors that affect the disparities in this category?

undiagnosed mental health issues at earlier ages.

Social support and connectedness to community

Individual and community trauma

Lack of prevention and early intervention for young children

Poverty, mental health stigma, racism

Culturally and linguistically relevant services

Cultural differences for immigrants.

lack of integrated behavioral health services with primary care

Poor utilization of existing infrastructure

lack of access to timely, culturally relevant behavioral health services/supports, especially where people live

Low income

Lack of access to home-based services. Limited mobile outreach/response.

It affects this category, as well as others, but whether a person has insurance could be an interesting variable

Questions

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Communicable Diseases

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN

MARCH 30, 2022

11:30 A.M. – 12:00 NOON



Indicators for Communicable Disease:

A review of the impact of communicable diseases such as sexually transmitted infections, hepatitis and influenza, termed “winnable battles” by the CDC.

1. Sexually Transmitted Infections
 - a) Chlamydia
 - b) Gonorrhea
 - c) Syphilis
 - d) HIV
2. Hepatitis C
3. Influenza

We will be presenting on several communicable disease indicators, specifically those related to sexually transmitted infections (or STIs), HIV, hepatitis, and influenza. Most of these indicators will be presented in terms of incidence rate per 100,000. Since the city and county vary in population size, looking at rates standardizes the data and makes comparisons between the city and county more meaningful.

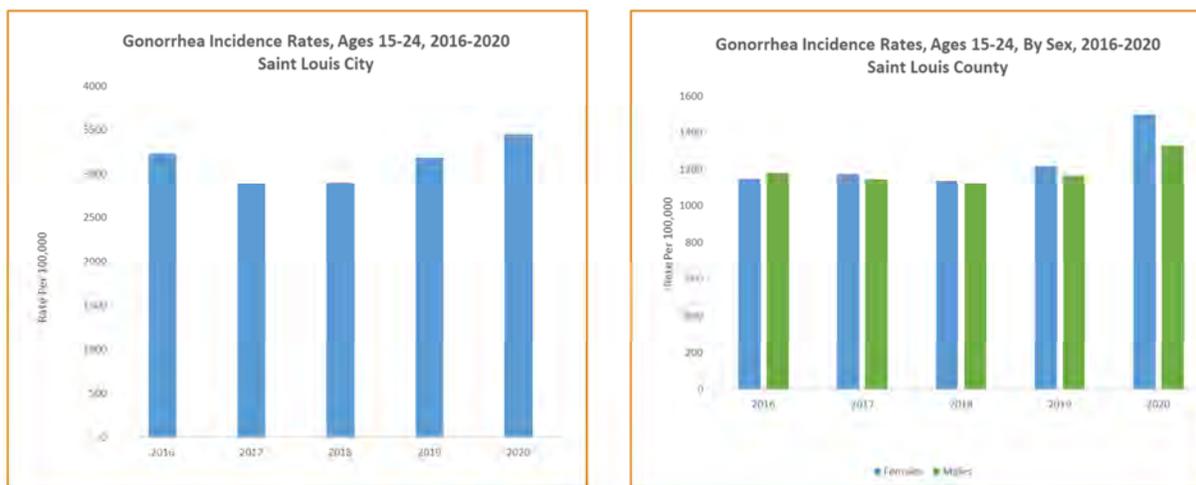
Sexually Transmitted Infections - Chlamydia



Source: Missouri Health Surveillance Information System (Websurv), 2016-2020

Here are the incidence rates for chlamydia for the city and county. The city rates are displayed on the left, and the county rates are displayed on the right, disaggregated by sex. For St. Louis City, the incidence ranged from 6071/100,000 in 2020 to 7357/100,000 in 2018. For the county, overall incidence ranged from 3066/100,000 in 2016 to 3552/100,000 in 2019. However, we wanted to display the data separated out by sex, as it reveals a difference. From 2016-2020, females had more than double the incidence rates of males. Due to anatomical differences, females can be at greater risk of contracting STIs, but this is clearly a disparity in the region. If untreated, chlamydia can cause pelvic inflammatory disease in women, leading to the potential of further reproductive system damage and even infertility. Further data analysis is required to determine if this disparity is evident in the city as well.

Sexually Transmitted Infections - Gonorrhea

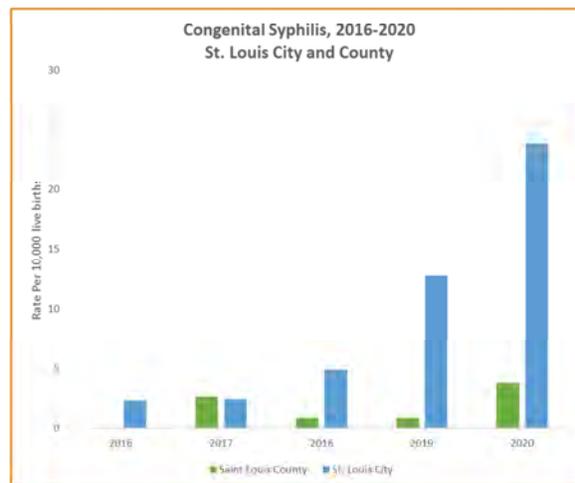
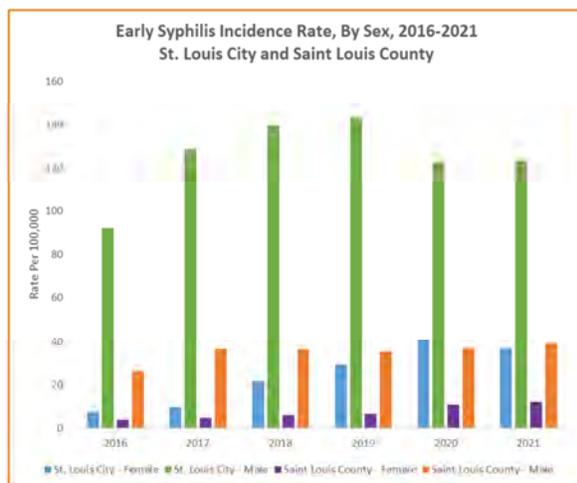


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Source: Missouri Health Surveillance Information System (Websurv), 2016-2020

Now here are incidence rates for gonorrhea for the city and county. Once again, the city rates are displayed on the left, and the county rates are displayed on the right, disaggregated by sex. For St. Louis City, the incidence ranged from 2894/100,000 in 2017 to 3448/100,000 in 2020. For the county, overall incidence ranged from 1133/100,000 in 2018 to 1412/100,000 in 2020. We were able to separate out the county data by sex, and unlike chlamydia, there isn't a huge difference in incidence rates between males and females in the county.

Sexually Transmitted Infections - Syphilis



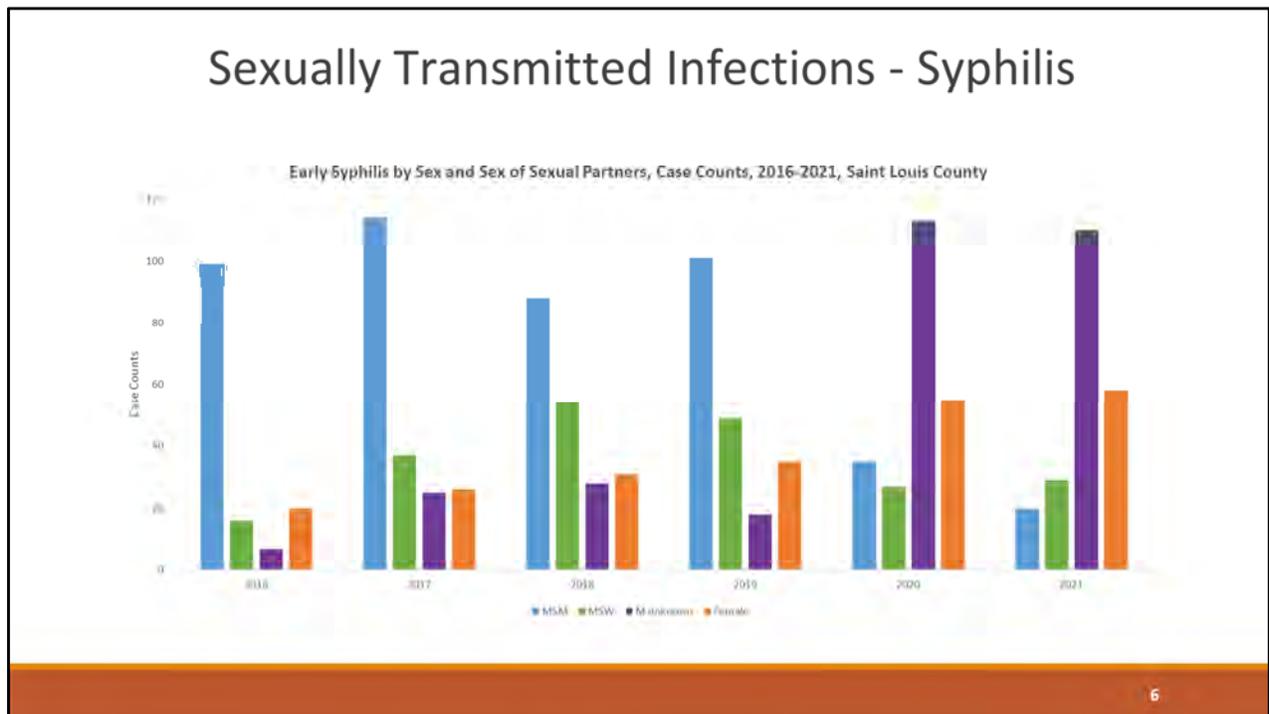
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Source: Missouri Health Surveillance Information System (Websurv), 2016-2021

Now these graphs are displaying the incidence rates of early syphilis on the left and congenital syphilis on the right. Syphilis is a condition with multiple stages of disease, so for the purposes of this report we will be reporting on early syphilis, which contains early latent syphilis, primary syphilis, and secondary syphilis. We were able to separate out data by sex for both the city and county for this dataset. St. Louis city has higher early syphilis incidence rates than the county for both males and females. It should be noted that the incidence rate for males is much greater than females for both jurisdictions. We will take a deeper dive into early syphilis data from the county in the next slide. Meanwhile, congenital syphilis occurs when a pregnant mother passes the condition down to her fetus in-utero, and the baby is subsequently born with syphilis. Symptoms can take anywhere from weeks to years to appear, but children born with congenital syphilis require treatment for syphilis as well as for any health conditions caused by the infection. Congenital syphilis incidence is reported as a rate per 10,000 live births. For St. Louis City, the incidence of congenital syphilis has been increasing since 2016, when it was 2.3 per

10,000, up to 23.9 per 10,000 live births in 2020, a ten-fold increase. The county's rates range from 0 in 2016 to a high of 3.8 in 2020.

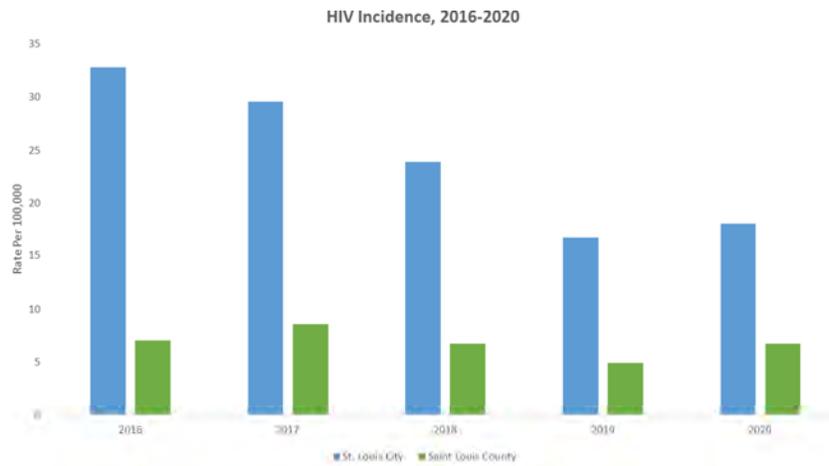
Sexually Transmitted Infections - Syphilis



Source: Missouri Health Surveillance Information System (Websurv), 2016-2021

Now on the previous slide we saw that men had a higher early syphilis incidence rate than women. We are reporting on counts here, not rates, because it is not possible to get a population estimate by sex of sexual partners. From 2016-2019, men who have sex with men have the highest reported case counts when compared to men who have sex with women, women, and men for whom we don't know the sex of their sexual partner. There's been a steady increase in the number of women who have been diagnosed with early syphilis. Also, the number of men for whom we don't know the sex of their sexual partner dramatically increased in 2020 and 2021. This makes sense, because the staff who normally would conduct these types of questionnaires were diverted to the COVID response, and therefore were not able to obtain such data.

Sexually Transmitted Infections - HIV

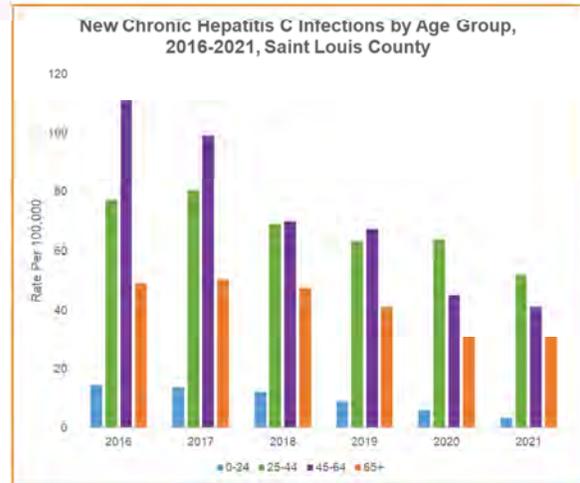
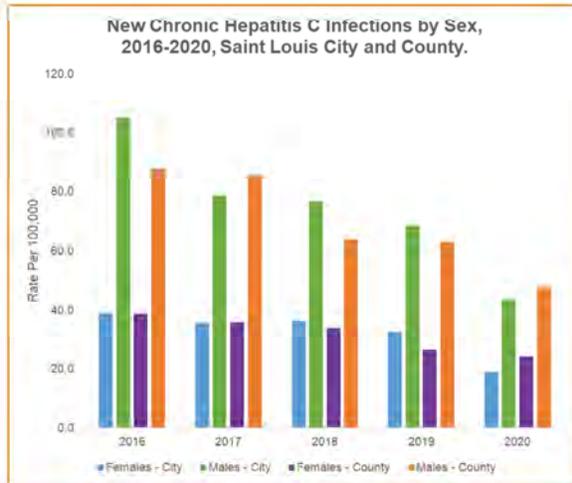


7

Source: <https://health.mo.gov/data/hivstdaids/data.php>

HIV data are more protected than other STI data, so we were able to get case counts from the state of Missouri and therefore calculate incidence rates per 100,000 from 2016-2020. Overall, the city has higher incidence rates than the county, and were trending downwards with the exception of 2020. Meanwhile, the county's rates are more varied, ranging from 4.9 in 2019 to 8.6 per 100,000 in 2017.

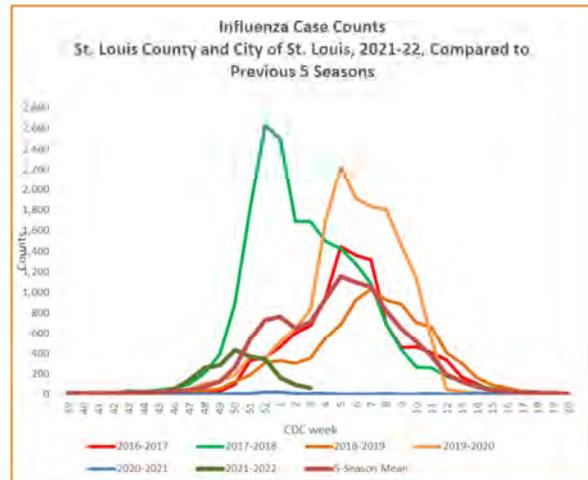
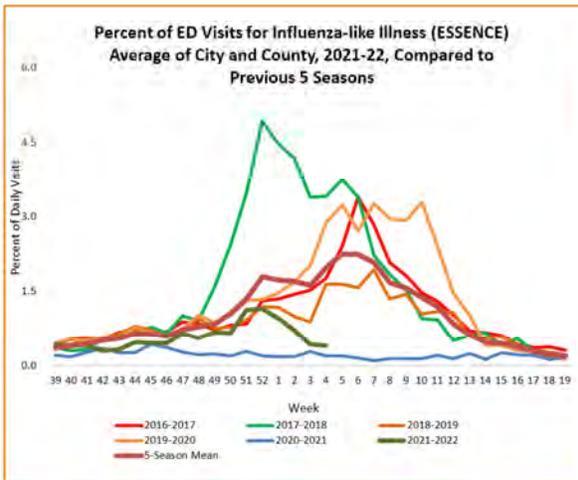
Hepatitis C



Source: Missouri Health Surveillance Information System (Websurv), 2016-2021

Moving on from STIs, here are the incidence rates of chronic hepatitis C for the city and county. The graph on the left is for both jurisdictions, disaggregated by sex, whereas the graph on the right is just for the county, disaggregated by age groups. For both regions, there was an overall decrease in incidence from 2016 to 2020, with males having a higher incidence than females. When examining the graph on the right, those who were between the 0-24 age group had a significantly lower incidence rate than the rest of the population. The group with the second lowest incidence rate was 65+. Rates for the 45-64 age group have been declining over time, with some slight fluctuation for the 25-44 age group.

Influenza



9

Source: Missouri Health Surveillance Information System (Websurv), 2016-2022

Last but not least is influenza. The graph on the left shows the percent of emergency department visits for influenza-like illness, whereas the graph on the right shows case counts. As you can see, the 2017-2018 season saw a dramatic peak in influenza cases and ILI, while the other seasons had a slightly flatter curve. It should come as no surprise that the 2020-2021 season saw a marked reduction in influenza, since that's when we all started taking mitigation measures to prevent another rather well-known viral illness. But that's a whole different topic our colleagues will cover in the next presentation!

Thank You!



References

- Missouri Health Surveillance Information System (Websurv), 2016-2020
- <https://health.mo.gov/data/hivstdaids/data.php>



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COMMUNICABLE DISEASES

The purpose of today's meeting is to identify measures and indicators are reflective of Communicable Diseases in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

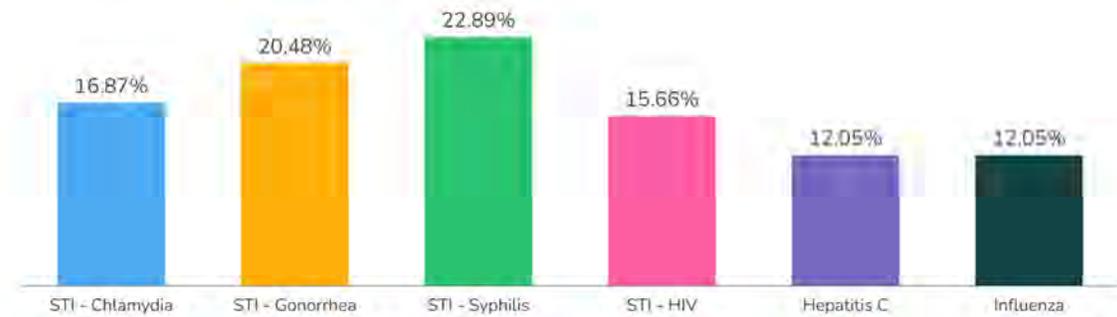
PREETI PULLURI
PRIYA KATTI



Menu

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Select the indicators which effectively tell the story of Communicable Diseases in our community



Menu

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How does the data reflect your experience? How do they differ from your experience?

More detail on ethnographic input

Risk behaviors

Positivity only tells part of the story

Data seems to be under reported.

Reflects my experience that we do a poor job in discussing sexual health in our schools - from elementary to high school.

Context on STI testing availability would be helpful for any detailed reports.

Interesting that we only seem to think of sexually transmitted diseases as communicable diseases, except for influenza. We have COVID, which shows how important communicable diseases are.

Data on Herpes HSV 1 and 2

Negative tests -- providers can share all tests if they are already sharing positive tests. Dr. Hilary Reno is working on building this platform

 Menu

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What indicators do you feel are missing? Please share data sources.

- Age breakdowns would be helpful to see in detailed report.
- More on HIV
- Race and ethnicity, income
- We need to be able to measure the 90-90-90 targets for HIV
- Data on Herpes I and II
- Any data on vaccine rates that are available for applicable diseases could be helpful.
- Enterics - shigella, salmonella, etc
- Is there data available on number of folks receiving treatment? Access to treatment.
- Are people being treated, able to afford treatment?
- Context on availability of STI testing and capacity for follow-up by DOHs
- TB and enterics
- Hep B
- Connection with primary care
- Trans or non-binary input even if ...
- Appreciated context comments added by
- A special focus on youth STDs

Menu

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What indicators do you feel are missing? Please share data sources.

Enterics- shigella, salmonella, etc

Context on availability of STI testing and capacity for follow-up by DOHs

Trans or non-binary input even if qualitative

receiving treatment? Access to treatment

TB and enterics

Connection with primary care

Appreciated context comments added by presenters. Would like to see those reflected in any reporting.

Are people being treated, able to afford treatment?

Hep B

A special focus on youth STDs

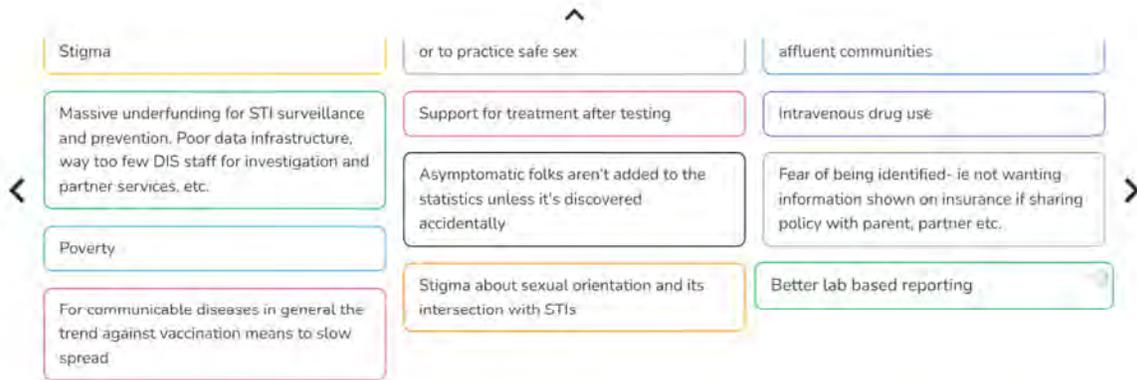
There are lots of communicable diseases. What about mosquito-borne illnesses? Measles/mumps/pertussis, legionella?

What are the underlying causes and external factors that affect the disparities in this category?

- Access to care
- Vaccination acceptance (e.g. flu)
- Access to free testing
- Non quantitative data collection on gender identity, risks
- Shame
- Knowledge of resources
- Stigma
- Lack of education to recognize symptoms or to practice safe sex
- Doctors under-reporting cases in more affluent communities
- Massive underfunding for STI surveillance and prevention. Poor data infrastructure, way too few DIS staff for investigation and partner services, etc.
- Support for treatment after testing
- Intravenous drug use
- Poverty
- Asymptomatic folks aren't added to the statistics unless it's discovered accidentally
- Fear of being identified- ie not wanting information shown on insurance if sharing policy with parent, partner etc.



What are the underlying causes and external factors that affect the disparities in this category?



Menu

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Questions

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COVID-19

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN

MARCH 30, 2022

12:15 P.M.– 12:45 P.M.



The COVID-19 pandemic has affected every part of society over the past 2 years. Nearly 1 million Americans have died, with millions more dealing with morbidities like “long-COVID”. It has disrupted the economy, requiring businesses to rapidly adapt to accommodate prevention measures like masking, social distancing, and gathering restrictions. While COVID has affected all parts of society, its effects have varied significantly by race, age, and geography, which we’ll highlight in this presentation.

COVID-19 Update:

A review of COVID-19 pandemic data from 2020-2021, with special focus on inequities in cases, mortality, and vaccination rates.

COVID-19

1. Case Rates

- a) Age
- b) Sex
- c) Race
- d) Geography

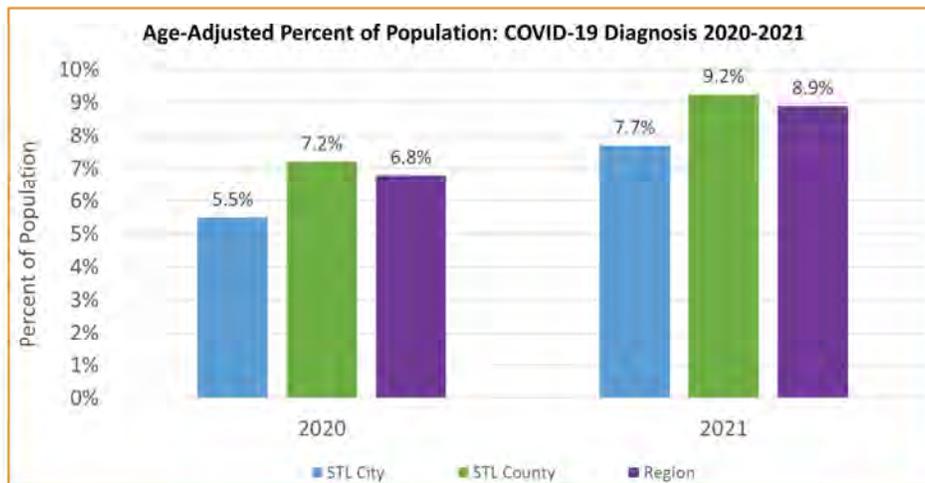
1. Mortality Rates

- a) Age
- b) Sex
- c) Race

1. Vaccination Rates

- a) Age
- b) Geography

COVID-19: Case Rates



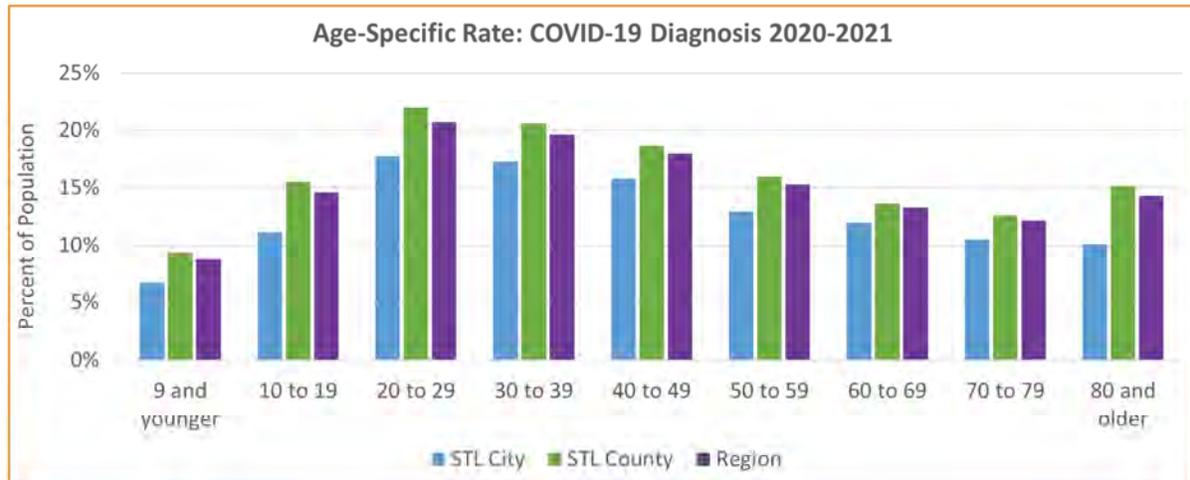
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Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

We will be focusing primarily on data from the start of the pandemic in March of 2020 through the end of 2021, and case rates include both confirmed and probable cases, which are treated the same in terms of quarantine and isolation guidance. In 2020, 6.8% of the region's population was diagnosed with COVID-19. In 2021, the Delta variant contributed to a severe rise in case counts in the summer, and the beginning of the Omicron surge began in November of the same year, leading to another 8.9% of the population being diagnosed in 2021. In total, 15.7% of the region's population was diagnosed with COVID-19 over the first two years of the pandemic, more than 1 out of every 7 people.

And we know that the true infection rate is even higher, since many infected people did not get tested during their illness. Everyone in our community has been affected by COVID, either directly by becoming infected themselves, or through a close connection – a family member, friend, coworker, or neighbor.

COVID-19: Cases by Age



4

Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

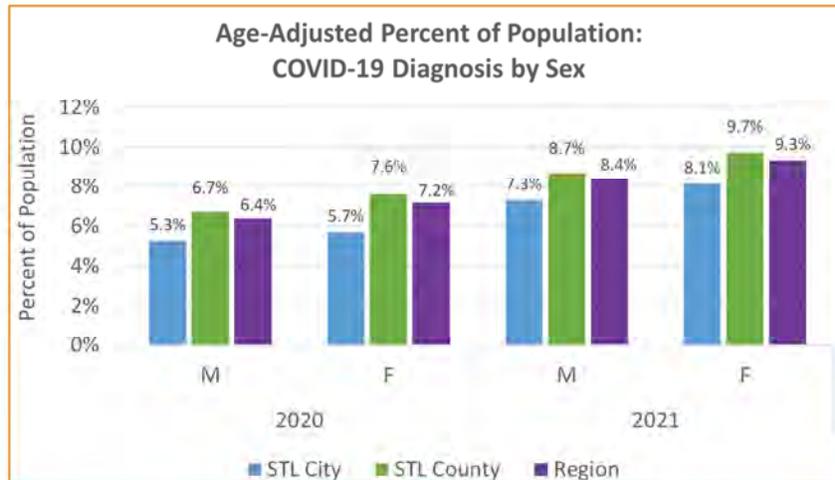
Young children were largely spared early on in the pandemic, and have the lowest rate of any age group in 2020-2021. The Delta variant had mutations that seemed to have a greater impact in the pediatric population, and the proportion of cases ages 17 and under rose during the Delta wave.

However, the age groups with the highest case rates are adults between the ages of 20-49. The higher rates in these age groups may be partially explained by the role that they play in society. These adults are working age and many have jobs that interact with the public, or in-person with coworkers; they may be parents of children who go to and from school, and they may be caring for elderly parents. Increased interactions and activities can increase the risk of exposure to SARS-cov-2.

As a general trend, case rates in adults decreased with increasing age, with the exception of those aged 80 and above. Outbreaks in long-term care facilities, particularly in 2020 when vaccines were not yet available,

contribute to these higher rates. This population is most vulnerable to severe outcomes associated with COVID-19, and great care was taken to improve prevention and containment strategies in long-term care facilities.

COVID-19: Case Rates by Sex



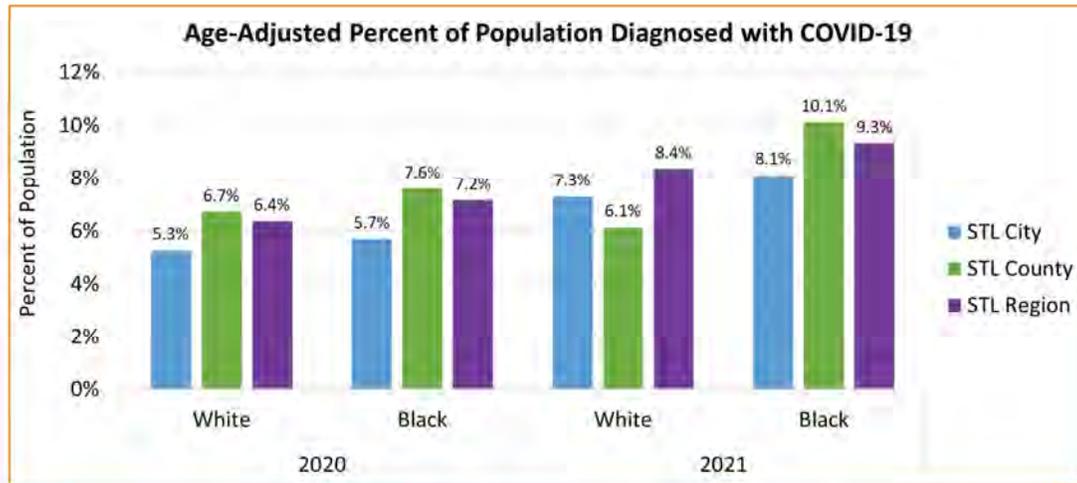
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Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

Females were diagnosed at higher rates than males throughout the first 2 years of the pandemic. In the St. Louis Region, females were 11% more likely to be diagnosed than males.

Generally, females tend to exhibit greater health-care seeking behavior, and were more likely to be tested for COVID-19, which may help explain the higher case rates.

COVID-19: Cases by Race



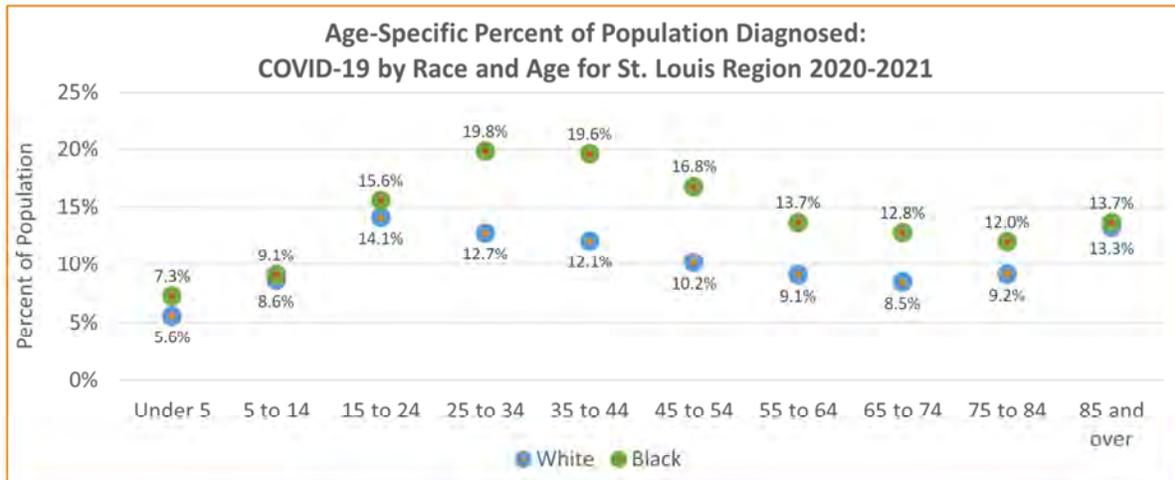
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Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

Black residents have been disproportionately impacted by COVID-19 in our community. The disparity is more pronounced in St. Louis County, where black residents were 1.7x more likely to be diagnosed than white residents in 2021.

St. Louis County and St. Louis City Health Departments have made equity a central tenant to the pandemic response, providing education, testing and vaccination clinics in ZIP codes with traditionally underserved communities.

COVID-19: Cases by Race and Age: STL Region

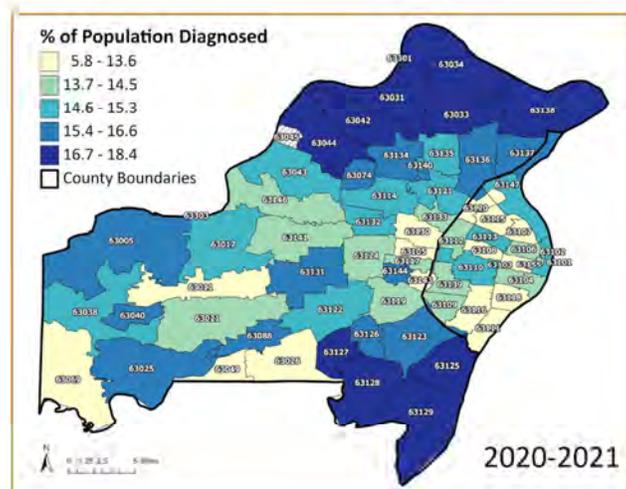


7

Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

As you can see, Black residents in the St. Louis Region have been disproportionately affected across all age groups. The largest inequities by race are among adults ages 25-54. Rates among the youngest and oldest age groups are more similar among White and Black residents, but a clear disparity remains nonetheless.

COVID-19: Cases by Geography (ZCTA)

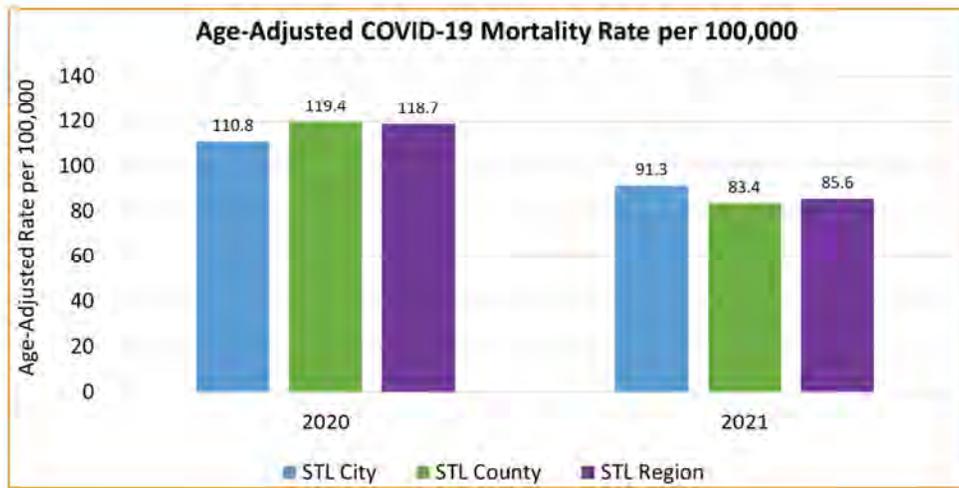


Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

Transmission behavior of COVID-19 shows migrating patterns and fluctuations from week to week. Some neighborhoods may become hot-spots of activity one week and then cool off after the virus runs out of available hosts or prevention measures disrupt the chain of transmission. New variants or changes in numerous environmental factors cause boom-bust cycles, and these waves hit communities at different times.

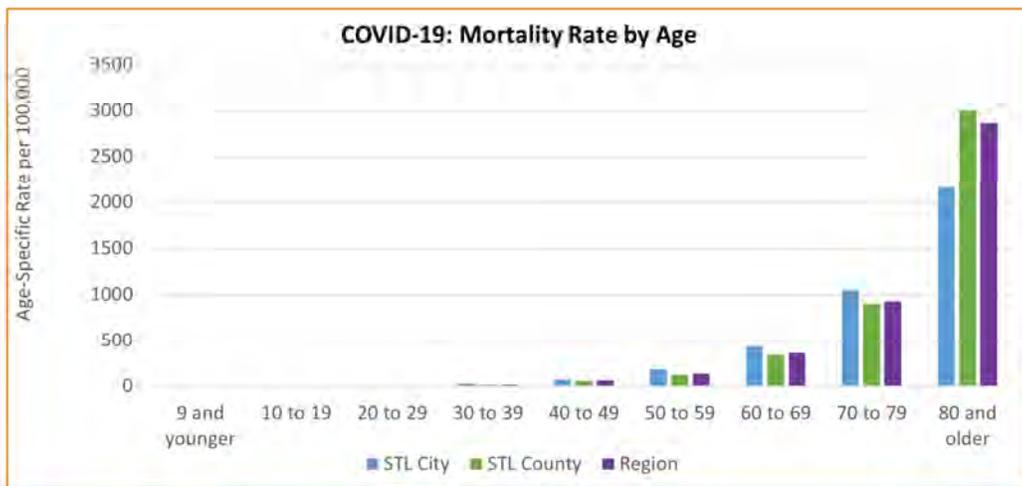
But when taking a birds-eye view of the first two years of the pandemic we see an unequal geographic distribution of cumulative case rates. North and South County had the highest proportion of the population diagnosed with COVID-19 during this timeline, with a maximum of 18.4% of the ZIP code's population diagnosed. St. Louis County also had the ZIP code with the lowest rate (5.8%), showing much greater variance in case rates than St. Louis City ZIP codes, which were middling in comparison to the County's ZIP code rates (range: 11.8%-15.3%).

COVID-19: Mortality Rate



Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

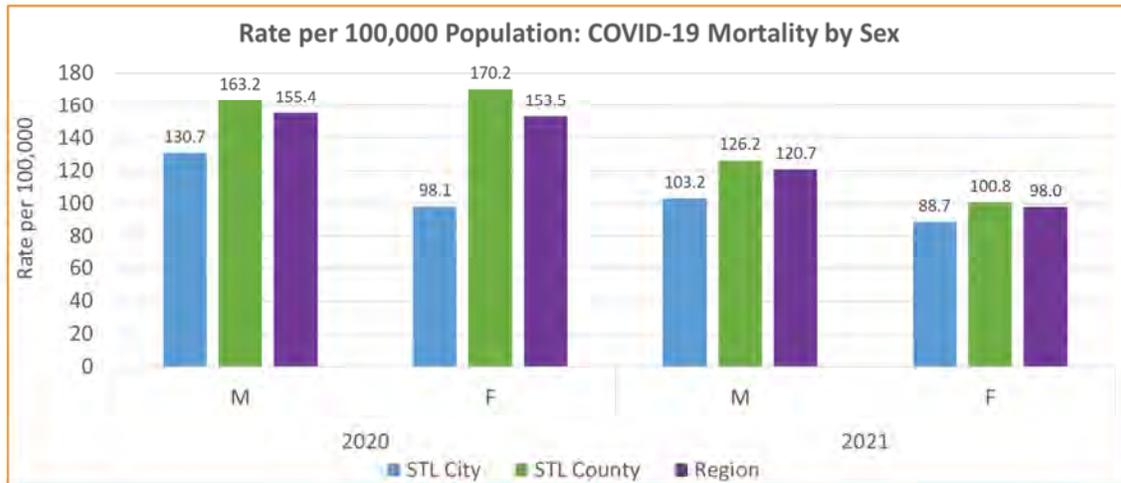
COVID-19: Mortality Rate by Age



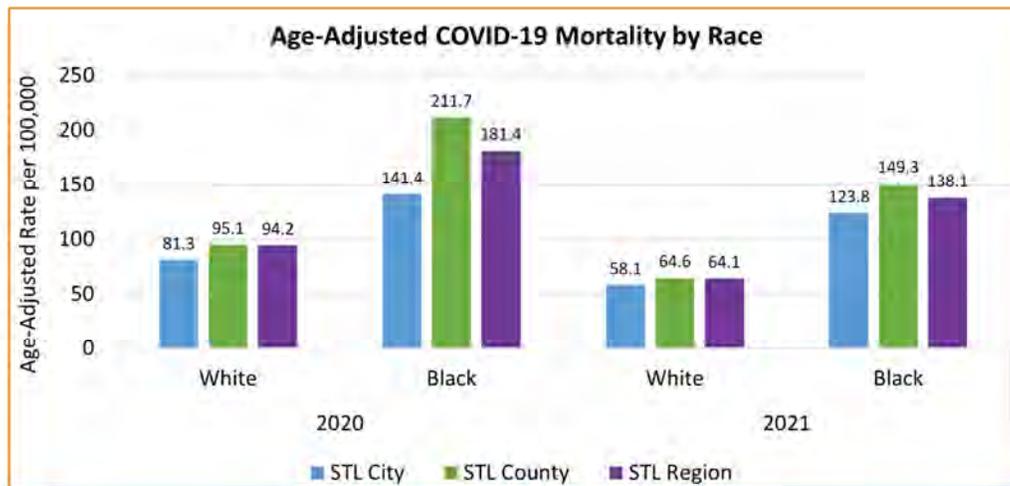
10

Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

COVID-19: Mortality Rate by Sex



COVID-19: Mortality Rate by Race



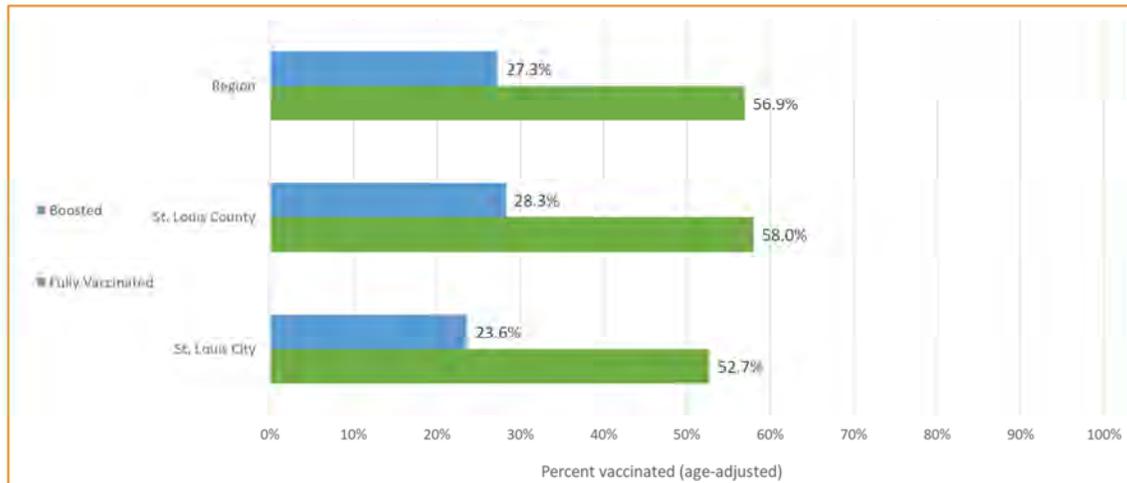
11

Sources: City of St. Louis DOH and St. Louis County DPH, EpiTrax, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

Black residents were more than twice as likely to die from COVID-19 than White residents.

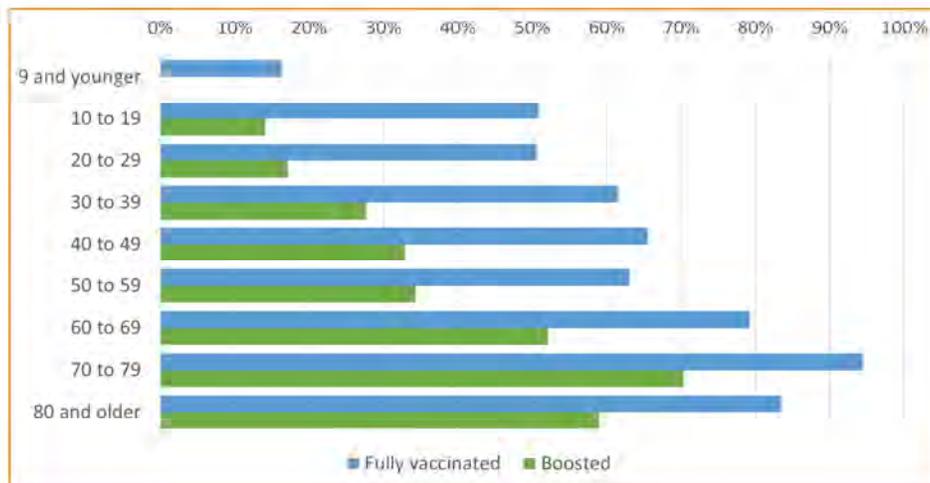
Mortality rates decreased by 25% despite many more diagnoses occurring in 2021. This demonstrates the effectiveness of vaccination, which did not become widely available until 2021. Groups at highest risk of mortality and severe morbidity were prioritized for vaccination in a tiered rollout system. The first tier to receive access were the elderly and those with health complications or suppressed immune systems.

COVID-19: Vaccination Rates



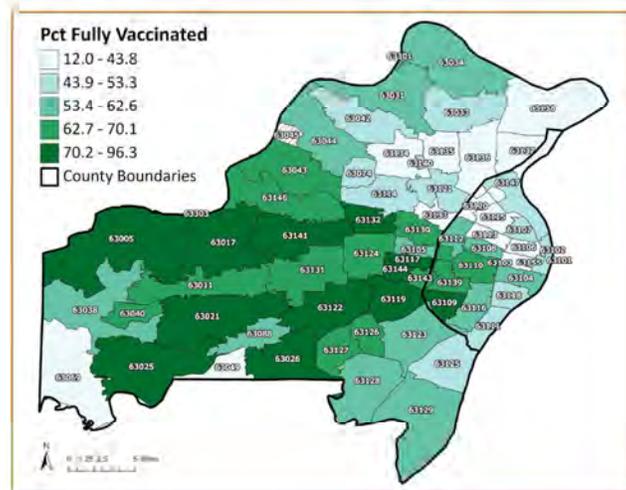
Sources: ShowMeVax MO DHSS, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

COVID-19: Vaccination Rates by Age Group



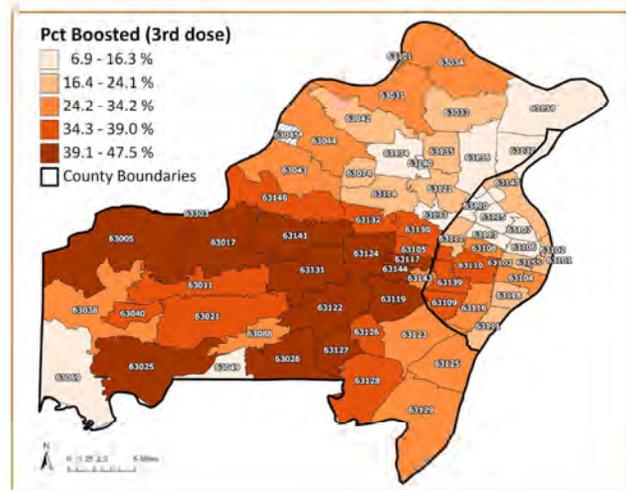
Sources: ShowMeVax MO DHSS, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

COVID-19: Vaccination Rates by ZIP Code



Sources: ShowMeVax MO DHSS, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

COVID-19: Vaccination Rates by ZIP Code



Sources: ShowMeVax MO DHSS, Census Bureau American Community Survey (ACS) 5-year estimates 2015-2019

Thank You!



References

- City of St. Louis DOH and St. Louis County DPH
- EpiTrax
- Census Bureau
- American Community Survey (ACS) 5-year estimates 2015-2019



ahaslides.com/CHSADAYONE

COVID-19

The purpose of today's meeting is to identify measures and indicators are reflective of COVID-19 in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

MATT HASLAM
ANDREW TORGERSON



Menu

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Select the indicators which effectively tell the story of COVID-19 our community



Menu

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How does the data reflect your experience? How do they differ from your experience?

Interesting in vaccine hesitancy. Any ideas per St Louis?

Homebound older adults and people with disabilities was an issue that needs to be explored.

Vaccine hesitation

There needs to be a better way to track persons who are positive that do not have to go into the hospital for treatment

It's been helpful to bring vaccines into communities with trusted messengers

They reflect my experience

I've seen covid case rates by occupation at the national level - wish it was available locally.

Matches with my experience. Comparison with other regions/states would be helpful to see the overall picture on where we are.

Those in the COVID response agree that this reflects what has been found over the last year with vaccination service provision.

In the latest surge, we saw overwhelmingly that new admissions were from the same zip codes where

For a broad summary it reflects. Data on hospitalizations would be helpful. Comparison to other areas of the state

We should be building a local evidence base for hesitancy

Agree on hospitalizations



How does the data reflect your experience? How do they differ from your experience?

In the latest surge, we saw overwhelmingly that new admissions were from the same zip codes where vaccination rates were lower. Agree to need for local evidence for hesitancy

Curious to how much Covid is being brought home from schools/daycares

School and daycare closure data (if could be available).

For a broad summary it reflects. Data on hospitalizations would be helpful. Comparison to other areas of the state (e.g., Chris Prener's updates) were eye-opening about differences in various regions.

Overlaying the data with the disability population by zip code from the American Community Survey.

<https://www.tfah.org/initiatives/age->

base for hesitancy

Agree on hospitalizations

It would be great to present the same data on a different level for general population and literacy. It would go a long way

Long term effect data

It would be helpful to overlay implementation of transmission

Menu

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How does the data reflect your experience? How do they differ from your experience?

^

yaccination rates were lower, Agree to need for local evidence for hesitancy

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Long term effect data

School and daycare closure data (if could be available).

<https://www.tfah.org/initiatives/age-friendly-public-health/>

It would be helpful to overlay implementation of transmission prevention policies with case rates timeline

covid case rates by occupation

the infodemic

What indicators do you feel are missing? Please share data sources.

- Mortality data of people who passed from COVID in hospital vs in home
- Long covid cases
- Estimates on long covid from WashU clinic perhaps?
- maybe data related to vaccine delivery (sites in community, mobile vaccines to residents who were homebound). Could give some context to response.
- Hospitalizations
- Nursing home case and mortality rates
- <https://www.tfah.org/initiatives/age-friendly-public-health/>
- Pregnancy impacts
- Homebound includes people in the community and not just nursing homes.
- vaccination rates by education level
- Long term effect data. How many people are getting long term effects? What are the most common etc.
- MIS-C
- Quality data on why people are not getting vaccinated
- Mistrust of gov't; Systemic and structural

What indicators do you feel are missing? Please share data sources.

Long covid cases

Estimates on long covid from WashU clinic perhaps?

maybe data related to vaccine delivery (sites in community, mobile vaccines to residents who were homebound). Could give some context to response.

Geography, living conditions

<https://www.tfah.org/initiatives/age-friendly-public-health/>

Pregnancy impacts

Homebound includes people in the community and not just nursing homes

sources/mode of communication of "trusted" sources

are getting long term effects/ What are the most common etc.

MIS-C

Quality data on why people are not getting vaccinated

Mistrust of gov't; Systemic and structural racism;

 Menu

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Menu

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Pregnancy impacts

Homebound includes people in the community and not just nursing homes

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Quality data on why people are not getting vaccinated

Mistrust of gov't; Systemic and structural racism;

Menu

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Questions

Matthew D. Haslam, Epidemiologist
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Andrew Torgerson, Sr. Epidemiologist
atorgerson@stlouiscountymo.gov

ACCESS TO AND LINKAGE WITH CLINICAL CARE

COMMUNITY HEALTH STATUS ASSESSMENT

MARCH 31, 2022

9:15 AM – 9:45 AM



Health Insurance – 5-Year Estimates

10.8%

Adult Population Uninsured in St. Louis City

6.1%

Adult Population Uninsured in St. Louis County

9.4%

Adult Population Uninsured in Missouri

5.0%

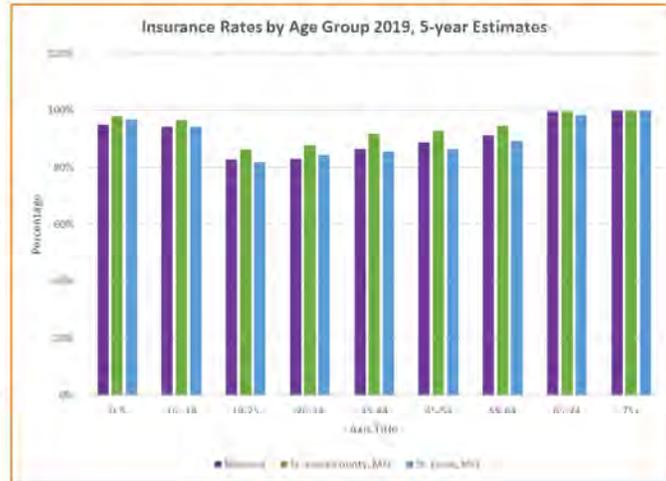
% Population with Disabilities in St. Louis City

12.0%

% Population with Disabilities in St. Louis County

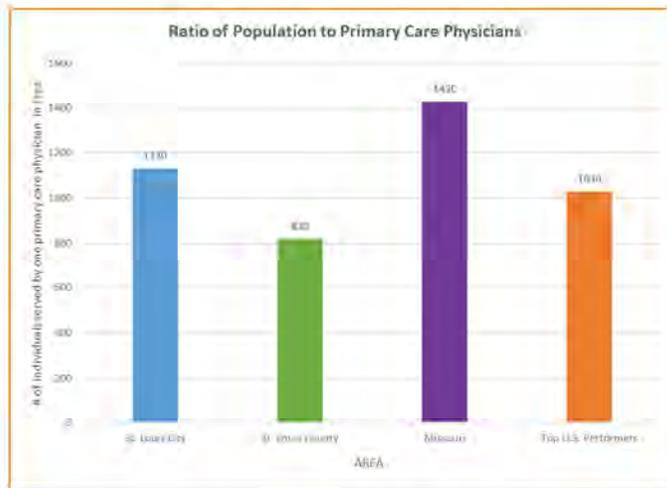
14.6%

% Population with Disabilities in Missouri



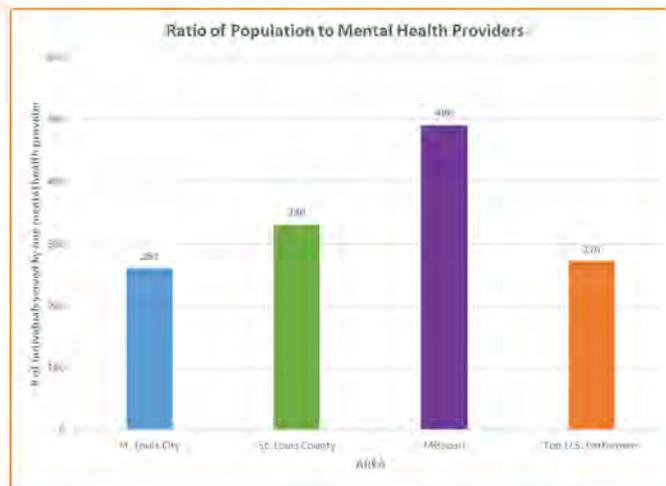
Primary Care Physicians

	Ratio of Population to Providers
St. Louis City	1130
St. Louis County	820
Missouri	1430
Top U.S. Performers	1030



Mental Health Providers

	Ratio of Population to Providers
St. Louis City	260
St. Louis County	330
Missouri	490
Top U.S. Performers	270



Thank You!





ACCESS TO AND LINKAGE WITH CLINICAL CARE

The purpose of today's meeting is to identify measures and indicators are reflective of Access to and Linkage with Clinical Care in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY TRACY KULIK & MARCOS ALCORN
MARCH 31, 2022
9:15 – 9:45 A.M.



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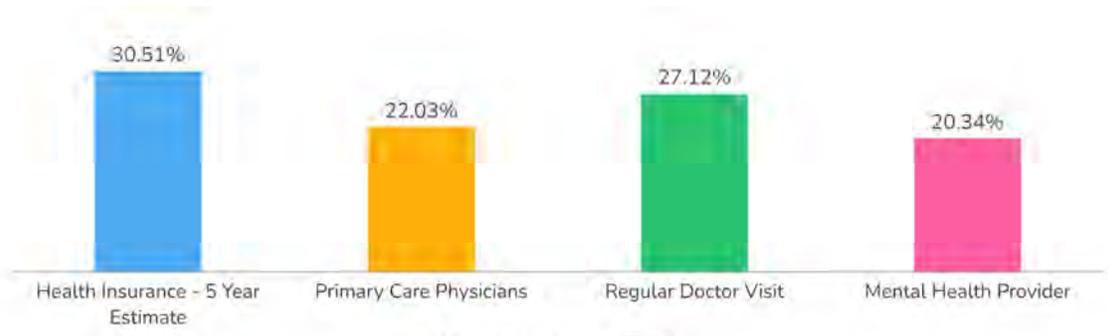
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To join, go to: ahaslides.com/CHSADAYTWO

AhaSlides

Select the indicators which effectively tell the story of Access to and Linkage with Clinical Care in our community



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Menu

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References

- <https://www.countyhealthrankings.org/app/missouri/2021/measure/outcomes/42/data>

How does the data reflect your experience? How do they differ from your experience?

I'm shocked we don't have an official provider shortage

Access needs to include specialists

This information is somewhat newer to me but I agree with the data.

The data is a little flat. Specialists are omitted.

the number of providers is one thing, but accessibility (e.g. transportation) is a major barrier to care

Number of trusted doctors would be interesting to know.

I'd be interested to know about diversity of providers.

Data from my experience is seeing a lot of Emergency Room visits/Urgent Care Visits at the peak of illness vs. regular Dr. Visits

All data does not reflect healthcare access barriers for immigrant/ethnic communities and language access.

Missing many other factors of access

St. Louis is a population center with multiple academic and tertiary referral hospitals, so we have lots of doctors. That doesn't necessarily mean that the people

Barriers to access is definitely a major problem

It's hard to find access to your pcp or specialist doctor when you have an urgent





How does the data reflect your experience? How do they differ from your experience?

Missing many other factors of access

It's hard to find access to your pcp or specialist doctor when you have an urgent emergency but not for the emergency room

Just because there are PCPs available that does not mean people have access to them. Availability does not equal access.

Having insurance may not mean that

at the peak of illness vs. regular Dr. visits

St. Louis is a population center with multiple academic and tertiary referral hospitals, so we have lots of doctors. That doesn't necessarily mean that the people who live here have access to those providers.

It's one thing if the MDs are there - but are they accepting all pts?

Clearly need a better access system given

and language access.

Barriers to access is definitely a major problem

Parents unable to take children to PCP prevents assessing their safety concerns, building trusting relationships, and utilizing the ED for routine care overwhelming the EMergency Departments.

Does access to insurance imply that

Menu

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in



How does the data reflect your experience? How do they differ from your experience?

100%

Just because there are PCPs available that does not mean people have access to them. Availability does not equal access.

providers.

It's one thing if the MDs are there - but are they accepting all pts?

prevents assessing their safety concerns, building trusting relationships, and utilizing the ED for routine care overwhelming the Emergency Departments.



Having insurance may not mean that necessary services are covered. Mental health, specialists Physical/occupational therapy, dental etc.

Clearly need a better access system given the data-or better system for helping people understand how to access/promoting access points.

Does access to insurance imply that coverage is continuous?



Patients per provider by zipcode.

Demographic Data for Immigrant and ethnic limited English communities.

Substance treatment centers

What indicators do you feel are missing? Please share data sources.

- Food security by zip code.
- Specialist access, acceptance of Medicaid
- Access to Interconception Care & Postpartum Care
- Behavioral Health providers for both pediatric and adult populations.
- Location of providers relative to zip code
- Mental Health Providers for Pregnant People
- How often residents switch doctors and why.
- Uninsured and Medicaid rates by race/ethnicity and geography. Huge disparities there.
- location of providers relative to public transit routes
- Substance treatment centers
- Alternative and holistic options for pregnant patients
- Amount of urgent cares and emergency room visits
- All points of access (urgent care, ED, MD office, fqhc), average time to appointment.
- Data for Immigrant and ethnic limited

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What indicators do you feel are missing? Please share data sources.

All points of access (urgent care, ED, MD office, fqhc), average time to appointment, transportation,...

Data for Immigrant and ethnic limited English communities.

room visits

Medicaid access pre and post expansion in Missouri

Pct of adults with a routine MD visit in last year, stratified by race/ethnicity, geography, and/or income, depending on what's available.

preventable ED/IP visits

Access to Medicaid, access to specialists, access to medical providers, along transit lines

How data is collected. Lack of consistency and not in line with Title VI.

ethnic not ethnic,...

Patients by zip code served by providers

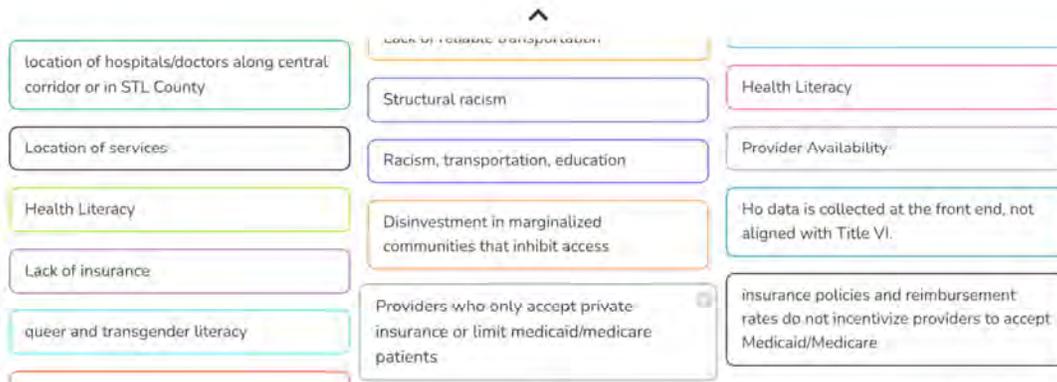
Racism, Medical Provider Bias

What are the underlying causes and external factors that affect the disparities in this category?

- Poverty
- Transportation
- Systemic racism
- Capitalism
- Cost of medical education/training
- uninsured
- Poverty
- Institutionalized racism
- medical provider bias
- inequitable transportation systems
- providers accepting all patient types
- Joblessness, education level, policy, and transportation are few of them.
- redlining and legacy of historic community disinvestment
- elected officials
- Lack of national and regional men's health campaign.
- location of hospitals/doctors along central corridor or in ST1 County
- Lack of reliable transportation
- Health literacy

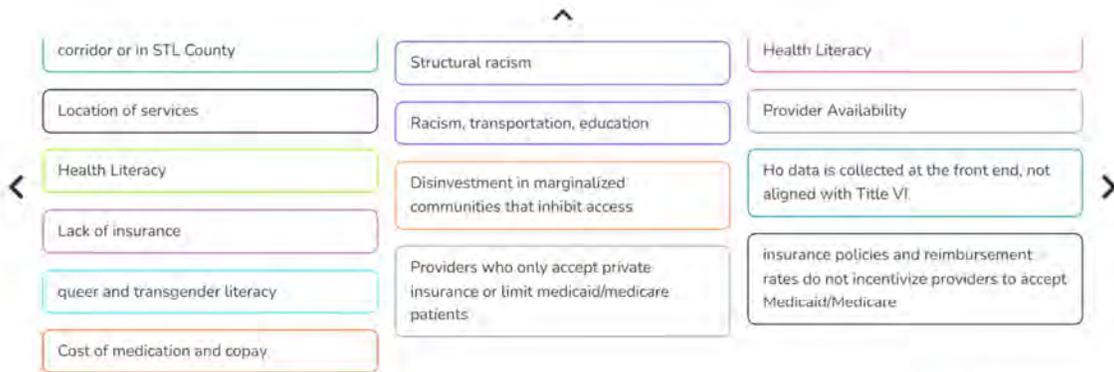


What are the underlying causes and external factors that affect the disparities in this category?





What are the underlying causes and external factors that affect the disparities in this category?



Questions

Tracy Kulik, Project Lead
tkulik@kulikstrategic.com

Marcos Alcorn, Project Manager
malcorn@kulikstrategic.com

Environmental Health

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY ELLEN HUTTI & MICHAEL WIRICK
MARCH 30, 2022
10:45 – 11:15 A.M.



Good morning and welcome to our presentation on environmental health. My name is Ellen Hutti and I am an epidemiologist with Saint Louis County Department of Public Health. This presentation is brought to you through a partnership between the City of Saint Louis Department of Health and the Saint Louis County Department of Public Health. At the end of this presentation, there will be a facilitated discussion and time for questions and answers. Please include any questions that you have in the Q&A box on your screen.

Indicators for Environmental Health:

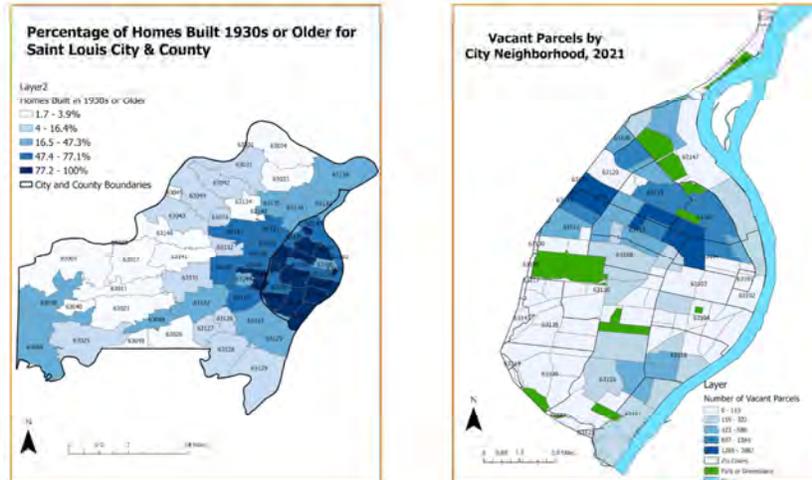
A community's health is affected by where and how people live. Clean air, water, sanitary living conditions and safe housing are part of this as is access to healthy food.

1. **Housing Conditions**
 - a) Old Housing Stock (% of housing built before 1930)
 - b) Vacant Parcels
 - c) Critical Housing Violations
2. **Childhood Lead Poisoning**
3. **Air Quality**
4. **Asthma**
5. **Food Insecurity**

2

Today we will be discussing several indicators that are important to environmental health in our communities. These include housing conditions, childhood lead poisoning, air quality, asthma, and food insecurity. When available, we will present data for both St. Louis City and St. Louis County, in addition to combined regional numbers. For a few indicators, however, data are only available for St. Louis City.

Housing Conditions



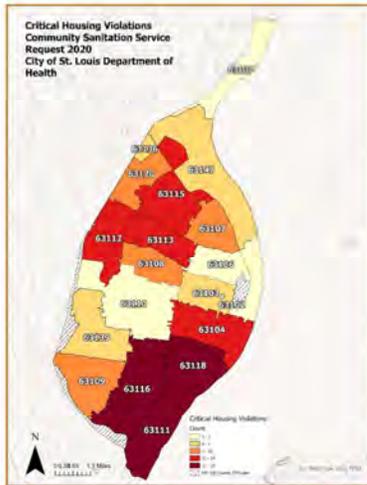
To begin, we will look at housing conditions. First, we have a figure representing the percentage of homes built in the 1930s or earlier. Zip codes represented with a darker blue color have a greater percentage of homes built before 1939. Of all the homes across our region, approximately 55 percent were built in 1939 or earlier in St. Louis City, followed by 10 percent for St. Louis County. The greatest concentration of older homes is in St. Louis City. In St. Louis County, older homes are more prevalent in the zip codes surrounding the city. Older

homes are important to note because they are at greater risk of having adverse conditions, such as lead paint. In the second figure, we are looking at vacant parcels in St. Louis City. Areas with darker blue coloring represent neighborhoods containing a greater number of vacant parcels. As you can see from the map, there are more vacant parcels in neighborhoods located in the northern region of St. Louis.

Homes Built in 1930s. Assessor's Office City of Saint Louis. 2021

Vacant Parcels by City Neighborhood. 2021. Retrieved From <https://www.stlvacancytools.com/> Retrieved on Feb 2nd, 2022

Housing Violations



Critical Housing Violations

- Plumbing: No hot or cold water, flushing toilet
- No bathtub or shower
- Kitchen facilities without a faucet

South City reports more violations and complaints than any other region, with zip code 63116, 63111, 63118 at the **highest**.

The **lowest** city zip codes are 63102, 63137, 63110

Here, we are looking at a map of critical housing violations in St. Louis City. These violations include a lack of adequate plumbing, such as no hot or cold water, or flushable toilet, no bathtub or shower, or kitchen facilities that do not have a sink with a faucet. Areas with darker red coloring represent zip codes containing a higher number of critical housing violations. The southeastern region of St. Louis has the most reported violations, with the zip codes 63116, 63111, and 63118 having the highest number of housing violations.

63116 = 22 violations

63111 = 18 violations

63118 = 16 violations

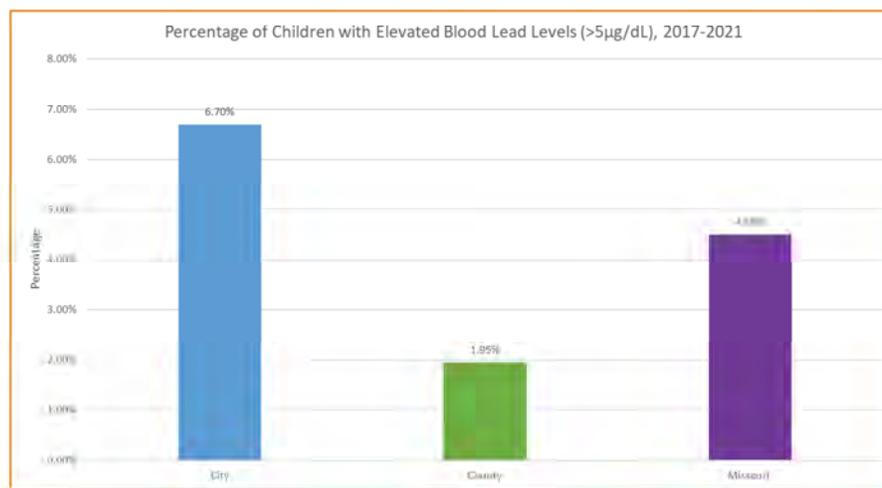
63102 = 1 violation

63137 = 1 violation

63110 = 3 violations

Critical Housing Violations. Cityworks. Community Sanitation. 2021.

Childhood Lead Poisoning



5

Now we are moving on to childhood lead poisoning. This figure shows the percentage of children with elevated blood lead levels in St. Louis City, St. Louis County, and Missouri from 2017 to 2021. The cutoff for elevated blood lead levels here is 5 micrograms per deciliter. Compared to Missouri, the percentage of children with elevated blood lead levels was higher in St. Louis City and lower in St. Louis County. Children in St. Louis City were nearly 3.5 times as likely to have elevated blood lead levels compared to children in the county and nearly 1.5 times as likely as children in Missouri overall.

Source: BiPortal

Air Quality

Outdoor Air Quality Index By Number of Days, St. Louis Region, 2020

Jurisdiction	Total AQI Days	Good Days	Moderate Days	Unhealthy Days (Sensitive Groups)	Unhealthy Days	Very Unhealthy Days	Days Hazardous
St. Louis City	366	224	137	4	1	-	-
St. Louis County	366	287	73	6	-	-	-
St. Louis MO-IL	366	161	194	10	1	-	-
Standards Value Range	-	0-50	51-100	101-150	151-200	201-300	301+

6

Source: Air Quality Index Report, United States Environmental Protection Agency retrieved from <https://www.epa.gov/outdoor-air-quality-data/air-quality-index-report> on 1/3/2022

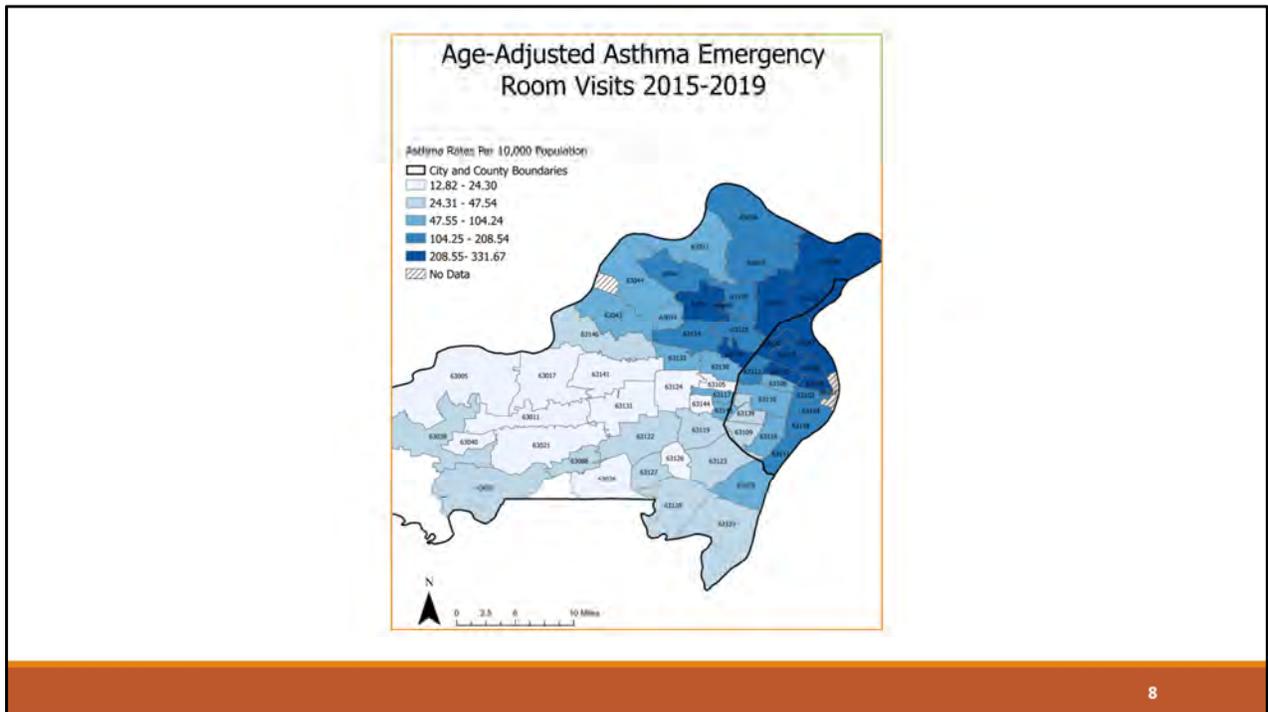
Next, we will look at air quality. Air quality index is an indicator used to understand the level of air pollution on a given day and the corresponding health concern posed to the public. Higher AQI values suggest a greater health concern. These values are divided into categories, which are shown in the columns on this table. As you can see, this table shows the number of days that the outdoor air

quality in jurisdictions were at each category level. In St. Louis City and St. Louis County, the majority of days were rated as “Good” in terms of air quality index. St. Louis City, however, had nearly twice as many days that were rated as “Moderate” when compared to the county. Both the city and the county reported few unhealthy days. The St. Louis Missouri-Illinois region, which accounts for a greater geographic area than the city and the county, reported a majority of “Moderate Days,” followed by “Good Days.”

Asthma Emergency Department Visits

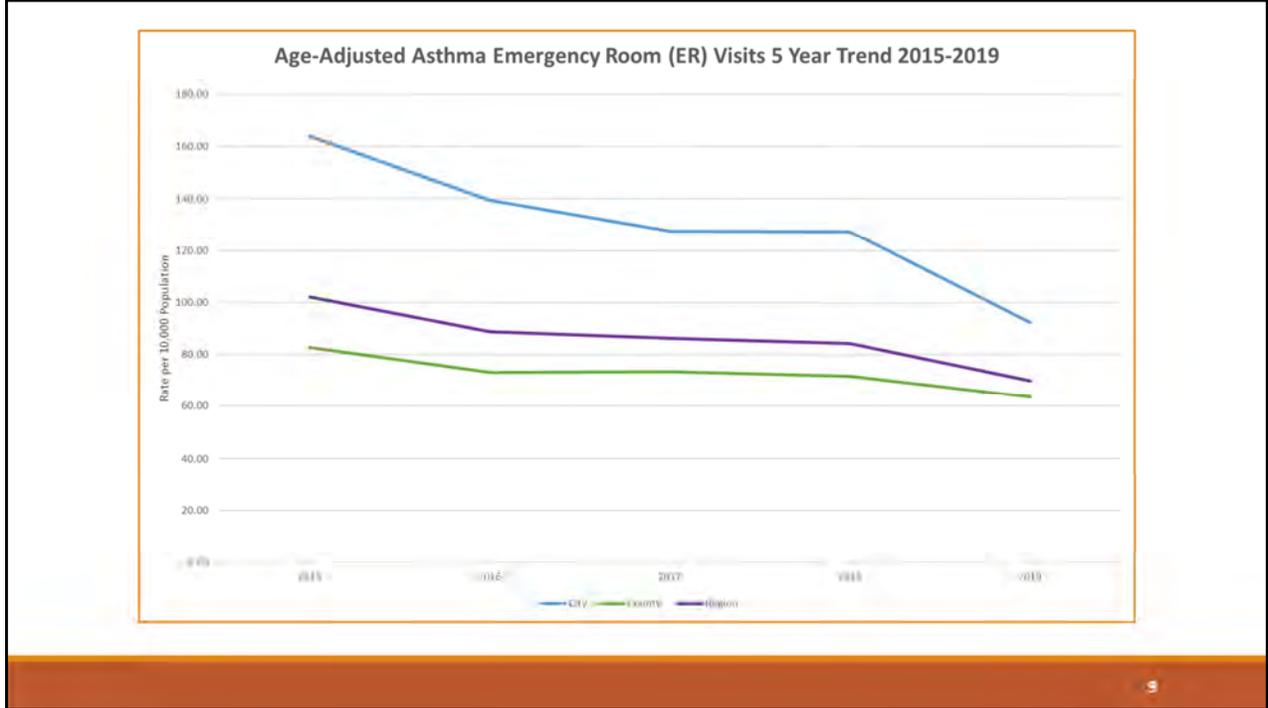
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Now we will shift our focus to asthma. In this presentation, we looked at asthma emergency department visits, which provide insight into the severity of asthma and how well our residents are managing their asthma.



This map shows the five-year average age-adjusted asthma emergency department visit rate per 10,000 population by zip code. Here, light blue corresponds with lower rates of asthma emergency department visits, whereas dark blue corresponds with higher rates of asthma emergency department visits. Rates of asthma emergency department visits were highest in the northern region of both the city and the county and in the southeastern region of the city. Rates were lowest in the middle region of the county.

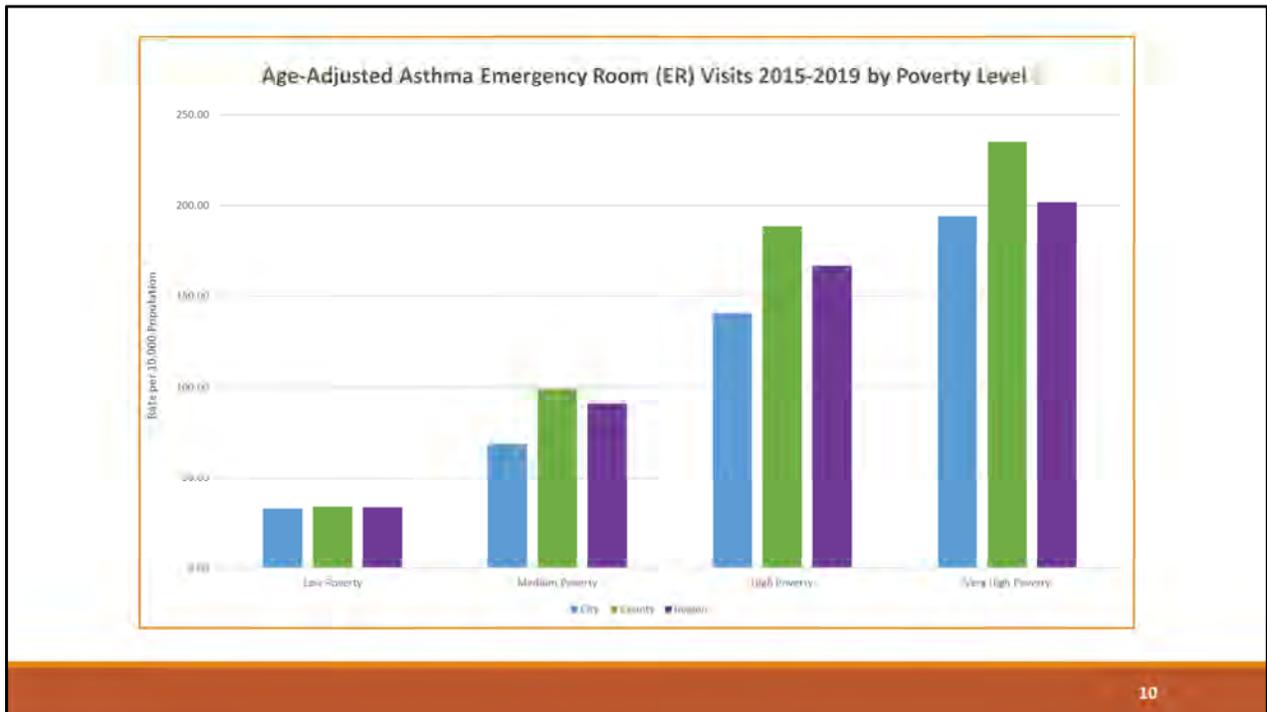
Data source: Missouri Department of Health and Senior Services (Missouri DHSS), Bureau of Vital Statistics



Rates of asthma emergency department visits decreased over the five-year period from 2015 to 2019 in both St. Louis City and St. Louis County. Additionally, the disparity between the city and the county decreased over this period. In 2015, the city had nearly twice the rate of asthma emergency department visits as the county, whereas in 2019, the city had about 1.3 times the rate as the county.

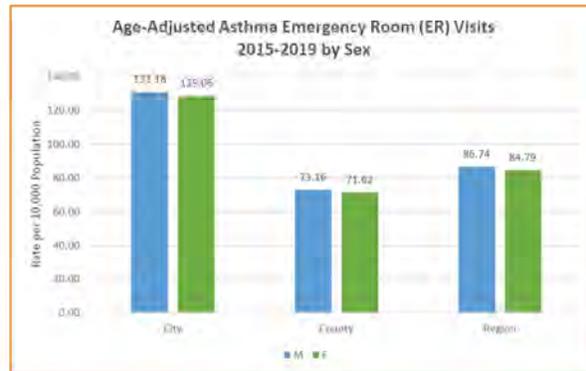
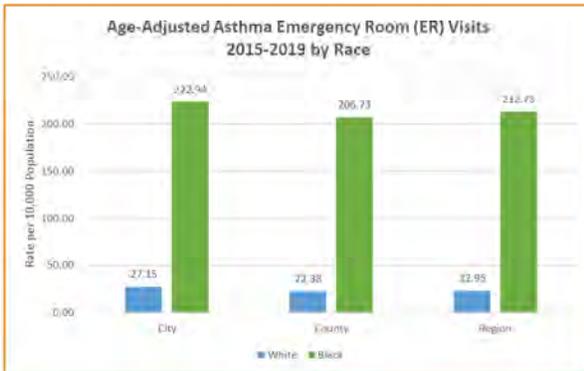
Data source: Missouri Department of Health and Senior Services (Missouri DHSS), Bureau of Vital

Statistics



In both the city and the county, higher rates of neighborhood poverty levels corresponded with higher asthma emergency department visits rates. Those living in low poverty neighborhoods had the lowest asthma emergency department visit rates, whereas those living in neighborhoods with high and very high poverty rates had the highest asthma emergency department visit rates. In addition, rates were higher in the county compared to the city for those in neighborhoods with medium, high, and very high poverty levels.

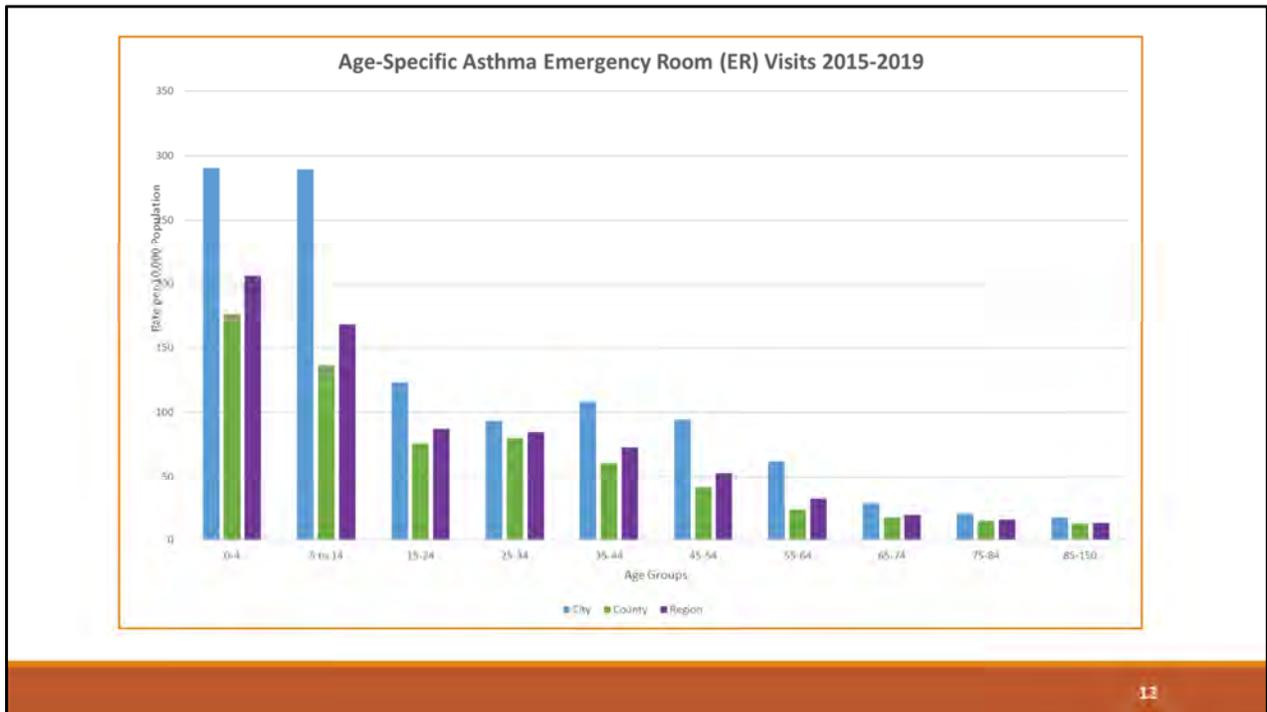
Data source: Missouri Department of Health and Senior Services (Missouri DHSS), Bureau of Vital Statistics



There was a large disparity by race in asthma emergency department visits. Black residents were more than 8 and 9 times as likely to visit the emergency department for asthma compared white residents in both the city and the county, respectively. There was not, however, a similar trend observed by sex. Within both St. Louis City and St. Louis County, male and female residents had similar rates of asthma emergency department visits. Nevertheless, male and female residents of St. Louis City were each about 1.8 times as likely to visit the emergency department for asthma compared to

male and female county residents.

Data source: Missouri Department of Health and Senior Services (Missouri DHSS), Bureau of Vital Statistics



Asthma emergency department visits corresponded with age in both the city and the county. Emergency department visit rates are the highest among those ages 0 to 4 and 5 to 14, and were particularly high among young people from St. Louis City in these age groups. Rates were lowest among seniors ages 65 and older. Across all age groups, rates were higher for residents of the city compared to the county.

Data source: Missouri Department of Health and

Senior Services (Missouri DHSS), Bureau of Vital Statistics

Food

23.3%

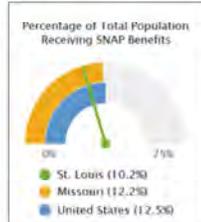
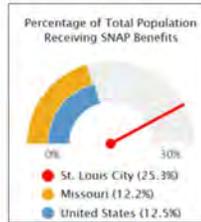
Food Insecurity Rate in
St. Louis City

13.8%

Food Insecurity Rate in
St. Louis County

14.2%

Food Insecurity Rate in
Missouri



8.4%

Living in Food Deserts in
St. Louis City

12.2%

Living in Food Deserts in
St. Louis County

18.1%

Living in Food Deserts
in Missouri



In this slide we will look at food insecurity. Compared to the overall rate for Missouri, there is a higher rate of food insecurity in St. Louis City, whereas the rate of food insecurity is slightly lower than Missouri in St. Louis County. Meanwhile, both St. Louis City and St. Louis County have a lower percent of residents living in food deserts compared to Missouri, with St. Louis City having the lowest percent of residents living in food deserts at 8.4 percent

Thank You!





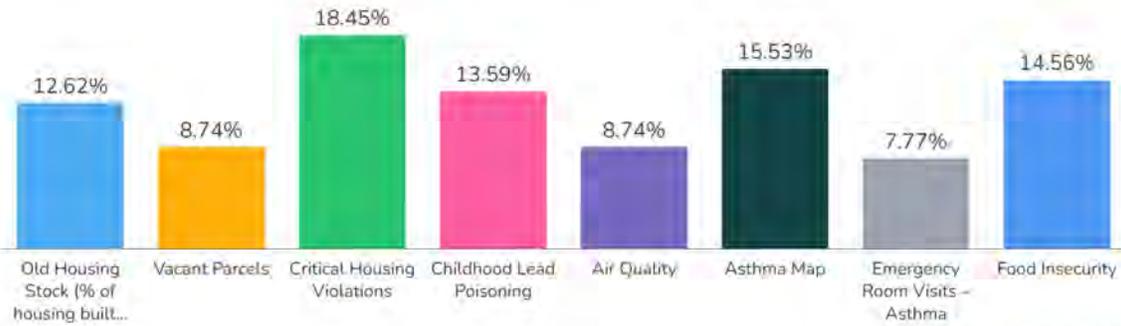
ENVIRONMENTAL HEALTH

The purpose of today's meeting is to identify measures and indicators are reflective of Environmental Health in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY ELLEN HUTTI & MICHAEL WIRICK
MARCH 31, 2022
10:00 – 10:30 A.M.



Select the indicators which effectively tell the story of Environmental Health in our community



Menu

14 5 29 0

How does the data reflect your experience? How do they differ from your experience?

There is so much opportunity here to improve our housing - to future-proof to be resilient and energy efficient and healthy.

Housing inspections aren't health focused but just basic life and safety. Homes are likely even more "unhealthy" than we have data to show

Reflects what we know about our region.

Heat island with few trees

In thinking about food insecurity - there is an overabundance of unhealthy food items + SSBs. What metrics/data can reflect that?

Housing situation is pretty bad in Saint Louis with old homes which are 50-100 years old. That could be a cause for Asthma, lead poisoning and mold/allergies.

Pest control to help with Asthma prevention and other allergies.

older homes + off-gasing abandoned buildings + poorly-maintained apartments = poor AQI, mold, mildew, pests.

Data is helpful. Do we need to include safe walkways challenges (areas lacking appropriate sidewalks or adequate lighting or stop signs)? Would these be considered environmental health?

There is also opportunity to partner with agencies that provide services that can not only weatherize and improve the energy efficiency of a home. but also improve air



How does the data reflect your experience? How do they differ from your experience?

only weatherize and improve the energy efficiency of a home, but also improve air quality.

= poor AqI, mold, mildew, pests.

considered environmental health?

Illegal dumping - is that reflected anywhere here?

Housing conditions affect birth outcomes in a variety of ways.

More resources for healthy homes issues

Low lead testing

data to reflect public housing conditions

Accessible housing stock/homes that can permit aging in place

Climate-related indicators are missing. Heat and flooding issues, vectors (mosquito and tick borne illnesses).

Better legislation holding landlords accountable for maintaining rental properties to align with healthy homes initiatives.

Weatherization

What indicators do you feel are missing? Please share data sources.

Recreation and parks	mapping crime and community safety with vacant properties	Weatherization
Abandoned housing and drugs	Lead testing numbers- are children tested according to laws	Prevalence of violent crime by geography. An environment isn't healthy if people aren't safe/don't feel safe there.
landlord accountability to align with healthy homes initiatives	mapping the history of multi family building and if corporate landlords have properly invested in fixing housing issues in their buildings.	Access to green space by geography?
Money and projects by zip code on neighborhood improvements.	Educating the occupants of rental properties of their rights holding landlords	housing in close proximity to heavy industry and to Interstate highways
Walkability score by geography, if available?		Lack of landlord accountability to maintain

What indicators do you feel are missing? Please share data sources.

A grid of 12 colored boxes containing text responses to the poll question. The boxes are arranged in three columns and four rows. The text in the boxes is as follows:

- landlord accountability to align with healthy homes initiatives
- Lead testing numbers- are children tested according to laws
- An environment isn't healthy if people aren't safe/don't feel safe there.
- Money and projects by zip code on neighborhood improvements.
- mapping the history of multi family building and if corporate landlords have properly invested in fixing housing issues in their buildings.
- Access to green space by geography?
- Walkability score by geography, if available?
- Educating the occupants of rental properties of their rights holding landlords accountable for property upkeep/safety
- housing in close proximity to heavy industry and to Interstate highways
- Landlords not taking care of their property
- Lack of landlord accountability to maintain rental properties in alignment with healthy homes initiatives.



What are the underlying causes and external factors that affect the disparities in this category?



Questions

Ellen Hutti

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Michael Wirick

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Maternal-Child-Family Health

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN

PREPARED BY ELLEN HUTTI AND ABIGAIL ANDRESEN

MARCH 31, 2022

10:45 – 11:15 A.M.



Good morning everyone and welcome to our presentation on maternal, child and family health. My name is Ellen Hutti and I am an epidemiology specialist with Saint Louis County. This presentation is the result of a partnership between the City of Saint Louis Department of Health and the Saint Louis County Department of Public Health. At the end of this presentation, Abigail Andresen and myself will be available to answer questions. There will also be time for a facilitated discussion led by Eboni Hooper.

Indicators for Maternal-Child-Family Health:

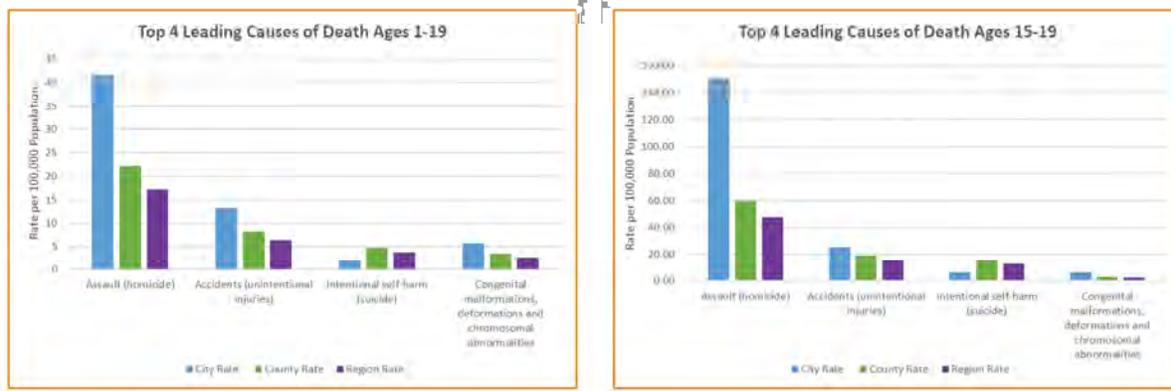
Access to prenatal, postnatal and maternal health care is a major issue in the health of a community and an area of concern related to disparities.

1. Leading Causes of Death, Ages 1-19 & 15-19
2. Prenatal Care in the First Trimester
3. Smoking during Pregnancy
4. Gestational Diabetes
5. Gestational Hypertension
6. Preterm Births
7. Teen Births
8. Fetal Deaths
9. Infant Mortality
10. Maternal Mortality
11. Child Abuse

2

Today we will be discussing several indicators important to maternal, child and family health, seen on this slide. For all indicators, we will look at rates for St. Louis City and St. Louis County individually, as well as for the region combined. We will also show trends over time and rates disaggregated by neighborhood poverty level and race for most indicators. With few exceptions, we see a similar trend in rates across these indicators. In general, rates were higher in the city compared to the county, among Black residents compared to white residents, and among those living in neighborhoods with high and very high poverty rates compared to those living in neighborhoods with low poverty rates.

Leading Causes of Death, Ages 1-19 and 15-19



3

Source: Missouri DHSS, Bureau of Vital Statistics

Rates are per 100,000 2000 US Standard population. Rank based on number of deaths.

Case Definition: *International Classification of Diseases, Tenth Revision* (ICD-10) codes: U02-Y87.1 (Assault; homicide); V01-X59, Y85-Y86 (Unintentional Injury); *U03, X60-X84, Y87.0 (Intentional self-harm; suicide); Q00-Q99 (Congenital malformations, deformations, and congenital abnormalities).

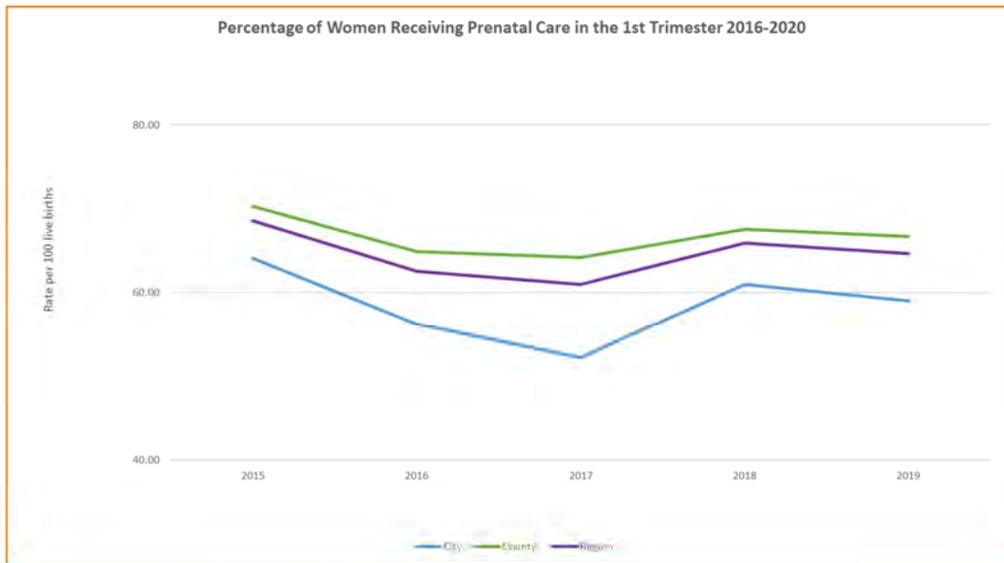
Please note that the scales are different for the two figures.

First, we have leading causes of death among one- to 19-year-olds and 15- to 19-year-olds. The top four leading causes of death were the same for both age groups: Homicide, accidents, suicide, and congenital malformations. The mortality rates, however, were much higher among the 15- to 19-year age group, particularly for the homicide rates, which were highest in St. Louis City at 151 homicides per 100,000 population aged 15 to 19.

Prenatal Care in the First Trimester

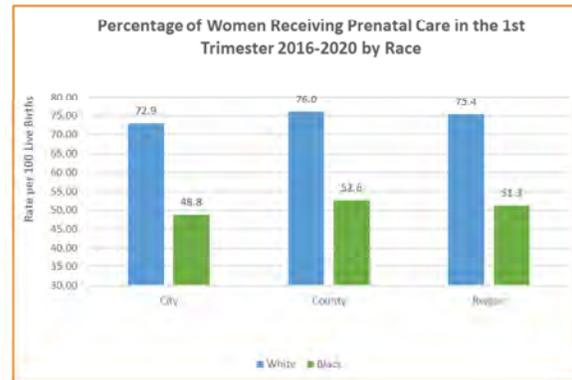
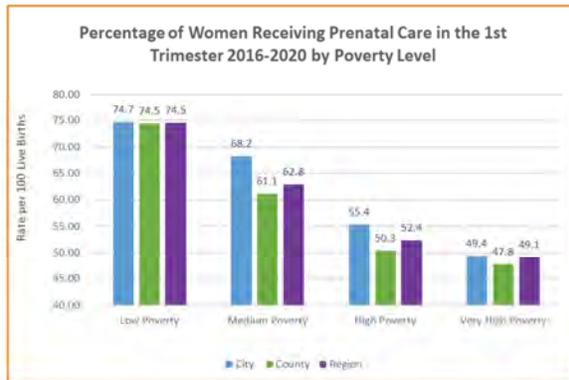
4

Next, we will look at prenatal care. For this indicator, we looked at the percent of mothers who received prenatal care during the first trimester.



Source: Missouri DHSS, Bureau of Vital Statistics

Here, rates were highest among those in St. Louis County. Both the city and the county showed a slight downward trend over the five-year period.



Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

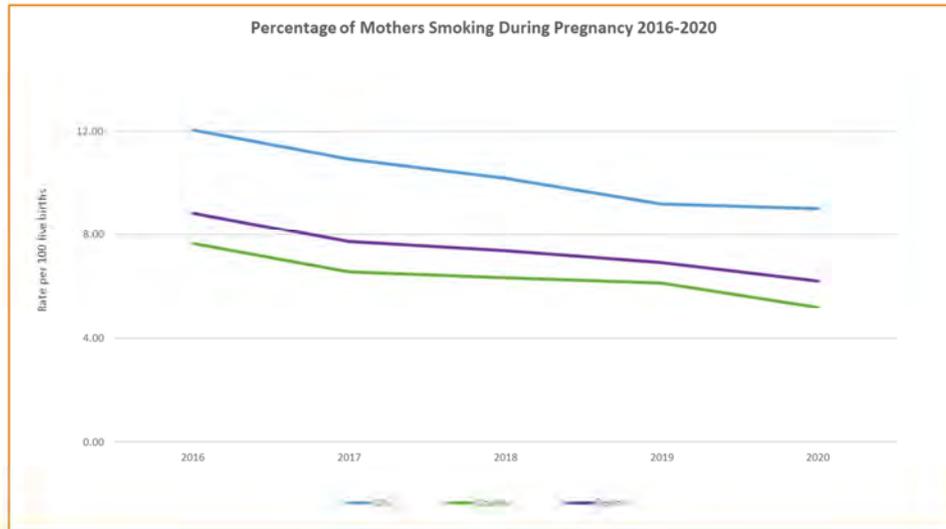
- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

Rates of prenatal care were highest among those living in low poverty neighborhoods and were lower in neighborhoods with higher poverty levels. We also observed a large disparity between Black mothers and white mothers, with white mothers receiving prenatal care in the first trimester at nearly 1.5 times the rate of Black mothers for both St. Louis City and County.

Smoking During Pregnancy

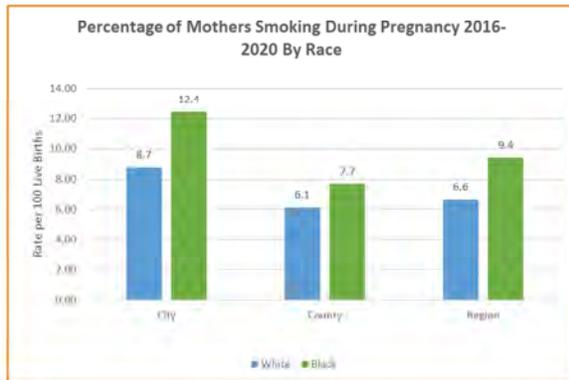
7

Now, for smoking during pregnancy, we are looking at the percentage of mothers who reported smoking at any point during their pregnancy.



Source: Missouri DHSS, Bureau of Vital Statistics

Overall, this figure shows a downward trend with the percent of smoking during pregnancy decreasing in both the city and the county.



Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

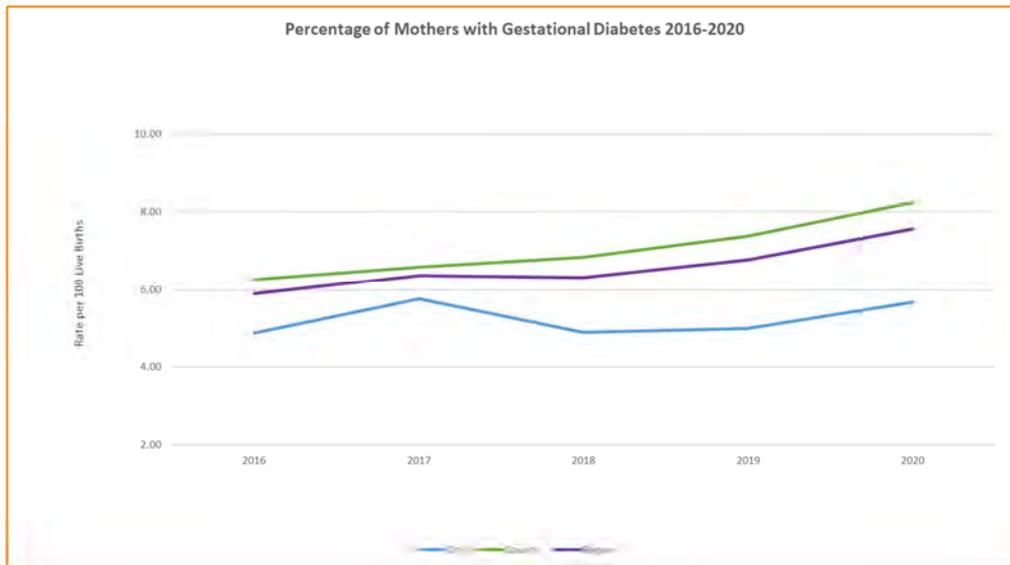
- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
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- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

Rates of smoking during pregnancy were highest among mothers living in very high and high poverty neighborhoods and lowest among those living in low poverty neighborhoods. In addition, rates were higher among Black mothers compared to white mothers.

Gestational Diabetes

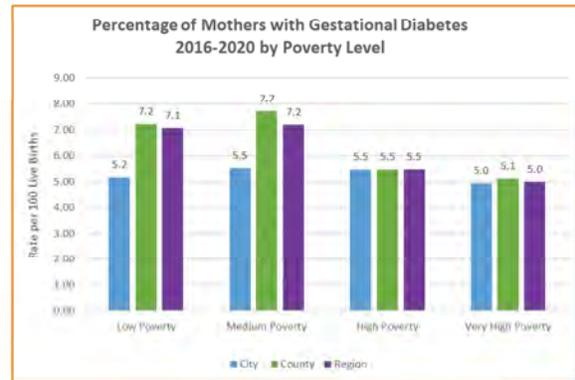
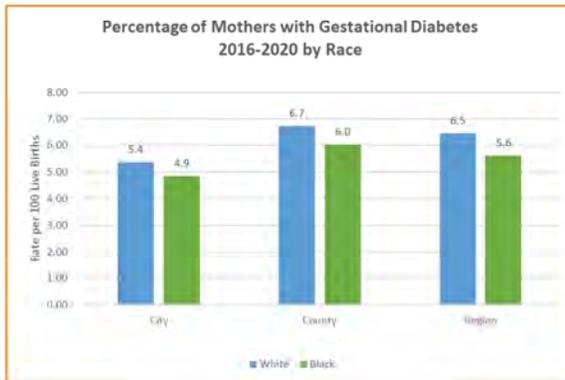
10

Next, we will look at the rate of mothers who were diagnosed with gestational diabetes.



Source: Missouri DHSS, Bureau of Vital Statistics

Rates of gestational diabetes increased over the five-year period that this analysis included. Moreover, rates were higher among mothers in St. Louis County, which is contradictory to the general trend that we see in the other maternal, child and family health indicators explored.



Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

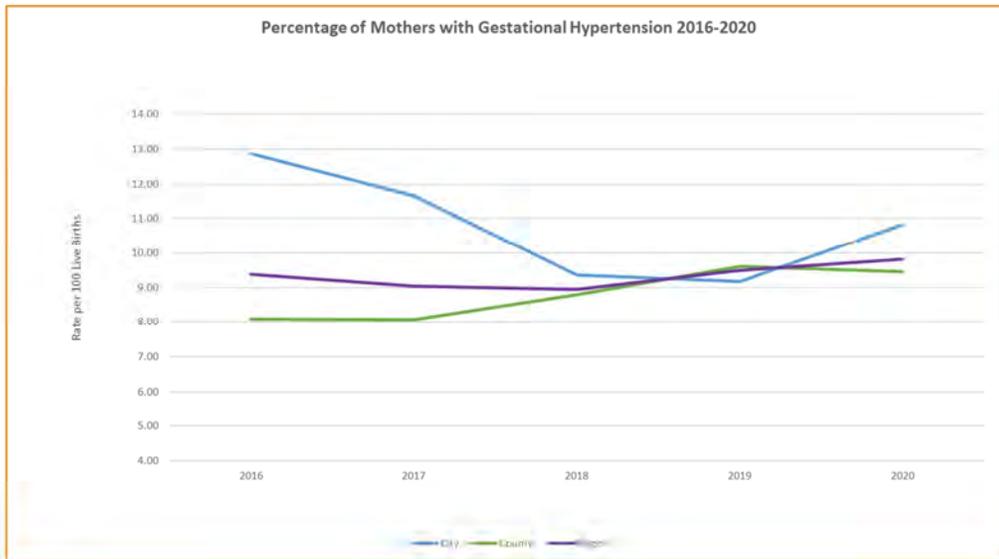
- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

As we look at rates of gestational diabetes disaggregated by neighborhood poverty level and race, we can also see that these trends differ from the other indicators. Rates of gestational diabetes were higher among white mothers compared to Black mothers. In St. Louis County, rates of gestational diabetes were highest among those living in low or medium poverty neighborhoods, whereas rates of gestational diabetes were relatively consistent across all neighborhood poverty levels in St. Louis City. While we are not positive what is causing these trends, it is possible that what we are seeing is a result of poor access to care or inadequate prenatal care.

Gestational Hypertension

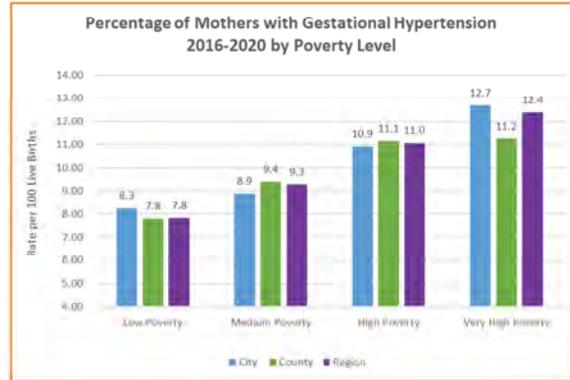
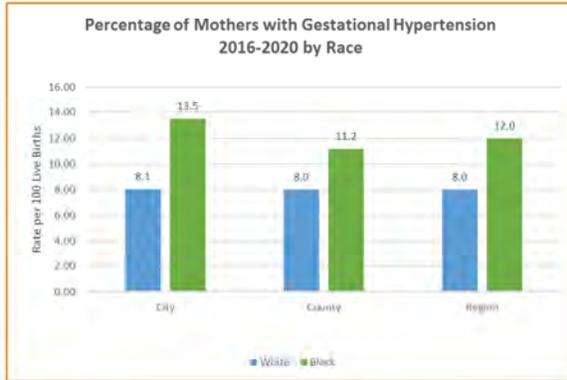
13

In the following slides, we will discuss gestational hypertension.



Source: Missouri DHSS, Bureau of Vital Statistics

From 2016 to 2020, rates of gestational hypertension decreased among mothers in St. Louis City, whereas rates increased among mothers in St. Louis County.



Source: Missouri DHSS, Bureau of Vital Statistics

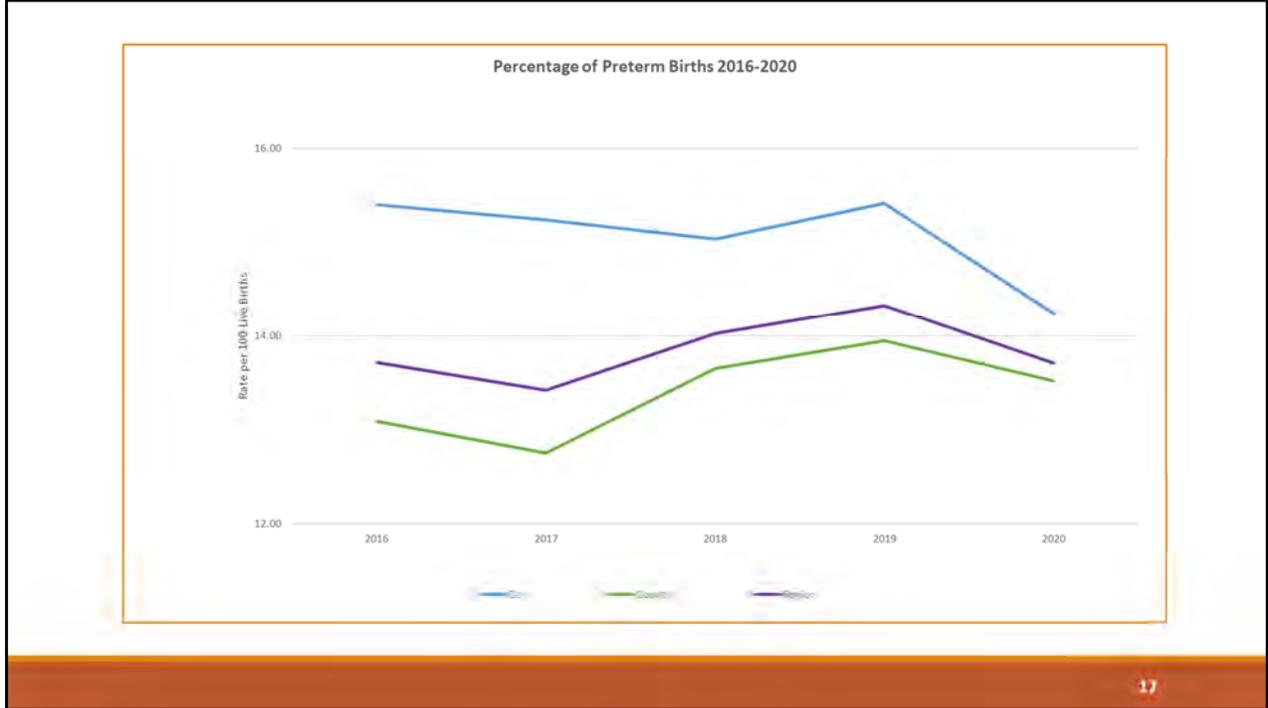
Poverty Level Definition: Four poverty levels for analysis by census tract:

- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

Across both the city and the county, rates of gestational hypertension were higher among Black mothers compared to white mothers. Additionally, rates were higher among those living in neighborhoods with high or very high poverty levels compared to those in low or medium poverty neighborhoods.

Preterm Births

In this next section, we will look at the rate of preterm births. Here, preterm births were defined as births occurring before 37 weeks of gestational age.



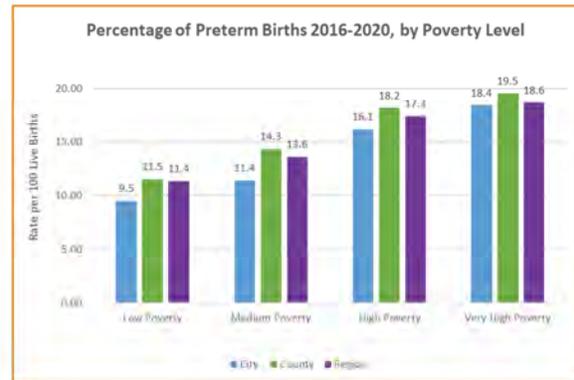
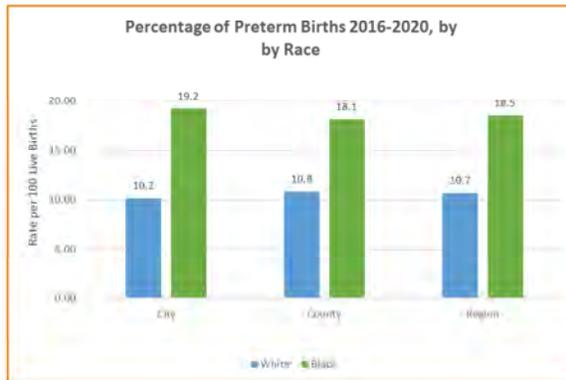
Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

Preterm birth definition: Childbirth that occurs before 37 weeks of pregnancy.

In St. Louis City, the rate of preterm births decreased from 2016 to 2020. Preterm births increased, however, in St. Louis County over the same five-year period.



Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

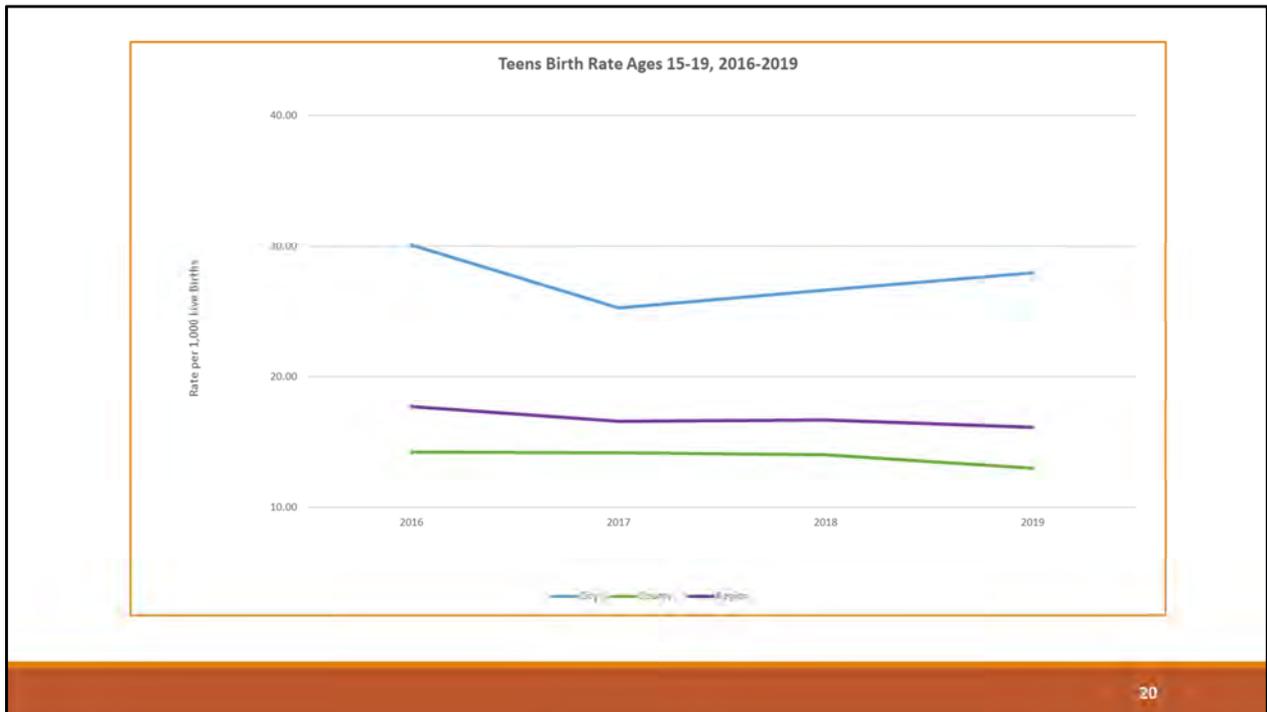
- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

The rate of preterm births among Black mothers was more than 1.5 times the rate of preterm births among white mothers in both the city and the county. In addition, higher rates of neighborhood poverty corresponded with higher rates of preterm births.

Teen Births

19

Next, we will look at the trend in teen births. Teen births included births to mothers who were between the ages of 15- and 19-years old.



Source: Missouri DHSS, Bureau of Vital Statistics

Despite decreasing slightly from 2016 to 2020, teen birth rates were nearly twice as high in St. Louis City compared to St. Louis County. There were approximately 25 to 30 births to teenage mothers per 1,000 live births in the city, whereas there were around 13 to 14 births to teenage mothers per 1,000 live births in the county.

Fetal Mortality

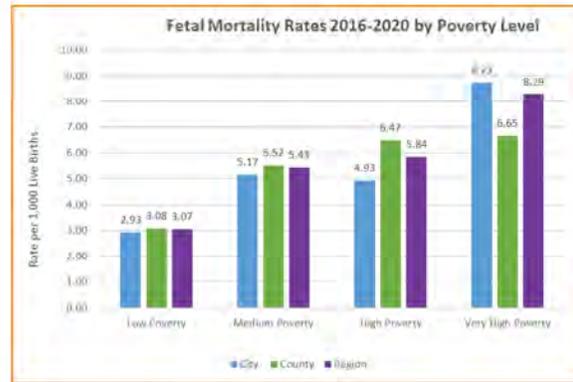
21

Now, we will look at fetal mortality. This number included fetal deaths occurring at a gestation period of 20 weeks or more and weight of 350 grams or more.



Source: Missouri DHSS, Bureau of Vital Statistics

The rate of fetal mortality fluctuated from year-to-year in both St. Louis City and St. Louis County. Overall, fetal mortality rates were higher in the city compared to the county.



Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

There was a sharp disparity in fetal mortality rates by race with Black mothers experiencing fetal deaths at more than twice the rate of white mothers. Fetal mortality rates were also highest among those living in higher poverty neighborhoods, particularly those in neighborhoods with very high poverty levels.

Infant Mortality

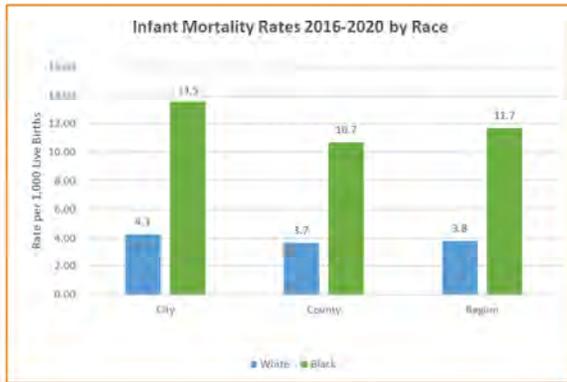
24

In the next slides, we will discuss infant mortality. Infant deaths were those occurring among children less than one year old.



Source: Missouri DHSS, Bureau of Vital Statistics

Infant mortality was higher in St. Louis City compared to St. Louis County. St. Louis City saw a relatively consistent rate of infant mortality, whereas St. Louis County showed a slight increase in infant mortality from 2016 to 2019. In 2020, however, infant mortality decreased by nearly 35 percent.



Source: Missouri DHSS, Bureau of Vital Statistics

Poverty Level Definition: Four poverty levels for analysis by census tract:

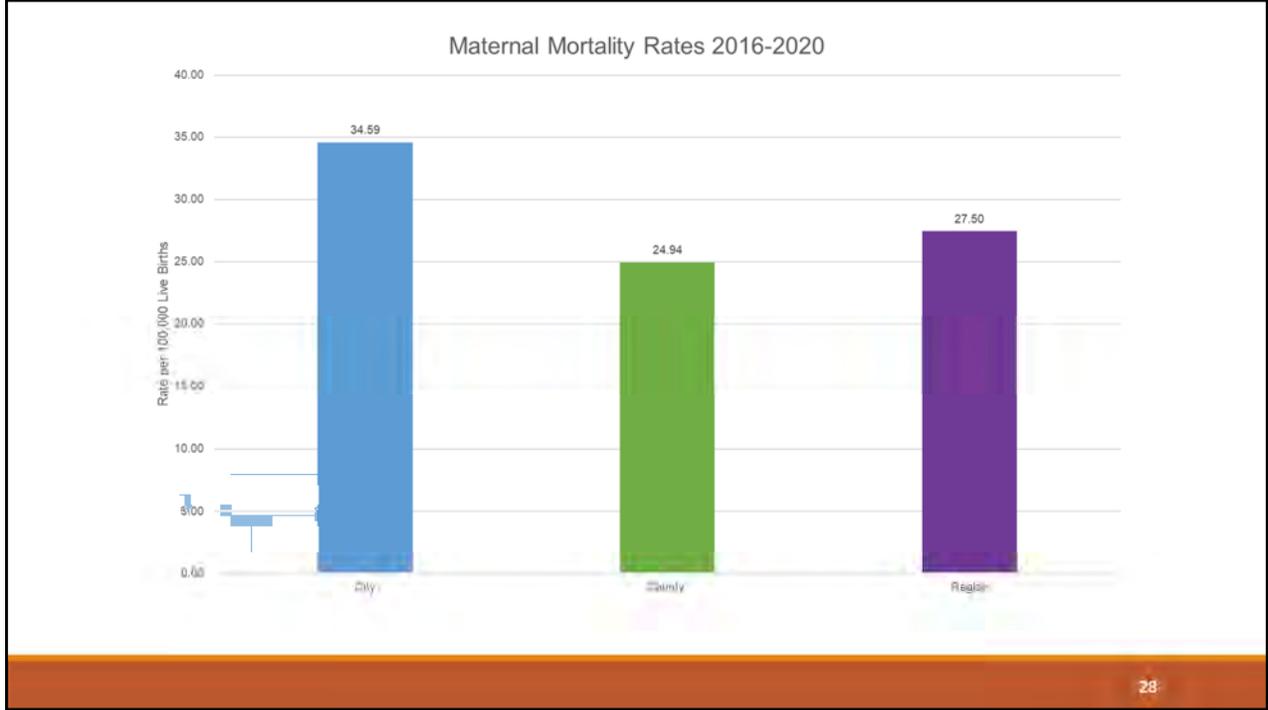
- <10% of residents below the Federal Poverty Level (FPL) (**low poverty**),
- 10 to <20% (**medium**),
- 20 to <30% (**high**), and
- ≥30% (**very high poverty**)

Mortality rates were much higher among Black infants compared to white infants. Meanwhile, those living in high and very high poverty neighborhoods had the highest rates of infant mortality.

Maternal Mortality

27

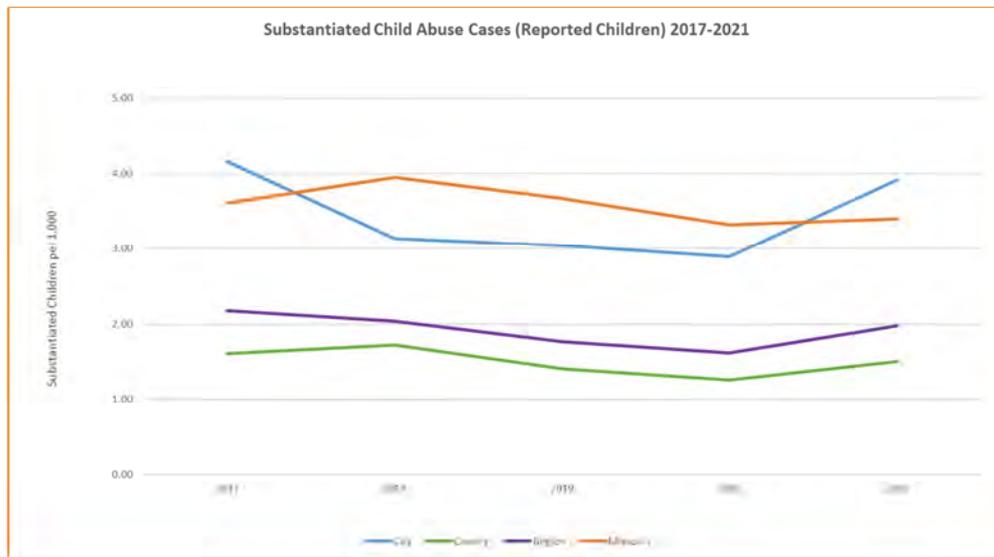
Next is maternal mortality. Maternal deaths were pregnancy-related deaths occurring among women who were pregnant at the time of their death or within 42 days of death. Any deaths caused by homicides or accidents were excluded.



Source: Missouri DHSS, Bureau of Vital Statistics

The five-year average maternal mortality rate was higher in St. Louis City compared to St. Louis County.

Child Abuse



The rates of substantiated child abuse claims were relatively consistent for each geographic area over the five-period. Rates in St. Louis City were higher than those in St. Louis County and corresponded more closely with rates of child abuse in Missouri overall.

Thank You!





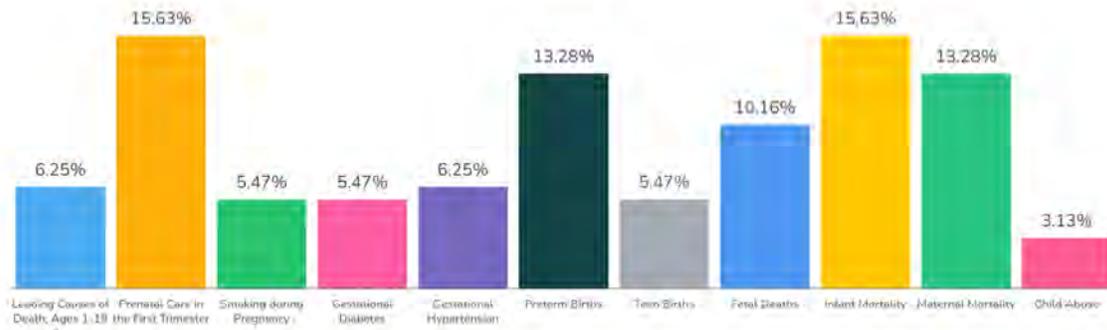
MATERNAL CHILD & FAMILY HEALTH

The purpose of today's meeting is to identify measures and indicators are reflective of Maternal Child & Family Health in the St. Louis Community. As we move through these assessments, Priorities will be developed for action at a later meeting.

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY ELLEN HUTTI AND ABIGAIL ANDERSEN
MARCH 31, 2022
10:45 – 11:15 A.M.



Select the indicators which effectively tell the story of Maternal Child & Family Health in our community



Menu

14 5 23 0

How does the data reflect your experience? How do they differ from your experience?

Spot on, but we need the funding to support the change.

Consistent with what I know. The ethnic difference between gestational diabetes and hypertension is new.

It aligns with my experience in general & these are some of our most important indicators predicting the overall health in our community

racism has a significant impact on Black birthing bodies...weathering, which contributes to other co-morbidities like gestational diabetes, hypertension, low birth weight and pre-term birth.

As an epi with concerns about congenital syphilis and perinatal hepatitis C, I'm not at all surprised to see those trends re: access to prenatal care.

Too many barriers for access to care preventing moms to get early prenatal care. Also food deserts prevent healthy food choices leading to increase in gestational hypertension and diabetes.

the rate of death related to assault/homicide across age groups was concerning

It shows why prenatal care and access to care in general can help improve outcomes - reducing smoking, improving mother's health, etc. Also, in these care meetings, questions about coping mechanisms can

Reflects most experience, but maternal mortality doesn't tell the whole story. Need data on maternal morbidity as well

health literacy



How does the data reflect your experience? How do they differ from your experience?

racism has a significant impact on Black birthing bodies...weathering, which contributes to other co-morbidities like gestational diabetes, hypertension, low birth weight and pre-term birth.

As an epi with concerns about congenital syphilis and perinatal hepatitis C, I'm not at all surprised to see those trends re: access to prenatal care.

our community

Too many barriers for access to care preventing moms to get early prenatal care. Also food deserts prevent healthy food choices leading to increase in gestational hypertension and diabetes.

the rate of death related to assault/homicide across age groups was concerning.

It shows why prenatal care and access to care in general can help improve outcomes - reducing smoking, improving mother's health, etc. Also, in these care meetings, questions about coping mechanisms can definitely be included (thinking of bringing in child abuse)

Reflects most experience, but maternal mortality doesn't tell the whole story. Need data on maternal morbidity as well.

health literacy

What indicators do you feel are missing? Please share data sources.

Definitely disaggregation of data by race and by geography whenever possible	access to early and adequate prenatal care	Rates of miscarriage and stillbirth (stratified by race/ethnicity and geography where possible)
Infant mortality in reference to absenteeism or presence of dad.	Alternative care methods	Race and ethnicity are great but we need language spoken at home
Birth families' access to doula care, birthing person's comfort level with care	How insurance affects adequate prenatal care	Population to prenatal care access ratio
access to home visitation, safe sleep education, connection to resources (like cribs, diapers, food, etc.)	Sense of self-agency during pregnancy and labor	Quality data on impacts of trauma on child health
	prenatal care access by geography (transportation distance to prenatal care)	





What indicators do you feel are missing? Please share data sources.



More information about the why there is a lack of prenatal care, etc (working multiple jobs, transportation, etc)

Mental health. Are depression and anxiety screenings being performed by providers?

PMADs are not being counted in Behavioral Health so maybe MCH needs to fill in that gap



Percent following gold standard prenatal practices

The presence of elder caregivers and fathered being included in being educated as well as caregivers related to safe sleep recommendations. Parents are tired and overwhelmed with the birth of a new baby. Providers must build trusting relationships with our pregnant families.

Maternity leave & how that affects birthing parents



Access to childcare!!

Data on the link between diabetes and autism. Studies have shown link between maternal diabetes and a higher risk of having child with Autism, ADHD

poverty, health literacy

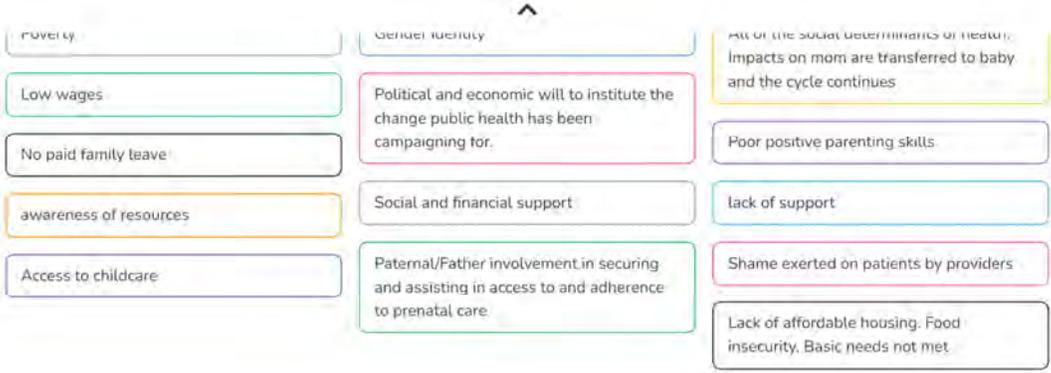
What are the underlying causes and external factors that affect the disparities in this category?

provider implicit and explicit bias	education from provider	Structural racism and sexism
Stigma	Health Literacy	Structural + institutional racism
Poverty	Gender identity	All of the social determinants of health. Impacts on mom are transferred to baby and the cycle continues
Low wages	Political and economic will to institute the change public health has been campaigning for.	Poor positive parenting skills
No paid family leave	Social and financial support	lack of support
awareness of resources	Paternal/Father involvement in securing	Shame exerted on patients by providers

Menu

14 5 20 0

What are the underlying causes and external factors that affect the disparities in this category?



Questions

Ellen Hutti

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Abigail Andresen, Epidemiologist

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Chronic Disease

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY DAVID COURTNEY AND DANA KELSEY
MARCH 31, 2022
12:15 – 12:45 P.M.



This is the second time St. Louis City and County have generated a joint Community Health Assessment (or CHA) for the region. The CHA includes four distinct assessments, including today's data sessions. The Community Health Status Assessment is a comprehensive study of the region utilizing data from hospitals, local health departments, and surveillance systems. The purpose of today's meeting is to determine if these measures and indicators are reflective of the chronic disease situation in our community. As we will discuss today, many health concerns and much of the burden of disease, including associated healthcare costs, stem from chronic diseases and their associated risk factors.

Indicators for Chronic Disease:

This review measures the illness and death (morbidity and mortality) of chronic diseases or long-term conditions that are typically progressive. Certain diseases relate to lifestyle choices or Social Determinants such as obesity and diabetes or smoking and heart disease. Reducing or managing these diseases can prevent illness and death.

1. Leading Causes of Death
2. Heart Disease Mortality
3. Cancer Mortality
4. Breast Cancer Incidence
5. Cervical Cancer Incidence
6. Lung & Bronchus Cancer Incidence
7. Prostate Cancer Incidence
8. Diabetes Mortality
9. Obesity
10. Insufficient Sleep
11. Use of Tobacco
12. Excessive Drinking & Alcohol Impaired Driving Deaths
13. Mortality by Poverty Level

2

Slide 3: Definition of Chronic disease. Impact on society and our region. List of Chronic Diseases most affecting St. Louis region, list of Indicators to be discussed. Lead to Discussion of leading cause of death

Chronic diseases are defined as conditions that last longer than a year and require ongoing medical attention, often limiting activities necessary for daily living. They include heart disease, cancer, diabetes, Alzheimer's disease, kidney disease, chronic lower respiratory disease, and cerebrovascular disease (stroke). Specifically, we examined the burden of heart disease, cancer, and diabetes on the St. Louis region. We also looked at health indicators such as insufficient sleep, tobacco use, and excessive alcohol use. Throughout the process, we also investigated the relationship between chronic disease and socioeconomic status.

Leading Causes of Death

Ten Leading Causes of Death and Age-Adjusted Rates by Year Highlighting Chronic Disease-Related Deaths, St. Louis City – 2016 to 2020.

Rank	2016	2017	2018	2019	2020	2016-2020
1	Heart Disease 232.8	Heart Disease 219.7	Heart Disease 218.1	Heart Disease 220.8	Heart Disease 218.1	Heart Disease 222.6
2	Cancer 193.1	Cancer 178.7	Cancer 169.9	Cancer 171.1	Cancer 160.5	Cancer 171.1
3	Unintentional injury 94.6	Unintentional injury 91.6	Unintentional injury 99.7	Unintentional injury 103.1	Unintentional injury 131.5	Unintentional injury 105.4
4	CLRD 44.5	Stroke 45.6	Stroke 45.8	Stroke 46.5	COVID-19 101.9	Stroke 46.4
5	Homicide 44.5	Homicide 47.3	Homicide 42.3	Homicide 41.6	Homicide 61.9	Homicide 48.6
6	Stroke 38.8	CLRD 40.5	CLRD 34.2	CLRD 30.8	Stroke 46.6	CLRD 36.9
7	Kidney Disease 28.5	Alzheimer's Disease 35.2	Alzheimer's Disease 31.9	Alzheimer's Disease 31.3	CLRD 35.1	Alzheimer's Disease 29.5
8	Diabetes 21.8	Diabetes 24.5	Diabetes 22.9	Diabetes 23.8	Kidney Disease 28.9	Kidney Disease 24.4
9	Alzheimer's Disease 20.6	Kidney Disease 21.3	Kidney Disease 23.2	Kidney Disease 21.4	Alzheimer's Disease 28.3	Diabetes 23.3
10	Septicemia 17.2	Septicemia 16.5	Septicemia 14.6	Chronic Liver Disease 14.7	Diabetes 24.8	COVID-19 20.4

Ten Leading Causes of Death and Age-Adjusted Rates by Year Highlighting Chronic Disease-Related Deaths, St. Louis County – 2016 to 2020.

Rank	2016	2017	2018	2019	2020	2016-2020
1	Heart Disease 180.1	Heart Disease 167.8	Heart Disease 177.9	Heart Disease 160.9	Heart Disease 186.2	Heart Disease 176.9
2	Cancer 149.6	Cancer 153.5	Cancer 155.0	Cancer 142.9	Cancer 141.9	Cancer 147.3
3	Unintentional injury 53.6	Unintentional injury 56.1	Unintentional injury 60.5	Unintentional injury 59.2	COVID-19 92.2	Unintentional injury 59.8
4	Stroke 48.5	Stroke 41.8	Alzheimer's Disease 41.1	Alzheimer's Disease 41.5	Unintentional injury 67.2	Stroke 42.3
5	Alzheimer's Disease 32.7	Alzheimer's Disease 34.6	Stroke 42.8	Stroke 41.3	Stroke 44.2	Alzheimer's Disease 39.5
6	CLRD 32.6	CLRD 28.1	CLRD 31.3	CLRD 27.0	Alzheimer's Disease 41.0	CLRD 28.6
7	Kidney Disease 28.5	Kidney Disease 17.8	Kidney Disease 18.7	Kidney Disease 15.9	CLRD 25.3	COVID-19 18.4
8	Diabetes 16.4	Diabetes 14.8	Diabetes 16.3	Diabetes 15.8	Kidney Disease 19.8	Kidney Disease 11.8
9	Influenza/Pneumonia 14.9	Influenza/Pneumonia 13.3	Influenza/Pneumonia 15.6	Septicemia 10.8	Diabetes 18.1	Diabetes 16.3
10	Septicemia 10.4	Homicide 16.0	Alzheimer's Disease 13.1	Homicide 16.4	Influenza/Pneumonia 13.9	Influenza/Pneumonia 13.9

Difference: Top 2 are same for City & County, #3 in County was COVID in 2020, #3 was Unintentional Injury for City. Starts to vary with #4 with Alzheimer's appearing in the Top 4 for the County in 2018 and 2019. Homicide is #5 for the City.

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 4: Leading Causes of Death

To begin our discussion of chronic disease in the St. Louis region, we will first look at the leading causes of death. Unfortunately, many of the leading causes of death for our region are chronic diseases. On this slide are the top 10 causes of death for St. Louis City and St. Louis County from 2016 to 2020. Data were obtained from the Missouri Department of Health and Senior Services and rates were calculated per 100,000 population.

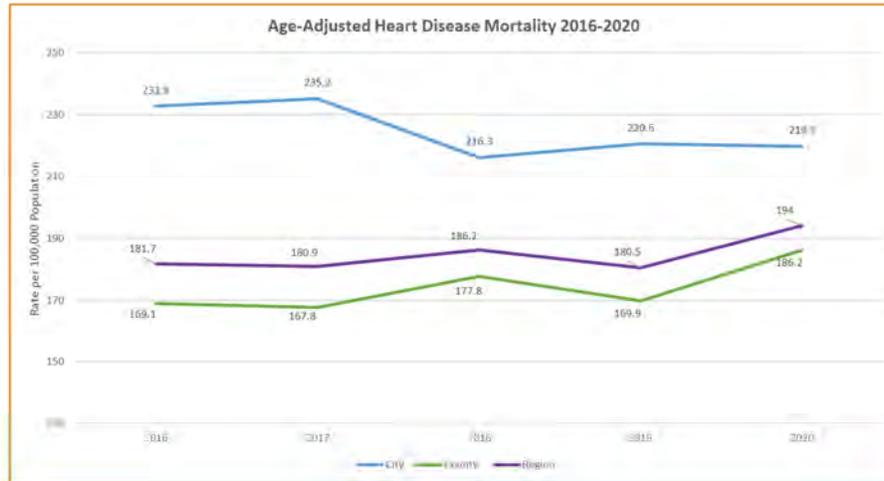
Chronic disease causes of death are highlighted in bold colors. For each year presented, seven of the 10 top causes of death were chronic diseases. For both the City and the County, Heart Disease and Cancer topped the list. You will also see the list included Chronic Lower

Respiratory Disease (CLRD), Stroke, Kidney Disease, Alzheimer's Disease, Diabetes, Chronic Liver Disease in 2019, and Parkinson's Disease in 2018. By far, Heart Disease and Cancer had the biggest impact.

Also noteworthy are homicide levels, specifically in St. Louis City. We have also highlighted COVID-19 on here to show its significant impact in 2020. We have specific sessions dedicated to Accidental and Intentional Injury and COVID-19 for those interested in delving deeper into these topics.

Death Rates for most causes increased in 2020. Cancer rates decreased from 2019 to 2020 for the City, and slightly for the County. Stroke rates increased for the county, as well as kidney disease and diabetes. Alzheimer's decreased for the city from 2017 to 2020. Across the board, the City had higher death rates, except for Alzheimer's, 39.5 to 29.5.

Heart Disease Mortality



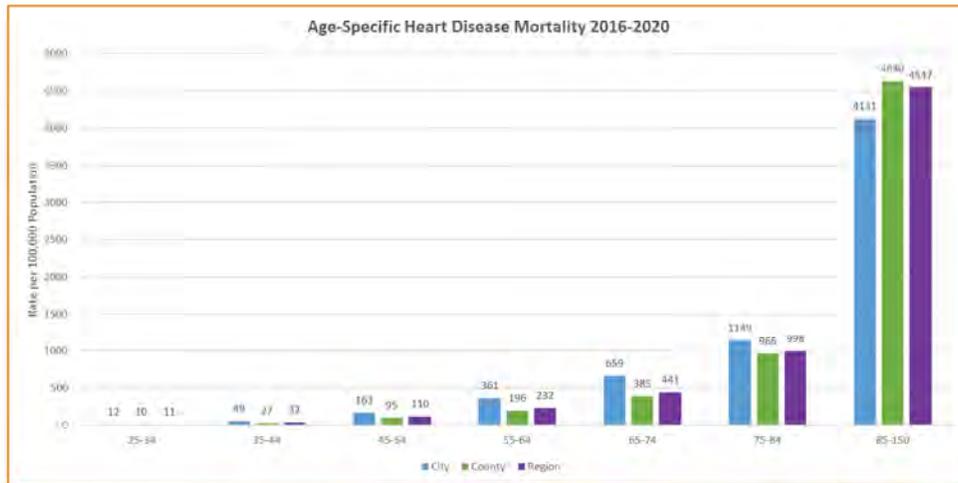
4

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 5: Heart Disease Deaths

Looking closer at heart disease (the number one leading cause of death), our first graph shows age-adjusted rates from 2016 to 2020 using data from the Missouri Department of Health and Senior Services. The city rates are noticeably higher, but have remained relatively stable, with a decrease from 2016 to 2020. The county progression followed a similar line to the greater region, increasing between 2016 and 2020 with a significant increase from 2019 to 2020.

Heart Disease Mortality

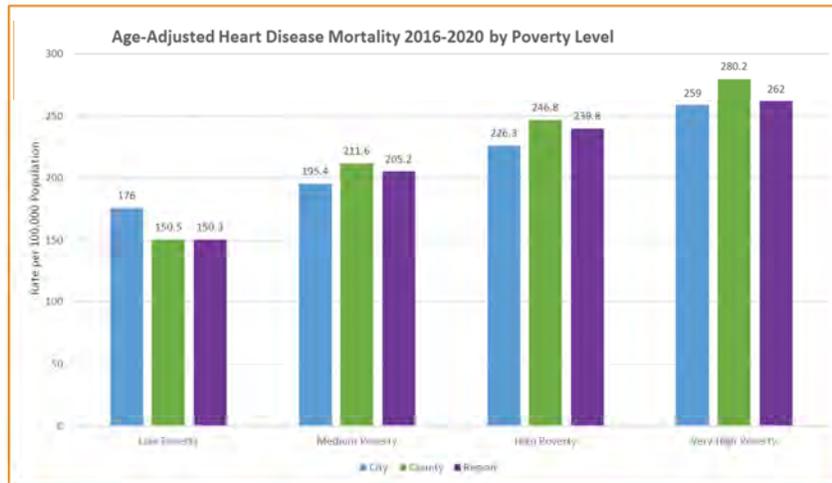


5

Source: Missouri DHSS, Bureau of Vital Statistics

And, examining the age-specific trends for heart disease mortality, we see age has a direct correlation with heart disease mortality, with significant risk after the age of 85.

Heart Disease Mortality



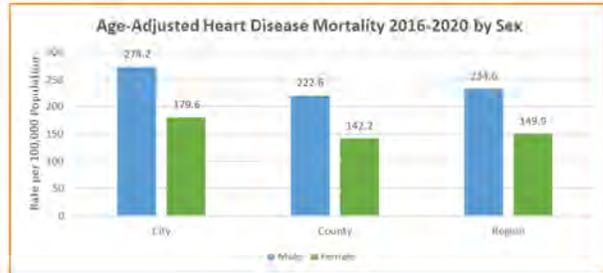
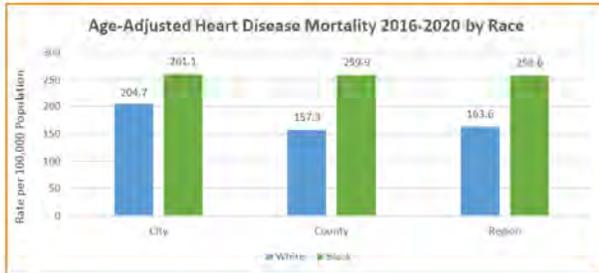
6

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 7: Heart Disease Deaths (cont'd.)

Looking at heart disease mortality by poverty level, mortality is highest among those living in very high poverty.

Heart Disease Mortality

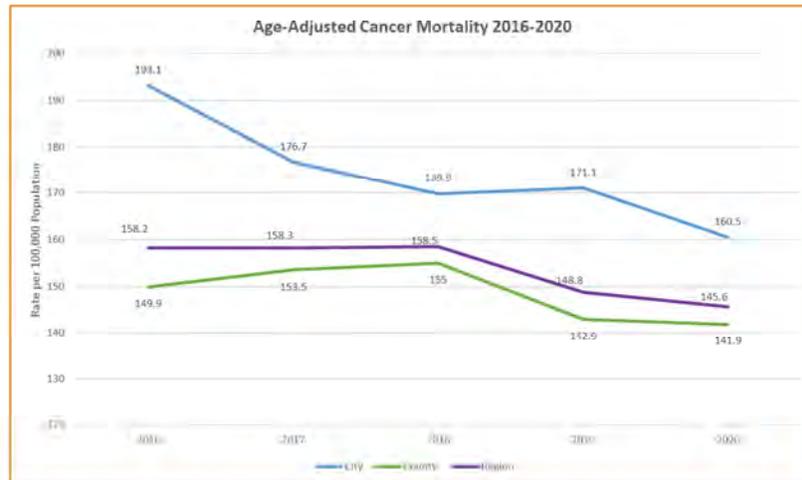


Source: Missouri DHSS, Bureau of Vital Statistics

Slide 7: Heart Disease Deaths (cont'd.)

In addition, we see disparities in both race and sex with heart disease mortality. African Americans had a higher rate of death in both the City and the County between 2016 and 2020. And, on the second graph, we notice men were more likely to die from heart disease.

Cancer Mortality

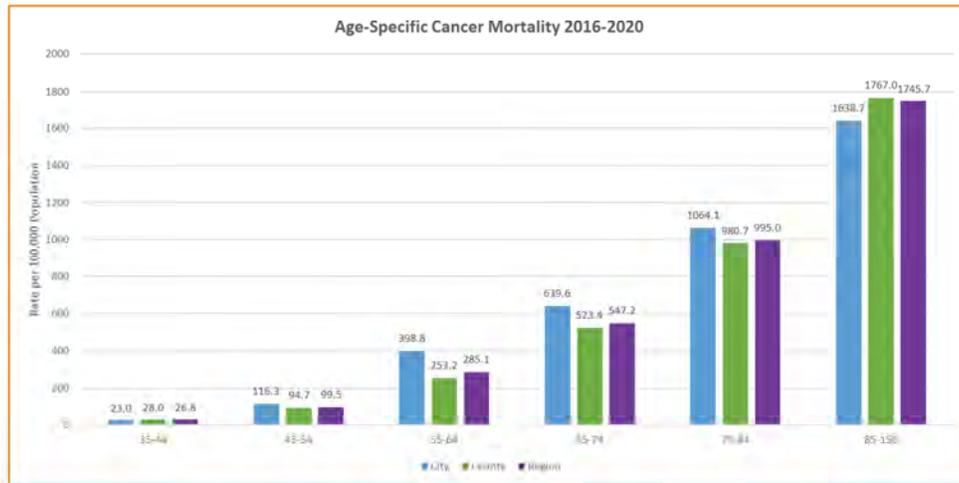


8

Source: Missouri DHSS, Bureau of Vital Statistics

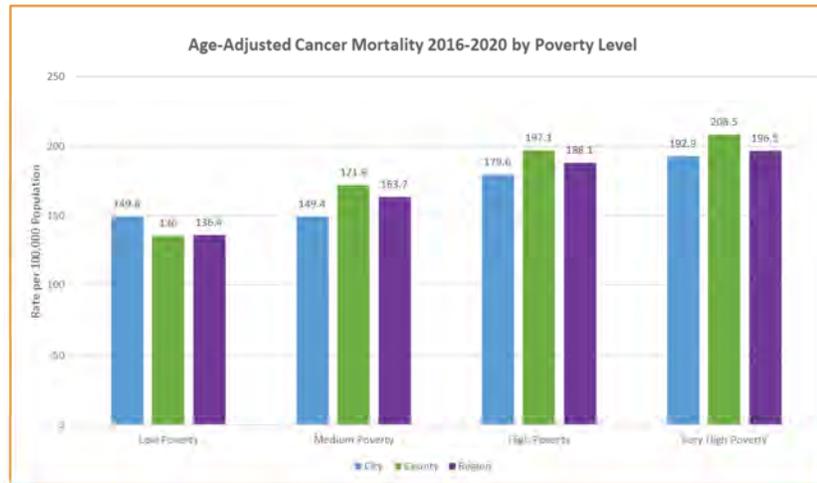
The second leading cause of death, Cancer, presents more favorable trends in terms of mortality. Looking at the age-adjusted graph, we see a steady decrease for the city and county that follows a similar pattern to the greater region. (Slide 9) But, similar to heart disease, the risk of death greatly increases as age increases.

Cancer Mortality



Source: Missouri DHSS, Bureau of Vital Statistics

Cancer Mortality

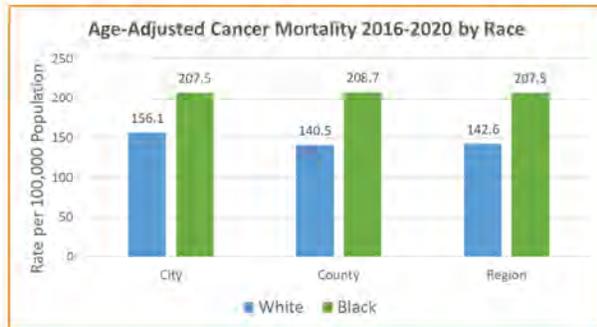


10

Source: Missouri DHSS, Bureau of Vital Statistics

These slides highlight some disparities surrounding Cancer mortality between 2016 and 2020. We see a direct correlation between poverty levels and mortality, with again the more extreme the poverty level, the higher rate of death.

Cancer Mortality

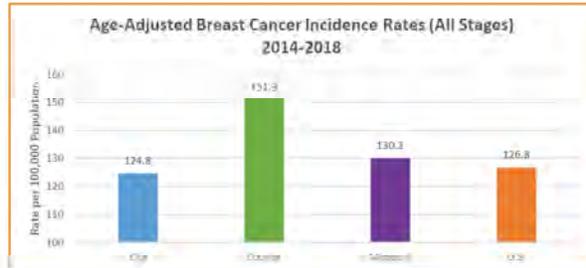


11

Source: Missouri DHSS, Bureau of Vital Statistics

(Slide 11) In addition, men had higher mortality rates than women. But, the most staggering difference presented is in regards to race. When comparing White and African American death rates, African Americans had a MUCH higher rate of dying when diagnosed with cancer.

Breast Cancer Incidence



11

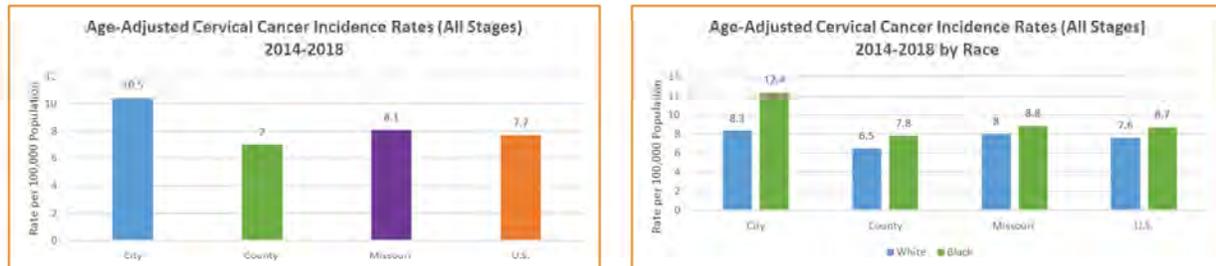
Source:

<https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=29&areatype=county&cancer=066&race=00&sex=1&age=001&type=incd#results>

Slide 12: Breast Cancer Incidence

As many individuals live for many years with chronic diseases, we further examined the incidence rates of four major forms of cancer: breast, cervical, lung and bronchus, and prostate cancer. Starting with breast cancer, the two graphs presented have data from 2014 to 2018 from the Missouri Cancer Registry. When adjusted for age, the City rate was similar to that of the state and the country. The County was significantly higher than the other regions. Looking at the second graph for race, White and Black communities in Saint Louis City had similar rates for breast cancer incidence, with the rate being slightly higher among caucasians in the County.

Cervical Cancer Incidence



13

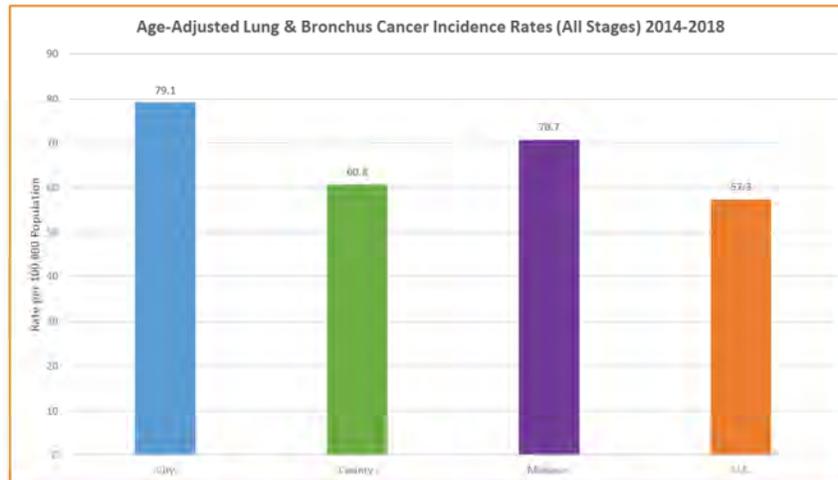
Source:

<https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=29&areatype=county&cancer=066&race=00&sex=1&age=001&type=incd#results>

Slide 13: Cervical Cancer Incidence

For cervical cancer incidence, we see that the city had a significantly higher incidence rate between 2014 and 2018, with the county's rate being below the state and country rates. On the second graph, we see a noticeable disparity between black and white women. African American women in the Saint Louis area were diagnosed with cervical cancer at a higher rate, especially in the City.

Lung and Bronchus Cancer Incidence



14

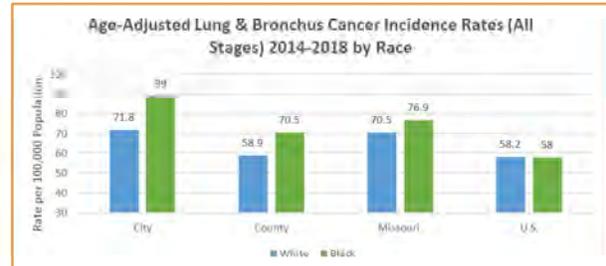
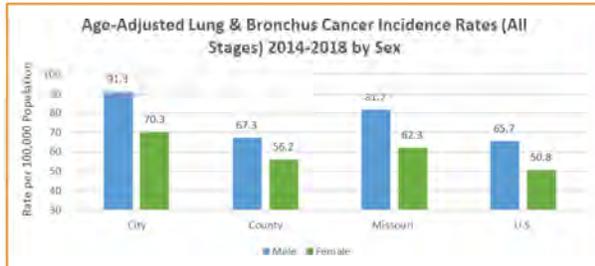
Source:

<https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=29&areatype=county&cancer=066&race=00&sex=1&age=001&type=incd#results>

- **Slide 14 and 15: Lung and Bronchus Cancer Incidence**

Similar to Cervical Cancer, the city had more new cases of lung and bronchus cancer between 2014 and 2018. Both the City and the County were higher than the national rate.

Lung and Bronchus Cancer Incidence



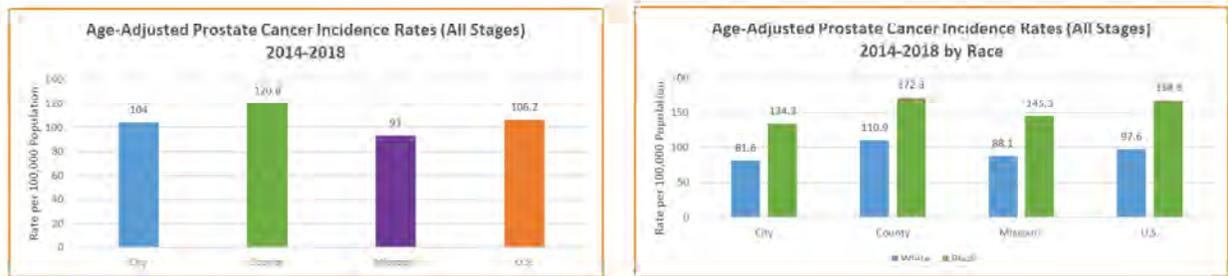
15

Source:

<https://statecancerprofiles.cancer.gov/incidencrates/index.php?stateFIPS=29&areatype=county&cancer=066&race=00&sex=1&age=001&type=incd#results>

(Slide 15) Looking at the top graph concerning sex, men were more often diagnosed with lung and bronchus cancer, with the rates in the City and Missouri being noticeably greater than the United States rate. Shifting our focus to the bottom graph: in the City, County, and state of Missouri, the African American population had a higher rate of new cases than the white population. If you notice, the national rate for incidence is similar for the two races, further highlighting a disparity in our region. .

Prostate Cancer Incidence



16

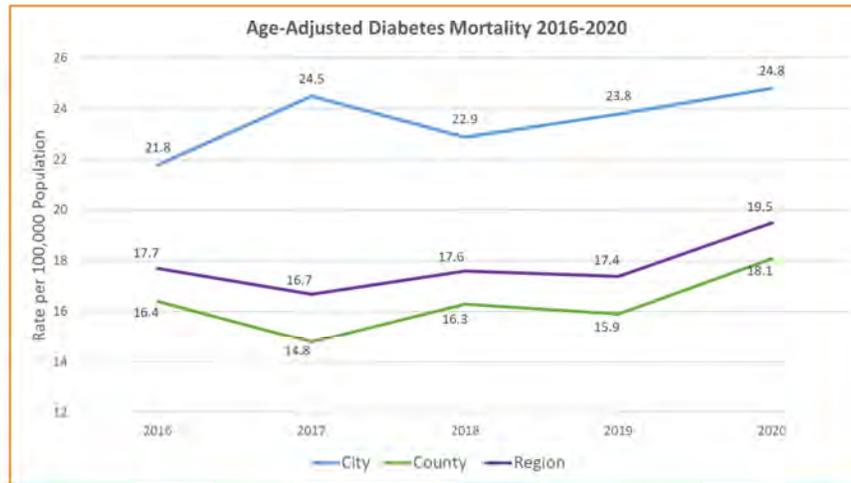
Source:

<https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=29&areatype=county&cancer=066&race=00&sex=1&age=001&type=incd#results>

Slide 16: Prostate Cancer Incidence

Concerning prostate cancer, the County had a higher incidence rate, noticeably greater than the state rate and higher than the national rate. And, similar to Cervical Cancer, we saw a huge disparity in the number of African Americans diagnosed with Prostate Cancer across all regions. There is an extremely high rate of diagnosis in the County for prostate cancer.

Diabetes Mortality



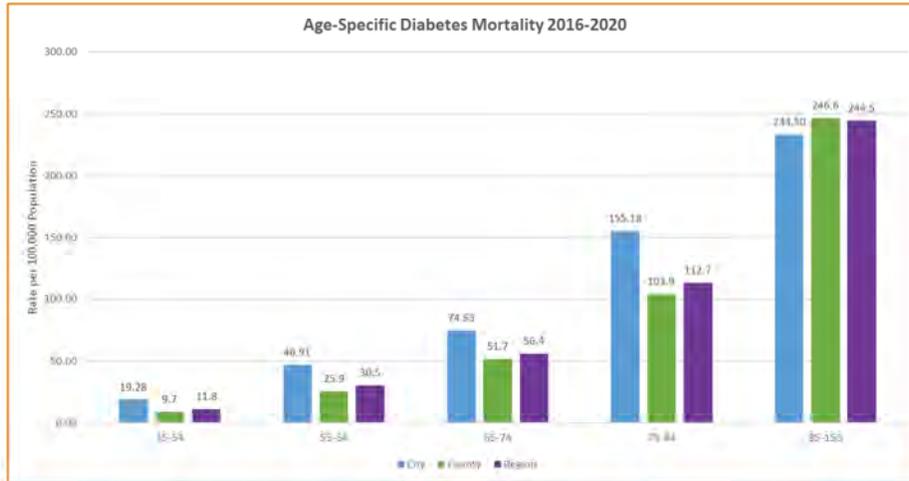
17

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 17 and 18: Diabetes Deaths

Diabetes has been a growing health concern for the past several years, and it appears to be increasing in the Saint Louis area. Looking at the mortality rates from 2016 to 2018, we see the City had a much higher rate than the county. Actually, the County's rate is lower than the regional rate. But, again, we see that both areas of the St. Louis region trended upward between 2019 and 2020.

Diabetes Mortality

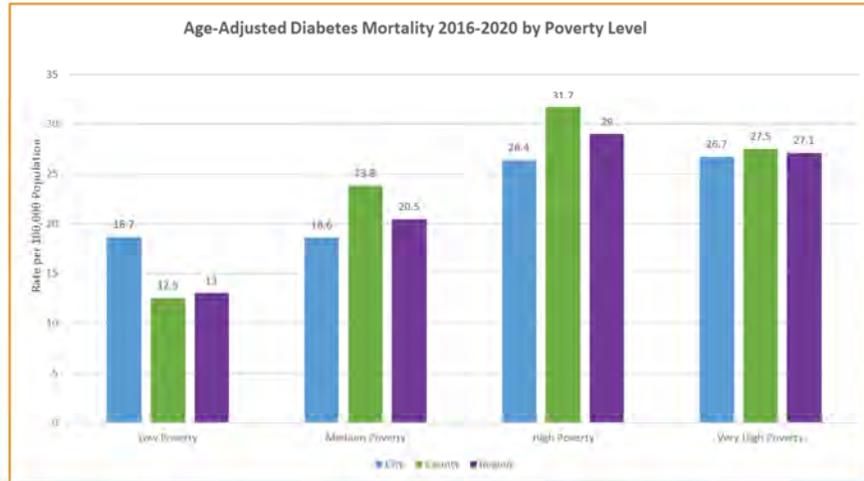


18

Source: Missouri DHSS, Bureau of Vital Statistics

(Slide 18) And, again, we see a positive correlation between age and disease mortality, with the chance of death significantly increasing after the age of 75 for those with diabetes

Diabetes Mortality



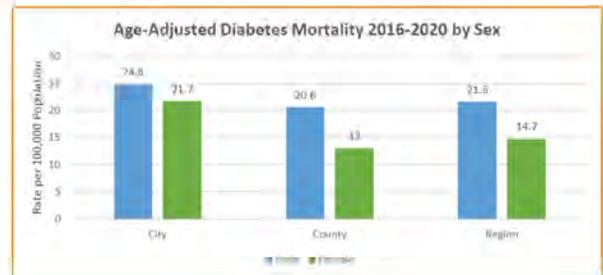
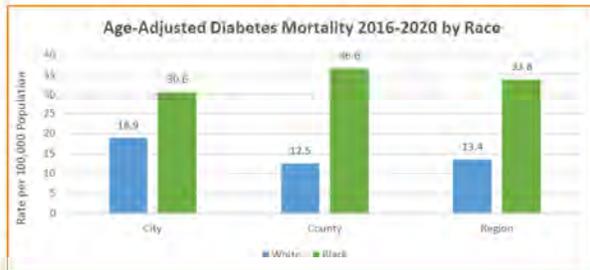
19

Source: Missouri DHSS, Bureau of Vital Statistics

Slide 19 and 20: Diabetes Deaths (cont'd.)

Continuing to examine Diabetes mortality, we see some noticeable disparities. Here, we can see the diabetes mortality rate has a direct correlation with poverty level, increasing as the poverty level increases.

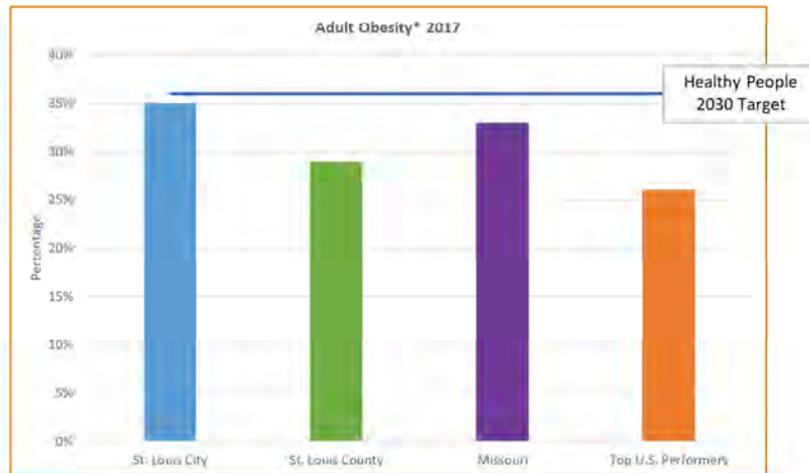
Diabetes Mortality



Source: Missouri DHSS, Bureau of Vital Statistics

(Slide 20) As we see on the bottom graph, men were more likely to die when diagnosed with diabetes between 2016 and 2020. But, similar to other diseases, the most staggering disparity involved race. On the top graph we see the rate for African Americans was nearly double in the City and triple in the County.

Obesity



*Percentage of the adult population >20 that reports a body mass index (BMI) greater than or equal to 30 kg/m².

21

Source: County Health Rankings, 2021

<https://www.countyhealthrankings.org/app/missouri/2021/measure/factors/143/data> **Healthy People 2030** <https://health.gov/healthypeople/objectives-and-data/browse-objectives/sleep/increase-proportion-adults-who-get-enough-sleep-sh-03>

Obesity

Chronic Diseases are associated with certain lifestyle health indicators. This graph shows the percentage of adults aged over 20 who have a BMI of 30 or higher in 2017. Obesity is highest in the City. However, the city, county, and state of Missouri are below the Healthy People 2030 target.

Insufficient Sleep



22

Source: County Health Rankings, 2021

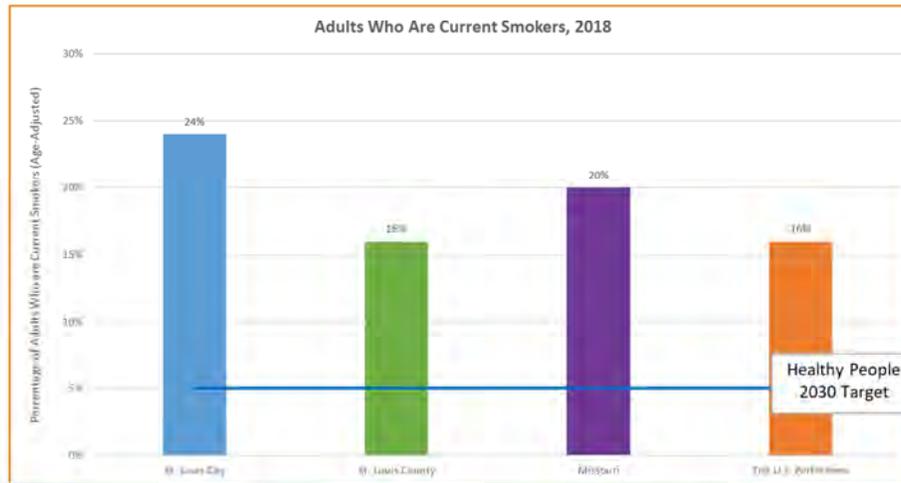
<https://www.countyhealthrankings.org/app/missouri/2021/measure/factors/143/data> **Healthy People 2030** <https://health.gov/healthypeople/objectives-and-data/browse-objectives/sleep/increase-proportion-adults-who-get-enough-sleep-sh-03>

Slide 22: Insufficient Sleep

On this slide we have Insufficient Sleep and Use of Tobacco. The data comes from the County Health Rankings for 2018. The line across each graph represents the Healthy People 2030 goal for each indicator.

“Insufficient Sleep” was defined as reporting less than 7 hours of sleep per night. The rates for the City and County are slightly higher than the national rate, but fortunately within the target range of the Health People goal.

Use of Tobacco



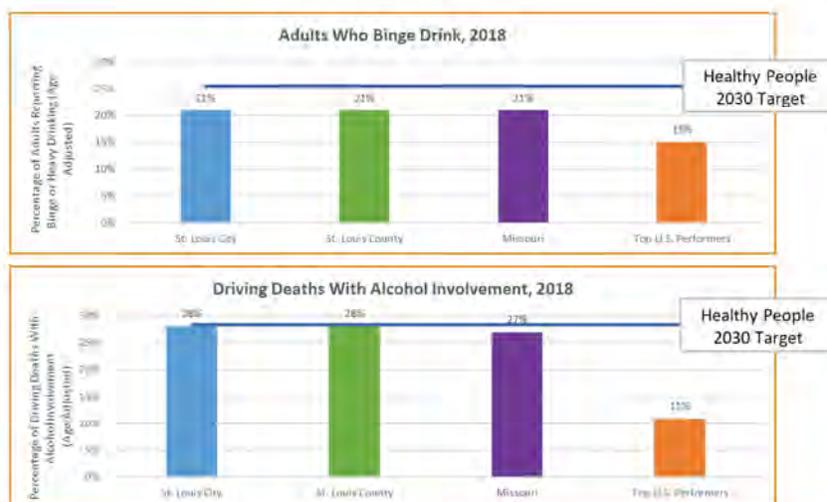
23

Source: County Health Rankings, 2021

<https://www.countyhealthrankings.org/app/missouri/2021/measure/factors/143/data> **Healthy People 2030** <https://health.gov/healthypeople/objectives-and-data/browse-objectives/sleep/increase-proportion-adults-who-get-enough-sleep-sh-03>

(Slide 23) To assess the rate of tobacco use for the region, we looked at the number of adults who stated they were current smokers in 2018. Unfortunately, the rates of Tobacco use for the City and County are well above the goal for Healthy People 2030. Smoking is a very unhealthy practice that correlates with many chronic diseases. As you can see, City had a higher rate of adults who currently smoke than the national average. A lot of work must be done to reach the set goal

Excessive Drinking & Alcohol-Impaired Driving Deaths



24

Source: <https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/health-behaviors/alcohol-drug-use/excessive-drinking>

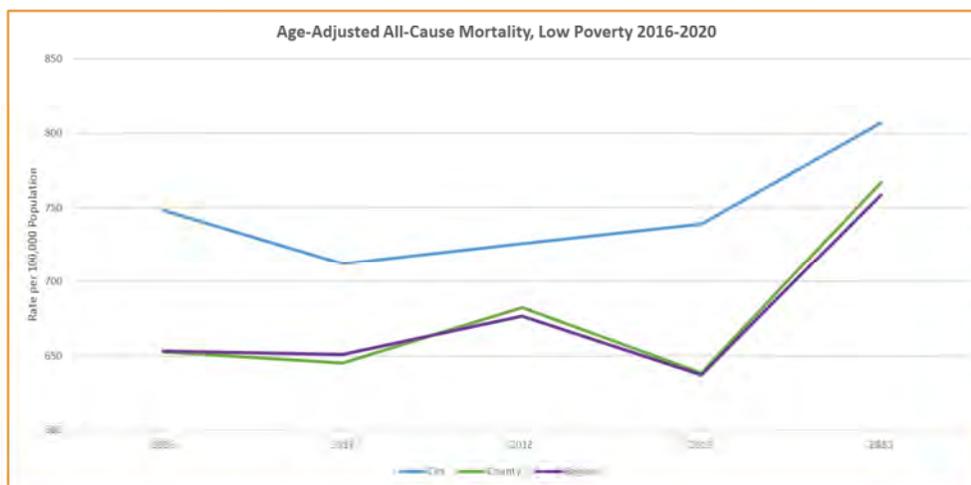
2020 Status Report on Missouri's Substance Use and Mental Health
US Department of Transportation, National Highway Traffic Safety Administration, 2015-2019

Slide 24: Excessive Drinking and Alcohol Impaired Driving Deaths

Another behavior that contributes to chronic disease and unintentional injuries, another leading cause of death, is excessive drinking. Like insufficient sleep and tobacco use, we looked at the County Health Rankings. Excessive drinking utilized reports of binge drinking within the past 30 days from 2018, and alcohol impaired deaths were assessed from 2015 to 2019. The City, the County, and the State had similar rates for adults who binge drink, and all were below the 2030 target. Similarly, the rates for mortality related to driving with alcohol

involvement were below the 2030 target. Unfortunately, the percentage of driving deaths was double the top US performers, and it is still an unhealthy behavior that needs to be addressed.

Mortality by Poverty Level



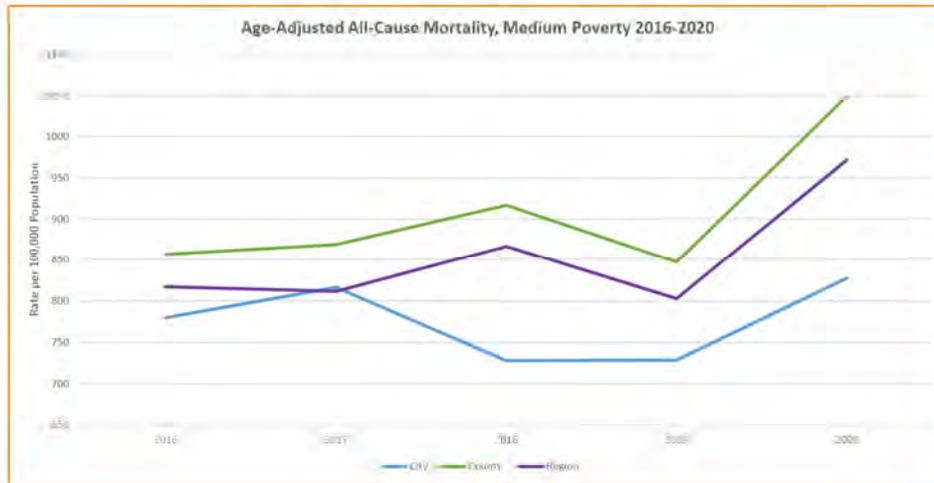
23

Source: Missouri DHSS, Bureau of Vital Statistics

Again, it is important to address these and other health indicators because of their potential to lead to chronic disease and possible death. Another important indicator is socioeconomic status: throughout the presentation, we have also discussed poverty levels and their relationship with chronic disease mortality. In hopes of creating a more equitable Saint Louis with better health outcomes, we want to circle back and end our presentation with a discussion of death rates and their association with poverty.

This first slide, adjusted for all causes of mortality, further emphasizes the association. This slide looks at death rates for those considered in low poverty. Between 2019 and 2020, we see a significant increase across all regions for all levels of poverty. St. Louis rates trended higher than the county and region, but the trend for the county from 2019 and 2020 is very steep

Mortality by Poverty Level

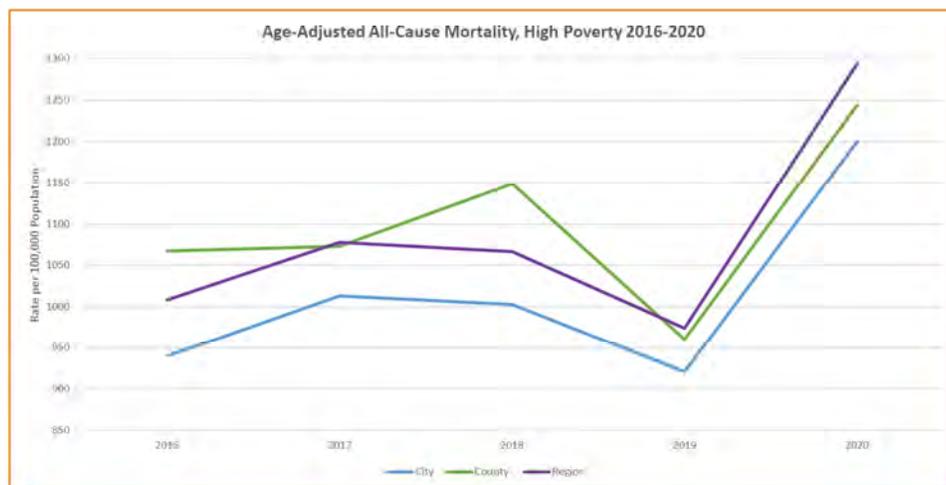


28

Source: Missouri DHSS, Bureau of Vital Statistics

Medium poverty shows death rates for the County tend to be higher. The county followed a similar trend to the greater region, and again we see a steep climb between 2019 and 2020 for all areas

Mortality by Poverty Level

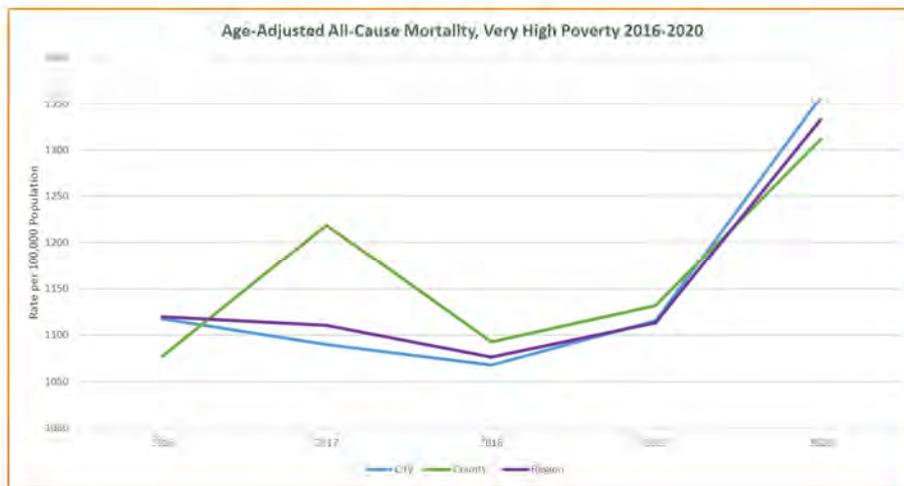


27

Source: Missouri DHSS, Bureau of Vital Statistics

(Slide 27) As poverty level increases, we see higher numbers for the death rates. For both high poverty and very high poverty, the rates greatly increased from 2019 to 2020.

Mortality by Poverty Level



28

Source: Missouri DHSS, Bureau of Vital Statistics

(Slide 28) On the very high level poverty graph, we see the trend upward started in 2018. Again, the rates for death are even higher within this category.

This is the final slide for today, and we end with it to highlight our regional downfalls and remind everyone of our goal. Our Community Health Status Assessment aims to showcase disparities in health outcomes for different populations. By having a better sense of where we fall short, we can better address the major health concerns and create better outcomes. Chronic diseases and their health indicators have a big burden on our community. However, with this examination of available data, we can all work together in a more efficient manner to make St. Louis a healthier home for us all.

Thank You!





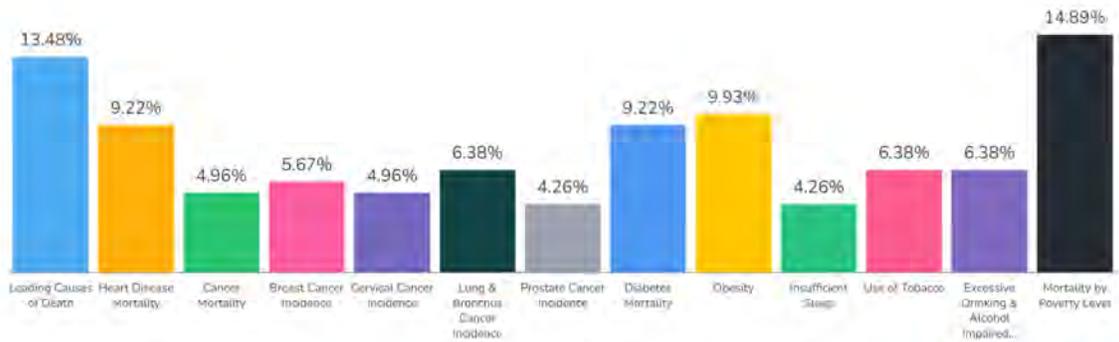
CHRONIC DISEASE

The purpose of today's meeting is to identify measures and indicators are reflective of Chronic Disease in the St. Louis Community. As we move through these assessments, priorities will be developed for action at a later meeting.

COMMUNITY HEALTH ASSESSMENT & IMPROVEMENT PLAN
PREPARED BY DAVID COURTNEY AND DANA KELSEY
MARCH 31, 2022
11:30 – 12:15 A.M.



Select the indicators which effectively tell the story of Chronic Diseases in our community



Menu

14 5 25 0

How does the data reflect your experience? How do they differ from your experience?

Stress	Confirms disparity between black & white and poverty levels	Trauma, nutrition/diet - healthy food access, systemic racism are real
Impacted by Covid	Confirms national trends for leading causes of death	Confirms disparities. Would like to see more representation of other race/ethnicity indicators in detailed report.
The steppe rise in 2020 may be indicative of the impact of COVID-19 on those on the lower end of the SES	Lack of healthy food in geographic areas show disparities between races	Interesting steep increases from 2019-2020
Intersections among all of the indicators we have addressed over 2 days	Confirms my experience	Great wrap-up of all prior presentations!
Poverty level associations with higher chronic disease	Can see influence of age for this area in distinctions between County and City	are: Alzheimer's disease as a leading

How does the data reflect your experience? How do they differ from your experience?

Poverty level associations with higher chronic disease

Can't access check-up and maintenance care and medications.

May rates declining in city and increasing in county for certain chronic disease be a result of residents moving

Life expectancy is greater in other areas

Can see influence of age for this area in distinctions between County and City (County pop being older), particularly with CDs that tend to happen in later life (for various reasons).

Poverty is St. Louis' (and America's) number 1 public health problem. Virtually every health metric is worst in the poorest neighborhoods.

when we stratify by age and zip, we really

are: Alzheimer's disease as a leading cause in the County ...the intersection of longer life-spans and disease associated with older age

chronic pain impacts many

Intersection of chronic pain, chronic disease, mental health, and substance use disorder

How does the data reflect your experience? How do they differ from your experience?



What indicators do you feel are missing? Please share data sources.

Movement disorders in more detail— Parkinson's, etc

Chronic pain is a great addition suggested earlier.

comparison of incidence vs. mortality to see where disease is being managed vs. where disease management is still needed

Obesity

How behavioral health fits within CD work.

I think we talked about this in environmental, but connecting with food access & nutrition; active living and relationship to built environment and safety to exercise

Age at diagnosis

screening rates for CKD so that it doesn't progress to ESRD

additional races

Where diagnosis are made. ER vs Specialists vs PCP

More data from the community on their healthy and unhealthy habits

screening rates and other prevention

\$ spent on prevention over

What indicators do you feel are missing? Please share data sources.

Specialists vs PCP

healthy and unhealthy habits

To build on Dana's comment, chronic disease care management among school health care providers

How insurance status affects cd

Exercise that can be adapted to different people's function

\$ spent on prevention over treatment(RIO/Cost benefit analysis) to inform strategic regional planning against major population-level indicators.

Access to preventative screenings by recommended age groups

Not an indicator, but could be helpful to include pop-out box/resource on CD management supplies (e.g., Diabetes related) that are or are not covered by common insurance sources.

School Health Clinics and relationship to better health

age, poverty, health literacy.

Preventive/supportive measures available by geography



To join, go to: ahaslides.com/CHSADAYTWO

AhaSlides

What indicators do you feel are missing? Please share data sources.

^

To build on Dana's comment, chronic disease care management among school health care providers

How insurance status affects cd

treatment(RIO/Cost benefit analysis) to inform strategic regional planning against major population-level indicators.

Exercise that can be adapted to different people's function

Access to preventative screenings by recommended age groups

Not an indicator, but could be helpful to include pop-out box/resource on CD management supplies (e.g., Diabetes related) that are or are not covered by common insurance sources.

School Health Clinics and relationship to better health

age, poverty, health literacy.

Preventive/supportive measures available by geography

Bias in healthcare

Too many too specialized doctors

Menu

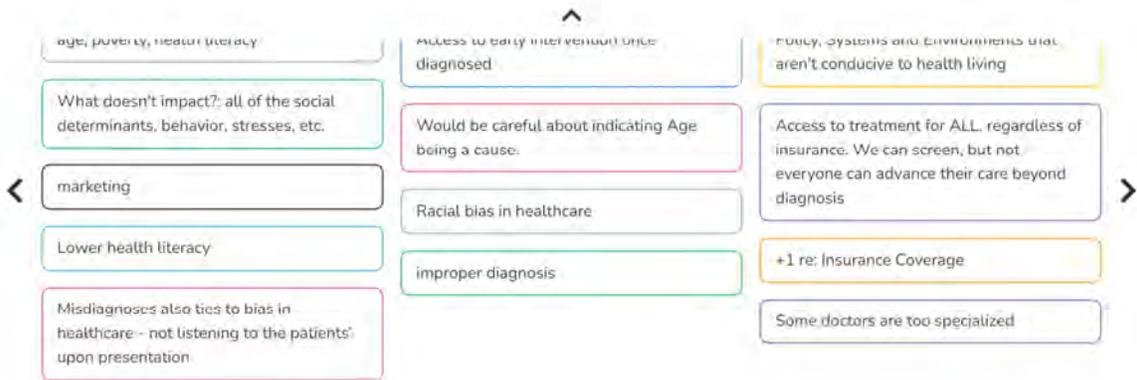
14 5 23 0

What are the underlying causes and external factors that affect the disparities in this category?

Income	Lifetime of neglect	Access to early intervention
Poverty	Built environment	Structural + institutional racism
age, poverty, health literacy	Access to early intervention once diagnosed	Policy, Systems and Environments that aren't conducive to health living
What doesn't impact?: all of the social determinants, behavior, stresses, etc.	Would be careful about indicating Age being a cause.	Access to treatment for ALL, regardless of insurance. We can screen, but not everyone can advance their care beyond diagnosis
marketing	Racial bias in healthcare	+1 re: Insurance Coverage
Lower health literacy	improper diagnosis	



What are the underlying causes and external factors that affect the disparities in this category?



Questions

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Appendix C

Segregating in St. Louis: Dismantling the Divide

2018

For the Sake of All Washington

University in St. Louis

SEGREGATION IN ST. LOUIS: **DISMANTLING THE DIVIDE**



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Cover Photo by R.J. Hartbeck

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An early community work group discussing “next steps” to achieve quality neighborhoods in the St. Louis region by supporting inclusive, affordable housing.



01

SEGREGATION AT THE CENTER

Place matters. Where people live in St. Louis has been shaped by an extensive history of segregation that was driven by policies at multiple levels of government and practices across multiple sectors of society. The effect of segregation has been to systematically exclude African American families from areas of opportunity that support positive economic, educational, and health outcomes.

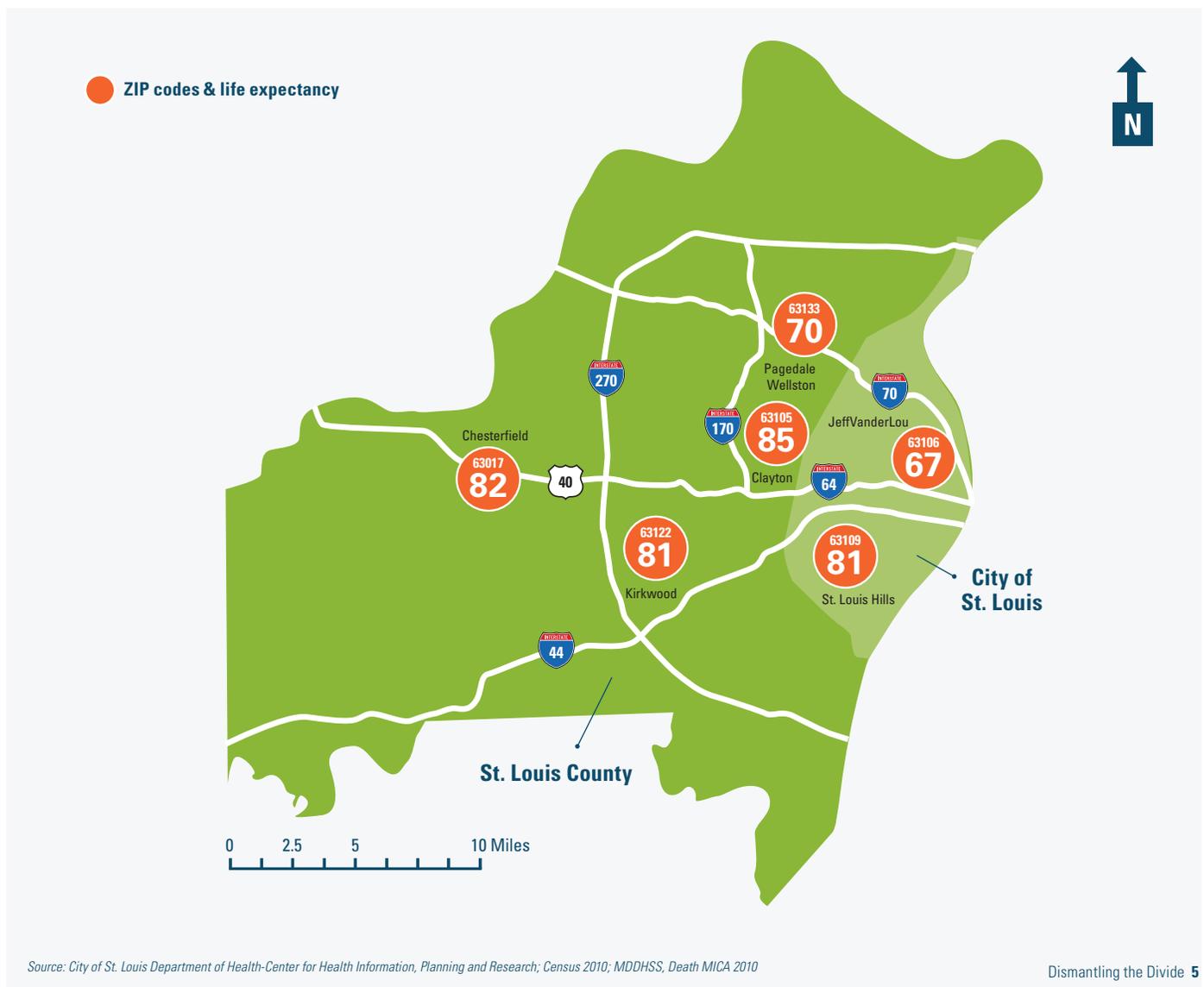
Health disparities in St. Louis

One of the most important messages in the original *For the Sake of All* report was that health is determined by multiple factors beyond the quality and availability of healthcare.¹ Through an extensive review of data on the St. Louis region, the report highlighted the critical links between health and education, income, and the quality of neighborhoods, among other factors. It noted that limited access to these crucial resources for many African Americans helps to explain differences in health outcomes like disease, disability, and ultimately, death. Indeed, public health research has confirmed that those with fewer social and economic resources experience worse health, poorer quality of life, greater disability, and earlier death than their more affluent peers.² Even after adjusting for socioeconomic status, though,

disparities often continue to be found between racial groups. In other words, even when African Americans and whites have comparable levels of socioeconomic status, health disparities remain. This suggests that attending to education, employment, and income alone will not entirely close the gaps between African Americans and whites detailed in *For the Sake of All*. Racism and the enduring legacy of systematic racial bias must be addressed along with social and economic resources.³

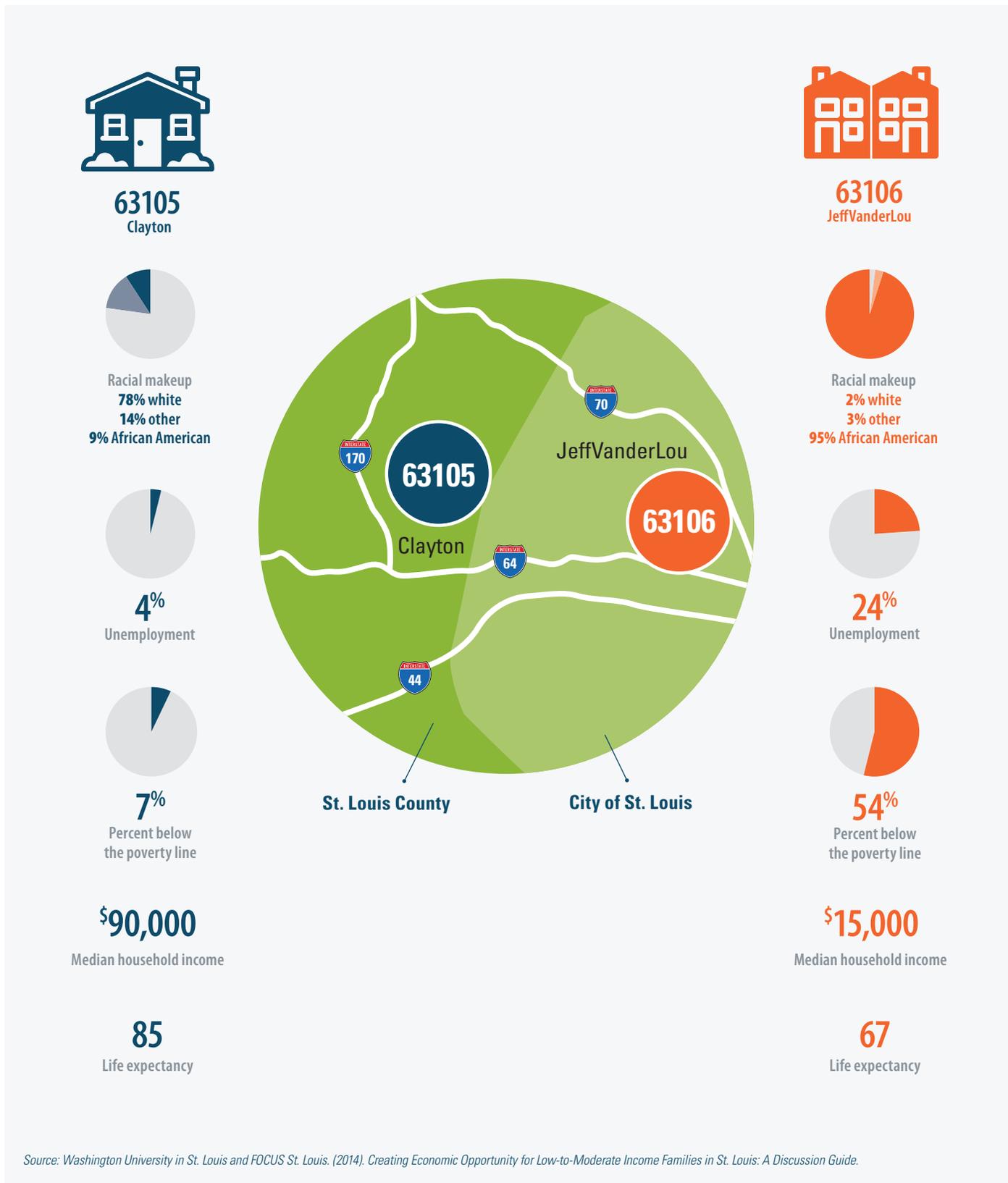
Of course, one of the most cited findings of the original report was the 18-year gap in life expectancy at birth between the 63106 ZIP code in North St. Louis City and the 63105 ZIP code in the Clayton area of St. Louis County—a geography separated by less than 10 miles (Figure 1). The differences between 63106 and 63105 are numerous, but perhaps most noteworthy are the very

Figure 1. Life expectancy at birth varies by ZIP code.



Source: City of St. Louis Department of Health-Center for Health Information, Planning and Research; Census 2010; MDDHSS, Death MICA 2010

Figure 2. The differences between 63105 and 63106 are numerous, but perhaps most noteworthy are the very different concentrations of affluence versus poverty and the racial composition of each place despite being less than 10 miles apart.



different concentrations of affluence versus poverty and the racial composition of each place (Figure 2). These differences are neither incidental nor accidental. The resources that are necessary to live a long and productive life are not equally distributed throughout the St. Louis region. They are not randomly distributed either. This unequal distribution of opportunity is the result of decades of policy at the local, state, and federal levels of government,^{4,5} and it is reinforced by systems, institutions, and industries (e.g., regulators, real estate, banks) that reproduce unequal outcomes in health and in access to the resources that influence health, like quality housing, education, employment opportunities, transportation, and basic services. Access to all of these is patterned along segregated lines in St. Louis. This was the subject of one of the original *For the Sake of All* policy briefs co-authored by Drs. Melody Goodman and Keon Gilbert.⁶

Scholars who study the link between segregation and health agree that one of segregation's most powerful impacts on health is its tendency to produce concentrated areas of urban poverty. Williams and Collins argue that "racial residential segregation is the cornerstone on which black-white disparities in health status have been built in the US" because of the way segregation "shapes socioeconomic conditions for blacks not only at the individual and household levels but also at the neighborhood and community levels."⁷(p. 405)

Segregated spaces that include sizable African American and Hispanic populations tend to have higher rates of poverty than similarly segregated spaces that are predominantly white. It is important to note that both spaces are segregated, but the impact of segregation on African Americans and Hispanics is associated with poorer outcomes. These highly segregated areas of concentrated poverty often lack access to municipal services, basic amenities like grocery stores, other retail, banks, and proximity to job opportunities. Educational resources also tend to be limited, with schools serving low-income student populations facing unique challenges. So, segregated places tend to produce worse health outcomes, particularly for racial and ethnic minority populations. Importantly, this is true whether or not individuals or households are poor themselves.^{7,8}

Proportion of St. Louis families living in neighborhoods of concentrated poverty



Paul Knittel

Even among the poorest residents in the region, white families are less likely to live in neighborhoods of concentrated poverty (defined as 40% of families or more in a neighborhood living at or below federal poverty level) than African American families.

Source: American Community Survey (ACS), 2012-2016, 5-year estimates; U.S. Department of Housing and Urban Development (HUD), Affirmatively Furthering Fair Housing Data and Mapping Tool

Trapped in poverty

The conditions of racially concentrated areas of poverty in segregated metropolitan areas like St. Louis hamper health and other outcomes and are also implicated in the kind of social mobility that is at the heart of the American Dream. Recent work by economist Raj Chetty and his colleagues has shown a great deal of local variation in the extent to which children who are born into poverty are able to escape it as adults. In groundbreaking, large-scale analyses of national data Chetty has found that the gap between rich and poor has widened, and in some places, it is relatively rare to escape from poverty.⁹

St. Louis is one of those places. It ranks 42nd out of 50 large metro areas when considering the probability that a child born into the lowest 1/5 of the income distribution will reach the top 1/5 in adulthood. And that finding is not restricted to poor African American children but includes all children. Segregation is one of the factors that the study led by Chetty identified as contributing to this local lag in mobility. According to its analysis, areas with greater racial segregation also had less upward mobility.

Those in higher status positions, who are predominantly white, are likely to pass on information about job opportunities only to those within their networks.

Cut off from empowering social networks

Closely connected to social mobility are social networks. These are the connections between individuals through which information and other vital resources flow. Segregation effectively forecloses opportunities for individuals and families from different racial groups to share information about jobs and other resources. People who do not know one another because of the physical and psychological separation imposed by segregation never have the opportunity to gain from the knowledge, experience, and perhaps most importantly, the connections of others. This has very real-world consequences, as economists estimate that a substantial proportion of jobs are obtained through social contacts and that unemployment and dropping out of the labor market can be predicted by the racial composition of social networks.¹⁰ In other words, those in higher status positions, who are predominantly white, are likely to pass on information about job opportunities only to those within their networks, excluding low-income and individuals from racial and ethnic minority groups.

Table 1. Unemployment status for the population 16 years and over in the civilian labor force.

	City & County Combined	National Rates
Total unemployment	5.7%	4.1%
African Americans	11.5%	7.3%
Whites	3.3%	3.6%

Source: American Community Survey (ACS), 2016, 1-year estimates

Sociologist Nancy DiTomaso summarizes her research on racial favoritism in the labor market in a 2013 *New York Times* op-ed entitled, “How Social Networks Drive Black Unemployment:”

“Through such seemingly innocuous networking, white Americans tend to help other whites, because social resources are concentrated among whites. If African-Americans are not part of the same networks, they will have a harder time finding decent jobs.... Help is not given to just anyone, nor is it available from everyone. Inequality reproduces itself because help is typically reserved for people who are “like me:” the *people who live in my neighborhood* [emphasis added], those who attend my church or school or those with whom I have worked in the past.... Because we still live largely segregated lives, such networking fosters categorical inequality: whites help other whites, especially when unemployment is high. Although people from every background may try to help their own, whites are more likely to hold the sorts of jobs that are protected from market competition, that pay a living wage and that have the potential to teach skills and allow for job training and advancement. So, just as opportunities are unequally distributed, [networks] are also unequally distributed.”¹¹

DiTomaso goes on to argue that this social networking effect is at least as important as ongoing (and still very real) employment discrimination in explaining African American unemployment rates that are consistently at least twice the rate for whites in the St. Louis region and nationally (Table 1). However, we should not overestimate the potential effect of living in closer proximity on greater social network integration. Homogeneity is one of the hallmarks of social networks, and concerted efforts are needed in order to break down deeply entrenched racial and economic barriers.¹²



2018

SCHOOLS ARE MORE SEGREGATED NOW THAN THEY WERE IN THE LATE 1960s

Photos courtesy of Whitney Curtis



Segregated schools harm health and opportunity

Another reason for racial disparities in employment and in representation among skilled labor sectors is a lack of training and education commensurate with those jobs. Several observers have noted that schools are more segregated now than they were in the late 1960s.¹³ Of course, access to schools follows the same pattern as access to housing, and because schools in the United States are funded by local property taxes, housing has an outsized impact on school quality. Indeed, school district quality often drives the choice of neighborhood for homebuyers and renters alike, particularly for families with children. When those neighborhoods are segregated by both race and income, the schools in those neighborhoods tend to be segregated as well. What many families with the resources to search

for the best housing and schools often fail to appreciate is the way in which patterns of residential segregation over several decades have shaped both the housing market and schools in neighborhoods throughout the region—and the ways in which their choices perpetuate housing, educational, and economic inequity. Richard Reeves of the Brookings Institution calls this “opportunity hoarding” in his book *Dream Hoarders: How the American Upper Middle Class is Leaving Everyone Else in the Dust, Why That is a Problem, and What to Do About It*.¹⁴

Scholars also have noted the relative lack of attention to school integration following the intensive efforts of the Civil Rights Movement era. For instance, Richard Rothstein argues that instead of focusing on the intent of the *Brown v. Board of Education* decision, federal, state, and local education leaders have shifted the conversation to the achievement gap and the needed resources to shore

up struggling schools—which are often urban, high-poverty, and majority African American or Latino.¹⁵ School integration along socioeconomic lines in particular has been associated with better performance for students from low-income households.¹⁶ Students who do not have access to the resources necessary to excel academically will not be competitive in the job market and are often at risk for school dropout and disconnection from the economic mainstream. Education is also one of the strongest and most consistent predictors of health outcomes, such as illness and death. Residential segregation places children at risk along multiple dimensions, and the stress associated with having limited resources among families and neighborhoods makes providing adequate developmental support in schools all the more challenging.

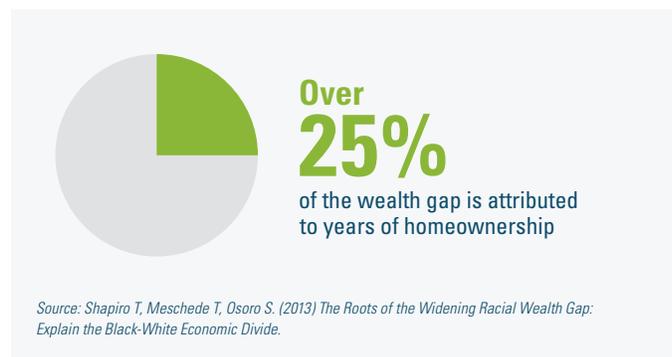
The wealth gap

An even more fundamental economic barrier, however, has been the inability to amass wealth in hyper-segregated African American communities like those in St. Louis. The majority of most Americans' net worth is held within the value of their homes.

It is the asset that contributes most significantly to their economic well-being. Because African Americans have been segregated into areas where housing values have declined due to disinvestment in surrounding resources—and not, as is commonly believed, because of the supposed character flaws of residents—they have not realized the same gains in home equity and property values as their white counterparts. African American and Hispanic families also hold more of their total wealth in home equity compared with Asian American and white families, which made these households particularly vulnerable during the housing crisis that led to the Great Recession. Between 1989 and 2013, African Americans were the only racial or ethnic group to

lose value in terms of home equity, at an average annual inflation-adjusted rate of -0.4%—compared with an increase of 0.5% for Hispanic, 1.2% for non-Hispanic white, and 2.5% for Asian or other households. African Americans also had the lowest average rate of growth in total wealth.¹⁷ This has intergenerational consequences, as parents barred from building wealth have nothing to bequeath to the next generation. As a result of these and other patterns, a recent report noted that at the current rate of growth, it would take 228 years for the average African American family to amass the same amount of wealth as the average white family.¹⁸ Even before the most recent recession the racial wealth gap had grown substantially. An analysis by the Institute on Assets and Social Policy at Brandeis University found that the absolute gap between the wealth of white families and African American families nearly tripled, from \$85,000 in 1984 to \$236,500 in 2009.¹⁹ And the largest driver of the gap was years of homeownership, which accounted for over 25% of the difference.¹⁹ It was followed by household income, unemployment, college education, and financial support or inheritance—all of which are tied to residential segregation in one way or another. All are also tied to health in important ways, as was discussed at length in the original *For the Sake of All* report.

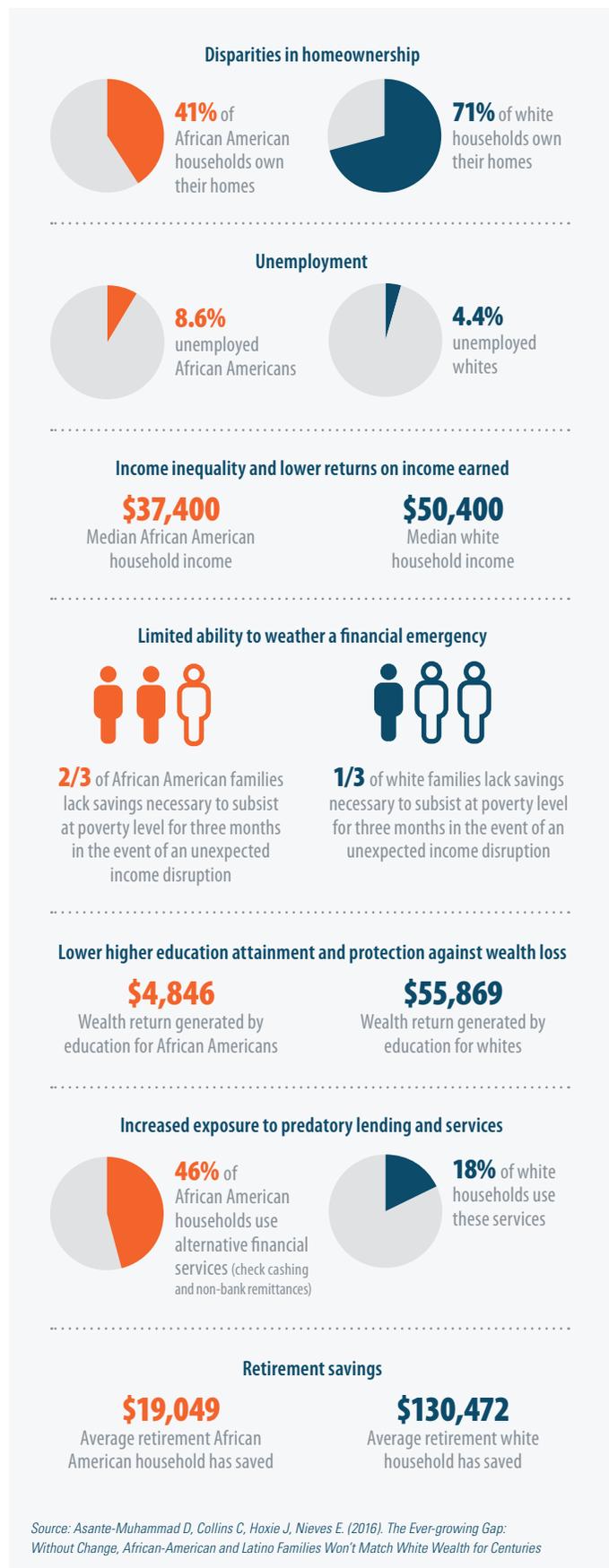
The wealth gap between African American and white families



228 Years for the average African American family to amass the same amount of wealth as the average white family

Source: Asante-Muhammad D, Collins C, Hoxie J, Nieves E. (2016). *The Ever-growing Gap: Without Change, African-American and Latino Families Won't Match White Wealth for Centuries*.

Figure 3. National barriers to achieving financial security.



Social fabric

In addition to these stark economic realities of segregation are the more subtle strains on the social fabric of the St. Louis region. There are individuals from various parts of the region who will not venture into other parts because they fear for their physical safety. And this is not a unidirectional phenomenon. Whites and others fear venturing into parts of the City of St. Louis, and African Americans are afraid of being harassed in parts of St. Louis County. Segregation is a substantial barrier to the kind of mutual understanding that is necessary for cooperation and a sense of community. The lines that divide us mean that an untold number of otherwise enriching relationships never form. And that division also has relevance for health, as social support and a sense of belonging are vital to health and longevity. Cutting off access to the human connections that allow individuals and communities to thrive from an emotional and relational perspective is among the most pernicious effects of segregation.

Conclusion

The St. Louis region is beginning to reckon with the economic and human costs of our segregation and inequity. In part informed by reports like *For the Sake of All* and accelerated by the unrest in Ferguson following the fatal shooting of Michael Brown, St. Louis has been engaged in a serious discussion about the enduring significance of race in our region. This report extends that conversation and suggests that residential segregation is a chief and central cause of unequal outcomes across multiple domains. This is true because of the many resources and opportunities that are tied to where one lives, particularly as one grows and develops. Place matters. And because place has been so deeply imprinted by race in St. Louis and other metropolitan areas throughout the country, residential segregation mixed with economic disinvestment and neglect has produced pockets of particularly stubborn intergenerational poverty that result in the kind of foreshortened estimates of life expectancy predicted for ZIP codes like 63106.

It doesn't have to be this way. As you will read in subsequent pages, Americans of all backgrounds have been on the move since the nation's inception in search of more opportunity for themselves and their families. Tragically, that movement has not always been by choice, but often by force. The first African Americans were, of course, forcibly brought to

America as slaves. Following the collapse of Reconstruction, they were pushed to the North and the West by the oppressive social and economic conditions of the Jim Crow South in a Great Migration that forever changed American cities. Instead of welcoming these transplants, St. Louis erected barriers to their advancement that have had devastating consequences not just for African Americans but for the City of St. Louis and the St. Louis region as a whole. Years before the momentous events in Ferguson, historian Colin Gordon laid out this depressing trajectory for St. Louis in a book titled, *Mapping Decline: St. Louis and the Fate of the American City*. In it he argues that the City of St. Louis's loss of population and prominence was driven by policies and practices in government and private industry that had racial segregation as their central organizing principle. The “white flight” that Gordon details also drove the proliferation of municipalities in St. Louis County, whose governments instituted suburban segregation.

Conscious choices created our “geography of inequity” in St. Louis. Conscious choices can also help to reshape it. This report explores the origins, present-day manifestations, and recommended remedies to the persistent problem of segregation in St. Louis. In Chapter 2, we describe the early historical development of residential segregation, focusing primarily on the City of St. Louis, where most of the region's population resided at the time. The original tools of exclusion developed during this period would set the region's course and shape its growth and racial character for the next century. Chapter 3 picks up the historical overview following World War II, with the growth of suburban St. Louis and a particular focus on what is called exclusionary zoning. The chapter details the ways in which municipalities regulated land use to keep particular groups

out. Despite several civil rights gains during this period of tremendous change, new techniques would emerge to enforce segregation. Several specific mechanisms that continue to have currency today are explored, including the use of development incentives. Chapter 4 focuses on rapid demographic changes that particularly affected North St. Louis County in the past half-century, and the challenges and opportunities presented in a suburban area that contains both segregated cities and cities with unique diversity. Chapter 5 presents a more personal picture of contemporary segregation in St. Louis. Along with a series of maps that detail multiple dimensions of exclusion, we tell the stories of St. Louis residents grappling with its real-life consequences. Chapter 6 continues the storytelling, highlighting the strains on our social fabric that result from segregation. Finally, Chapter 7 explores multiple recommendations for more equitable and inclusive access to housing in the St. Louis region—along with examples of work that are already underway locally and around the country. There are formidable challenges to realizing this vision, but there are also committed individuals and organizations who believe that we will do better and be better as a community when all have the opportunity to live in places where they can thrive.

One final note before turning to the history that has separated the St. Louis region for more than a century. It involves the ingenuity and resilience of the African American. In the pages that follow you will read about the well-coordinated efforts at multiple levels of government and across sectors of society to keep families isolated from opportunity and advancement, and that is an important story to understand. What must not be lost in the telling of that story is the humanity and agency of African American

Conscious choices created our “geography of inequity” in St. Louis. Conscious choices can also help to reshape it.



James Byard, Washington University



Joe Angeles, Washington University



James Byard, Washington University

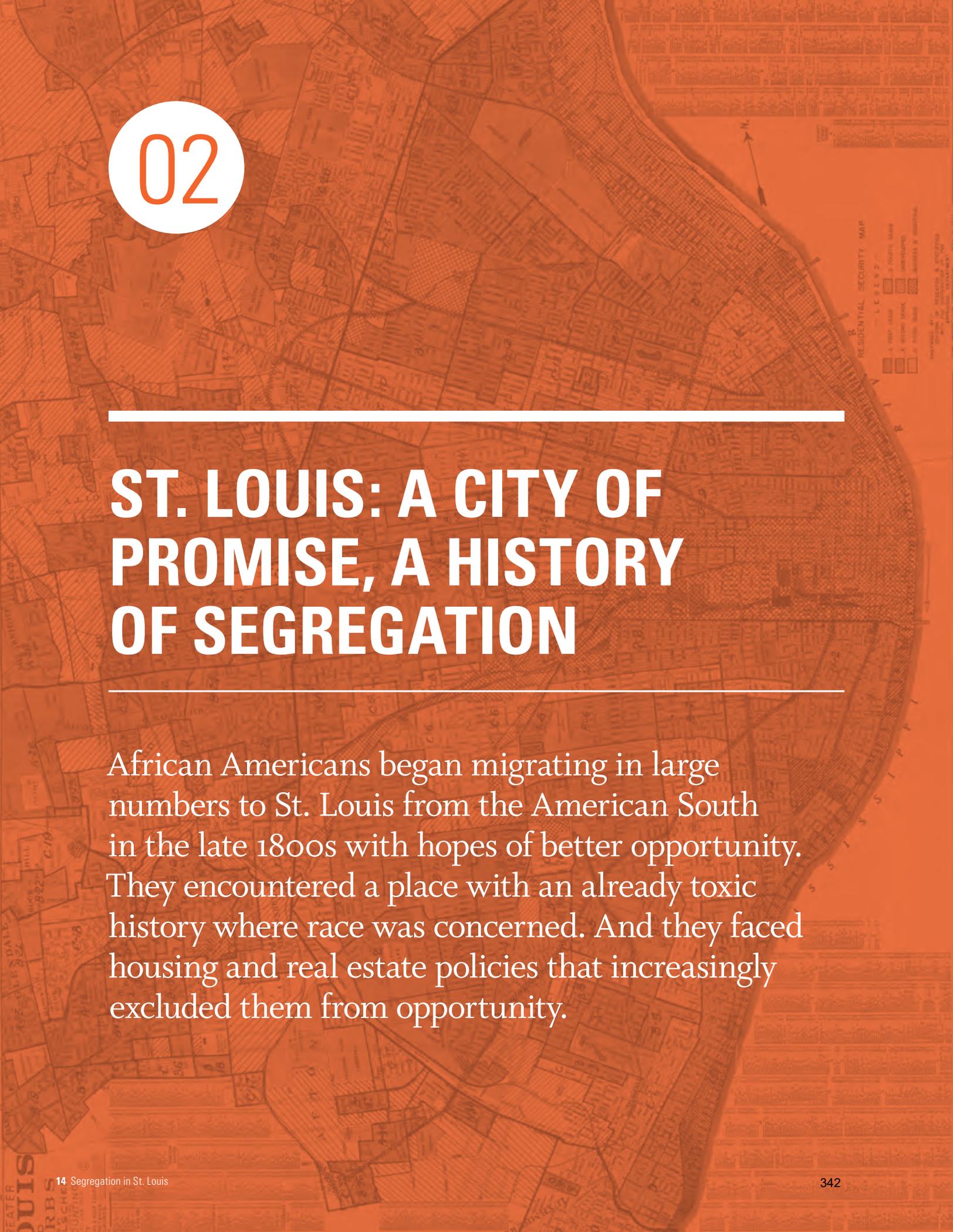


families, from the earliest arrivals to the residents of today. Throughout the African American experience in St. Louis, there have been countless examples of both dignity and defiance in the face of outright hatred, dismissal, displacement, and neglect. The African American communities we chronicle did not retreat in defeat when presented with obstacles on every side. They built businesses, churches, schools, civic organizations, social clubs, aid societies, and healthcare centers. Many of these institutions would nurture generations of professionals and more than a few internationally renowned educators, political leaders, activists, and artists—and many of them still do. African Americans also have a long tradition of challenging unjust conditions in St. Louis and working to break down barriers designed to hamper them.

The point of this report is not to negate the efforts of African Americans in the history of St. Louis, but to highlight the ways in which the vast potential of this community, and of the St. Louis region more broadly, was dampened by small, short-sighted thinking and disastrous policies. So much promise and power were realized, but there could have been so much more. African Americans have not only endured; they have excelled in many respects. But St. Louis has not made it easy. This report is ultimately about both how hard it has been and how much better it can be. It is to everyone's benefit for change to come, but we must face some hard truths before it does.

Final Thoughts

Conscious choices made throughout our history created a “geography of inequity” in St. Louis that has locked too many African American families in segregated areas lacking opportunity. Conscious choices can also help reshape this reality. Before we can discuss where to go, though, we must understand how we got here.



02

ST. LOUIS: A CITY OF PROMISE, A HISTORY OF SEGREGATION

African Americans began migrating in large numbers to St. Louis from the American South in the late 1800s with hopes of better opportunity. They encountered a place with an already toxic history where race was concerned. And they faced housing and real estate policies that increasingly excluded them from opportunity.



St. Louis Post-Dispatch

Tense beginnings: Arrival in a hostile city

African Americans from the South first came to St. Louis in large numbers more than a century ago to find better economic prospects and to escape a cruel Jim Crow system in which their rights were few and their safety perilous.

They left behind possessions, communities, and loved ones. They crept away from plantations and stood quietly in the corners of train platforms with few bags in order to avoid attention.

They hoped to leave behind a system that racially regulated nearly every aspect of daily life, and they went in search of better opportunities for themselves and their children.

These were the ambitious dreamers of the Great Migration, chronicled in journalist Isabel Wilkerson's Pulitzer Prize-winning book, *The Warmth of Other Suns*. They migrated to urban areas in the West, the Northeast, and the Midwest, including St. Louis, a bustling city up the river from Mississippi, Louisiana, Arkansas, and Tennessee.

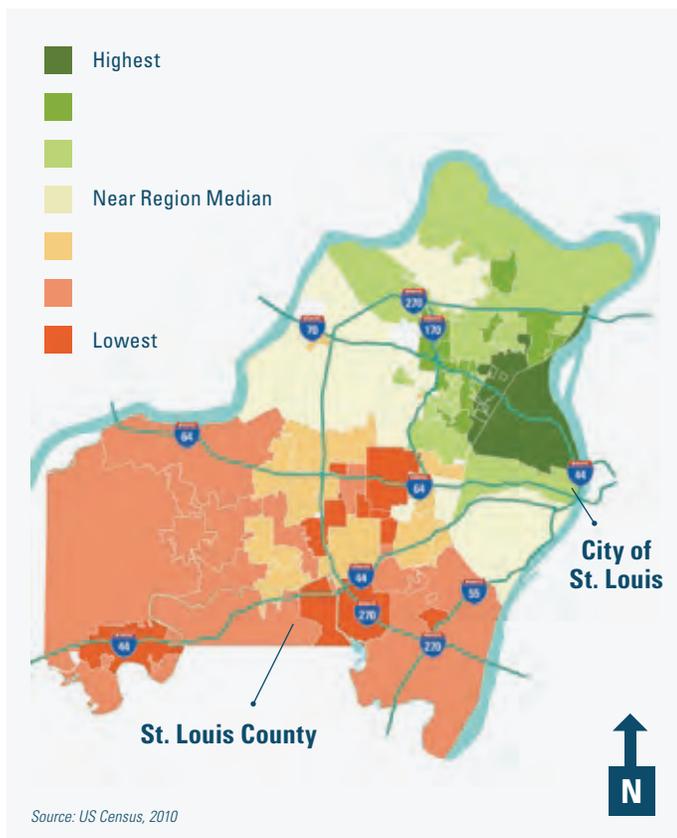
They came to St. Louis on foot, aboard steamboats, by railroad, in automobiles, and later, seated in the back of segregated buses.

In the period between 1900 and 1930, the African American population in St. Louis nearly tripled from 35,516 to 93,580.²⁰

When they arrived, African Americans encountered a hostile city with a notorious history regarding slavery and educational opportunity.

Missouri joined the Union as a slave state in 1821. Prior to the Civil War, St. Louis was where the *Dred Scott v. Sanford* case originated. Dred Scott, a resident slave, had petitioned for his freedom in Missouri under the claim that he had previously lived in the free state of Illinois and the free territory of Wisconsin with his owner. Scott eventually appealed to the Supreme Court. In 1857, in a decision that would roil abolitionists and increase tensions between the North and South, the high court ruled that all African Americans, both slaves and free men, were not and could not be U.S. citizens and could not petition the courts for freedom. The Court further declared the 1820 Missouri Compromise unconstitutional, which then permitted slavery in all of the nation's territories.

Figure 4. Present-day African American population in the St. Louis region by ZIP code.



Chief Justice Roger B. Taney, a staunch supporter of slavery and southern interests, wrote in his majority decision that African Americans “had no rights which the white man was bound to respect, and that the negro might justly and lawfully be reduced to slavery for his benefit. He was bought and sold, and treated as an ordinary article of merchandise and traffic whenever a profit could be made by it.”²¹

After the Civil War ended and the ratification of the 13th Amendment effectively outlawed slavery, the Missouri Constitution was amended with provisions in 1865 and 1875 that established separate schools for African American and white children. In 1889 the Missouri legislature passed a law ordering segregated schools for African American children. Though challenged, the Missouri Supreme Court ruled in 1890 that segregated schools did not conflict with the U.S. Constitution.²²

These were the state policies African Americans contended with as they began to migrate in larger numbers to St. Louis at the turn of the century. Multiple policies would soon

proliferate at the local, regional, state, and federal levels to separate neighborhoods, each one entirely white or entirely black.

As we will explore in this chapter, African American St. Louisans were at first barred outright from residing or owning property in many areas of the City of St. Louis and most early communities and railroad towns in St. Louis County. The neighborhoods in which African Americans were permitted to live often contained substandard housing, poor access to basic amenities, higher food costs, and inadequate healthcare services.⁴

Once these racial lines were drawn in our region, communities and interest groups sought to aggressively maintain these boundaries. In chapters to follow, this report will show how these original patterns of exclusion in education, housing, and opportunity continue to the present day in obvious and less overt forms, to the great detriment of the entire region. We begin by discussing tools of segregation dating back more than 100 years.

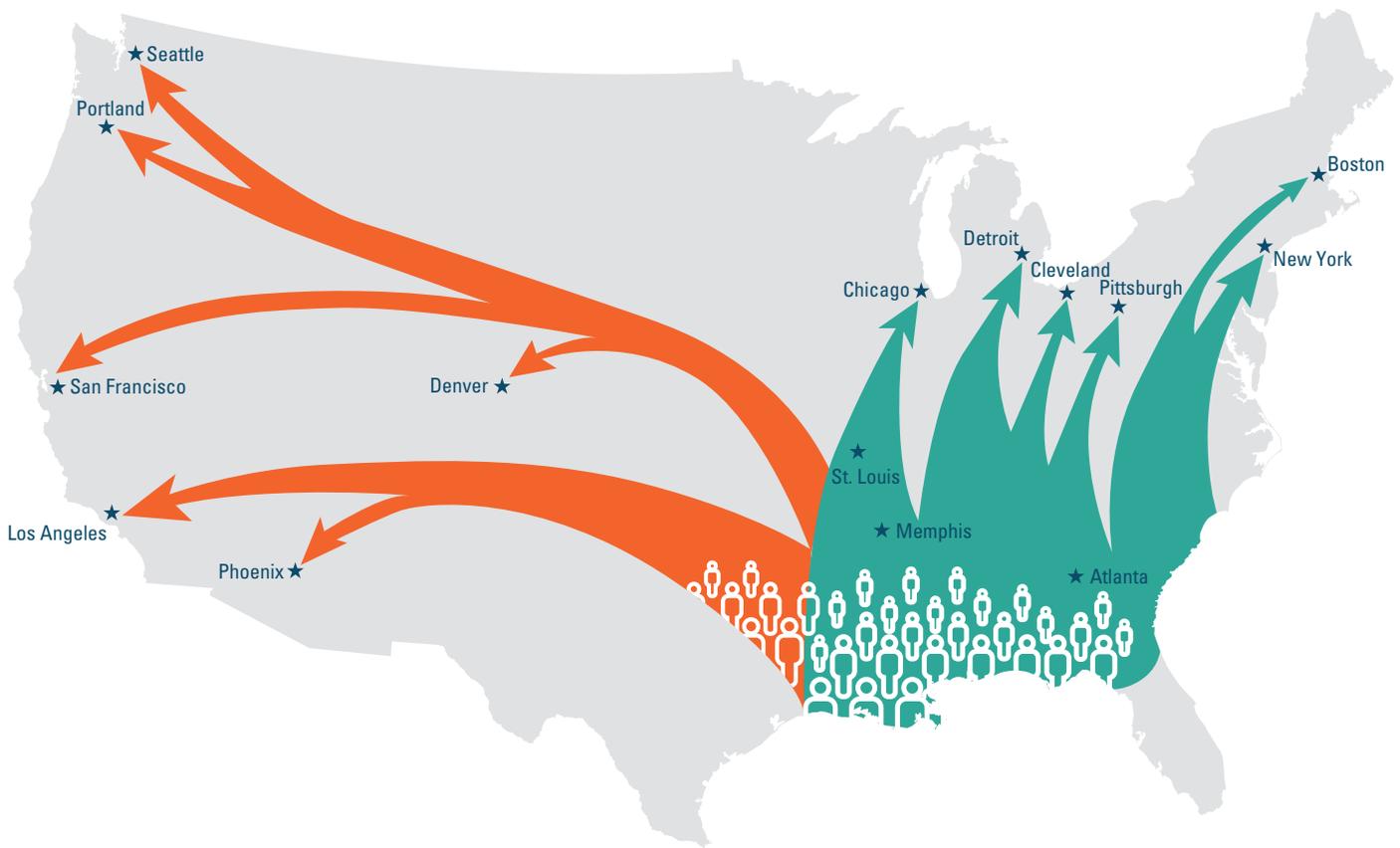
The Great Migration: A perceived threat to an already segregated city

Long before the first wave of African Americans migrated from the South to urban hubs in the North, housing in St. Louis was segregated by race.²³ But as more African Americans arrived in St. Louis in the late 19th and early 20th centuries, the “stability” of these long-established racial boundaries was threatened by the demand for more housing and the concurrent growth of services and businesses catering to new residents.

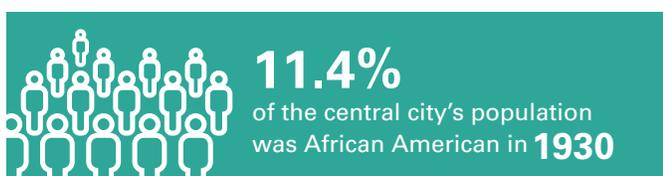
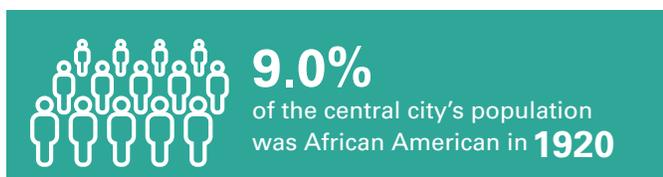
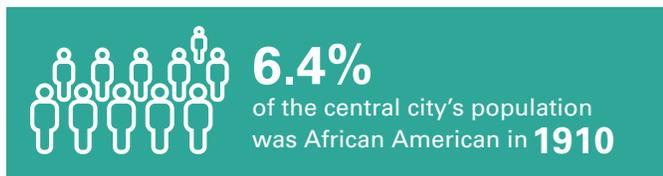
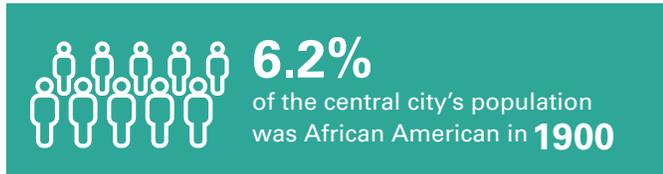
In the periods scholars call the First (1916-1940) and Second (1940-1970) Great Migrations the region saw the African American population grow suddenly and significantly.²⁴ African Americans made up 6.1% of the central city’s population in 1900, by 1920 that proportion had grown to 9% and to 13.3% in 1940.²⁰

The limited housing that had historically been made available to non-whites in the City of St. Louis, coupled with the desire by white civic leaders and citizens to remain separate from African Americans motivated leaders to establish rules and “protections” to preserve segregation. It was in this climate of rapid demographic change that housing policies and strategies damaging to African Americans took hold. The first was racial zoning.

Figure 5. The Great Migration: African American movement from the South to urban hubs across the nation. Green represents the First Great Migration from 1916 to 1940. Orange represents the Second Great Migration from 1940 to 1970.



ST. LOUIS POPULATION (1900–1930)



ST. LOUIS POPULATION (1940–1970)



Source: Campbell G. & Jung K. (2005). *Historical Census Statistics on Population Totals by Race, 1790 to 1990, and by Hispanic Origin, 1970-1990, for Large Cities and Other Urban Places in the United States.* (Population Division, Working Paper No. 76), U.S. Census Bureau



This editorial cartoon endorsed the increased use of zoning to stop “the blight bug” and protect residential communities. The zoning was misused to bar non-white residents from moving into most neighborhoods in urban areas.

Source: *St. Louis Post-Dispatch*

Explicit racial zoning: A misuse of city planning tools

The introduction of zoning practices gave city planners a powerful tool to potentially better the everyday lives of all of their citizens. In an attempt to protect residential areas from conditions considered nuisances, such as heavy industry producing noise or pollution, local governments used zoning to regulate land use. This began in the early 1900s²⁵ and was further strengthened by a 1915 U.S. Supreme Court decision sanctioning the authority of a city to “exercise... police power over land use.”²⁶

In response to the new legal protections, however, many cities went far beyond the initial intent of zoning, and immediately enacted racial zoning ordinances explicitly barring African American residence in most neighborhoods. That these city planners regarded African American residency as a “nuisance” is illustrated succinctly by former Baltimore Mayor J. Barry Mahool, who in introducing his city’s racial zoning law in 1910 took the position that:

“Blacks should be quarantined in isolated slums in order to reduce the incidence of civil disturbance, to prevent the spread of communicable disease into the nearby White neighborhoods, and to protect property values among the White majority.”

Source: Silver C. *The Racial Origins of Zoning in American Cities*. In: Thomas M, Ritzdorf J, Ritzdorf M eds. *Urban Planning and the African American Community: In the Shadows*. Thousand Oaks, CA: Sage Publications; 1997.

Leaders in St. Louis shared this attitude. Fearing African American residential expansion would destabilize their businesses, the St. Louis Real Estate Exchange (SLREE) began a campaign for a racial zoning ordinance to be placed on a city-wide ballot in 1916.⁴

The campaign used language designed to instill a fear of declining property values in the white majority population as a result of what the real estate group called the “Negro invasion.”

The proposed ordinance prohibited African Americans from purchasing or renting housing in blocks that were more than 75% white and included a “reasonable provision whereby gradually such blocks may become in time occupied wholly by either white or colored people.”^{4(p. 70)} On February 29, 1916, voters passed this ordinance by a comfortable margin, with 74.5% of the votes cast supporting it.

The SLREE’s racial segregation victory was short-lived. Racial zoning ordinances were challenged repeatedly in state courts and were struck down altogether by the U.S. Supreme Court in the 1917 *Buchanan v. Warley* decision.²⁵ Though many cities continued their efforts to create legally defensible racial zoning systems,²⁵ St. Louis turned its attentions to a new method: the racially-restrictive deed covenant.

Restrictive deed covenants: Racism built into enduring housing deeds

Restrictive deed covenants contractually bound homeowners to forbid certain types of land use on their property. These agreements bound not only the original signer, but any successive owner of the property, typically for a term of 20 to 50 years.⁴

**NEGRO'S INVASION ROUSES
COTE BRILLIANTE RESIDENTS**

**Property Owners Call Meeting to
Plan Purchase of House
Now Being Built.**

Residents of Arlington avenue, in the neighborhood of Cote Brilliante avenue, will hold a meeting Thursday night at Hart's Hall, Easton and Semple avenues, to decide on action to prevent a negro from moving into the neighborhood.

A house is being built at 1625 Arlington avenue for the occupancy of a negro family named Hoffman. The head of the family, a teacher in a negro school, owns the lot. Plans for buying Hoffman out will be considered by the owners of adjoining property. The house has now progressed as far as the foundations.

John Faust, Henry Grone, Charles Bossalier and John Madden are among those interested in the meeting. It was stated Thursday that only peaceable and lawful measures will be considered at the meeting.

Policy that would lead to the overt exclusion of African Americans in St. Louis neighborhoods was openly discussed in the early part of the 20th century as evidenced by this newspaper article.

Source: *St. Louis Post-Dispatch*

A horrific event helped fuel the creation of restrictive deed covenants in St. Louis. On July 2, 1917, what observers described as a nightmarish, two-day massacre, erupted in East St. Louis after months of racial labor tensions pitted white unions against newly migrating African American laborers. News accounts estimated that more than 100 African Americans were “beaten, shot, clubbed and stoned to death” when whites attacked on the city’s streets.

As the *St. Louis Post-Dispatch* reported, “Men were killed simply because they were black, and the only limit on the slaughter was the ability of the crowd to find Negroes.”²⁷

Homes were burned and hundreds of African Americans fled East St. Louis, some crossing the Eads Bridge to St. Louis under military protection. Others made perilous trips on rowboats across the Mississippi to safety in the City of St. Louis.

It is important to note that St. Louis experienced an unusually large first wave of African American migrants relative to other northern and western cities during the Great Migration. Historian Colin Gordon notes that this quick and early influx of African Americans, coupled with already present racial hostilities (as evidenced by the East St. Louis race riot), led the city to more aggressively impose segregation policies earlier in its development than other cities (personal communication, February 2018). Though many cities eventually adopted similar policies, those in St. Louis were particularly strong and damaging given their intensity and longevity.

Fear of this new influx of African American residents in St. Louis and the volatility of race relations clearly motivated the creation of racial covenants, which would only grow in use from the 1920s through the 1940s. The race of the occupant was the most common stipulation of most deed covenants. In *Mapping Decline* Gordon provides examples of legal language that was common to St. Louis’s restrictive covenants of this era:

“It is to the mutual benefit and advantage of all of the parties,” the preamble to most of the St. Louis restrictions read, “to preserve the character of said neighborhood as a desirable place of residence for persons of the Caucasian Race and to maintain the values of their respective properties.”

The restrictive covenant at the heart of the landmark U.S. Supreme Court decision originating in St. Louis that eventually outlawed them, bound “the signatories, their heirs, assigns, legal representatives, and successors in title to restrict the property against sale to or occupancy by people not wholly of the Caucasian race”—specified later in the same document as “people of the Negro or Mongolian Race.”

The boilerplate covenant drafted by the St. Louis Real Estate Exchange included “a restriction against selling, conveying, leasing, or renting to a negro or negroes, or the delivery of possession, to or permitting to be occupied by a negro or negroes of said property and properties of the other owners of properties in the said City blocks . . . for a term of such years said attorney may deem proper.”^{4(p. 73)}



LOOK At These Homes NOW!
 An entire block ruined by negro invasion. Every house marked "X" now occupied by negroes. ACTUAL PHOTOGRAPH OF 4300 WEST BELLE PLACE. SAVE YOUR HOME! VOTE FOR SEGREGATION!

73

1915-1917 NEWS OF THE DAY

A. Missouri Historical Society - Race Relations Collection, box 1

B. St. Louis Post-Dispatch

C. United Welfare Association, "Dear Neighbor" letter, 1915, Missouri Historical Society - Race Relations Collection, box 1

CLOUDY TONIGHT, RAIN OR SNOW TOMORROW

THIS TEMPERATURE

High, 20 at 4 p. m. Low, 10 at 7 a. m.

Yesterday's Forecast: High, 20 at 4 p. m. Low, 10 at 7 a. m.

IF THE DARK VOTE IS LIGHT SEGREGATION WILL WIN

OREGON UNIVERSITY TO TAKE GIRL FRESHMEN'S FOOTPRINTS

Closets in President Culture in Career Damage Done to High-Heeled and Pointed-Toed Shoes.

70,000 EXPECTED TO VOTE TODAY ON SEGREGATION!

Section Commissioners Estimate About Half of Those Registered Will Cast Ballots — Both Sides Confident.

They opened at 8 o'clock this morning in the Missouri precincts of the city for the initiative election on the proposed anti-segregation ordinance. The polls will remain open until 7 o'clock in the evening. A majority vote is necessary to have either ordinance.

Saloons were required closed at midnight last night to remain closed until midnight tonight. Attorney-General Barker having ruled that the law requires them to be closed at an initiative election. At the Hotel Jefferson, where the usual Monday evening supper dance was being held last night, the crowd of guests that filled the house during supper were told early that drinks would not be served after midnight.

Advocates and opponents of the ordinance exchanged heated statements in

OFFICE

UNITED WELFARE ASSOCIATION

Organized to Secure the Removal of an Ordinance that Will Prevent Further Extension of White Resident Neighborhoods by Nonconformity and Vice Versa

SAINT LOUIS

February 21st, 1917

Mr. W. C. Kirby,
 517 Century Bldg.,
 St. Louis.

Dear Neighbor:

WE DO BELIEVE that at this time you are likely to suffer an impression that the passing of ORDINANCE NO. 10000 is such a vital interest in property owners. A certain resident in your immediate neighborhood desires the repeal of your ordinance, perhaps you do not think that your neighborhood will be benefited, either by you believe you are going to bring a fire upon you and your neighborhood. This passage you have not yet seen. Although we are not in a position to say whether or not you will be benefited, we are sure that you will be benefited. It is possible that you will be benefited in a matter of this kind.

The UNITED WELFARE ASSOCIATION, composed of representatives from the organizations mentioned below, was organized to secure the amendment of the ordinance which will effectively cancel the benefits of negroes here and to prevent the same. The bill here is, not in any way, and satisfactory operation, and will be in conformity with the provisions of the Missouri Constitution, and will be in conformity with the provisions of the Missouri Constitution, and will be in conformity with the provisions of the Missouri Constitution.

The expenditure of a considerable sum of money will be necessary to succeed in this campaign of this kind, and we write to you because you are vitally interested in this proposed ordinance. It is our conviction that you readily perceive the urgent necessity of immediate and concerted action, and that you are willing to bear your proportion of the expense involved. You and we your description in the movement. We should be glad to have you join the St. Louis Real Estate Exchange, an organization composed of men of established business reputation, who will not be deterred by questions of this kind, and guarantee the proper expenditure.

Your work in the Central District is important, some 10,000 negroes are now living in that district and we would like to have you join the movement. We are sure that you will be benefited by this movement. We are sure that you will be benefited by this movement. We are sure that you will be benefited by this movement.

THIS MOVEMENT IS INDORSED BY THE FOLLOWING ORGANIZATION

- Birch Heights Improvement Association
- Central West Improvement Association
- Chateau-Lindell Improvement Association
- Civic Realty Co.
- Dakota Park Improvement Association
- Forest Park Residents' Association

Propaganda such as the flyer above warning of a "negro invasion" was used by the St. Louis Real Estate Exchange in its successful 1916 effort to pass a racial zoning ordinance in the City of St. Louis. Local reports said more than 70,000 people were expected to vote on that ordinance. Saloons were closed on voting day to encourage turnout at the polls.



St. Louis Post-Dispatch



Jason Purnell

Ethel Shelley reading the news of the 1948 decision. The Shelley home at 4600 Labadie is now a national historic landmark.

By the 1940s, nearly 380 neighborhood deed covenants were in place in the City of St. Louis, affecting hundreds of residential properties within each of them.⁴ As we will explore further in Chapter 3, these deed covenants spread to St. Louis County as well, where a large number of new housing developments in rapidly incorporating suburban municipalities made them comparatively easy to establish. Gordon estimates that over 80% of new suburban housing developed in the 1940s contained such agreements, with one observer noting: “Carefully drawn deed restrictions . . . preventing the sale of lots to any person not a member of the Caucasian race are found in practically all deed restrictions for residential subdivisions [in St. Louis County].”^{4(p. 73)}

Racially restrictive deed covenants in St. Louis would lead to the landmark 1948 U.S. Supreme Court decision, *Shelley v. Kraemer*, which prohibited the enforcement of a racial covenant at 4600 Labadie Avenue.

The case was brought by an NAACP legal team that included Thurgood Marshall, who would later argue *Brown v. Board of Education* and serve as the first African American justice on the U.S. Supreme Court. The plaintiffs were J.D. and Ethel Shelley, an African American couple who had purchased a tidy two-story brick home on Labadie, a street in North St. Louis with 39 homes, all occupied by whites.²⁸ The

Shelleys purchased the home from a seller who agreed not to enforce the racial covenant that forbade the sale to “people not wholly of the Caucasian race.”²⁹

The sale was challenged in municipal court by the Marcus Avenue Improvement Association, a local homeowner’s group. Though the local circuit court backed the sale, it was later reversed by the Supreme Court of Missouri, leading to the high court hearing the case. As an indication of just how prevalent restrictive covenants were nationwide, three of the Court’s justices likely recused themselves because their own deeds included such provisions.³⁰

The decision in the *Shelley* case prohibited courts from enforcing restrictive covenants, but it did not outlaw these private contracts between homeowners. The federal government would continue to support the use of such covenants for many years following the decision. It was not until *Mayers v. Ridley*, a 1972 federal appellate court ruling under the Fair Housing Act of 1968, that such covenants were considered a violation of federal law and barred from being recorded in deeds as a violation of the Fourteenth Amendment.³⁰ Other tools of segregation beyond restrictive covenants would enjoy the protection of the federal government as well.

Redlining: Mapping African Americans out of home mortgages and equity

In 1933 the Home Owners' Loan Corporation (HOLC) was established as part of President Franklin D. Roosevelt's New Deal package of reforms. Its creation was in response to the destabilizing effects of the Great Depression on the housing market. The HOLC restructured existing mortgages for homeowners in danger of foreclosure, extending the length of time to repay home loans, lowering interest rates, and including both interest and principal in monthly payments, or what is called *amortization*.³⁰ Prior to this innovation in financing, most home loans were interest only, with high down payment requirements and terms of only a few years. The HOLC helped middle-class homeowners stay in their homes, and for the first time, build equity as they paid off their home loans. But it did so almost exclusively for whites.³⁰

The HOLC wanted assurance that borrowers would not default on the new loans. It hired local real estate agents throughout the country to assess the condition of housing and the surrounding neighborhoods to determine whether the housing was a good or bad financial risk. It made funds available to the City of St. Louis and St. Louis County to conduct a massive re-survey and re-evaluation of their existing housing stock between 1933 and 1940.⁴

The assessment tool was devised by the same real estate industry professionals who were the architects of racial zoning and restrictive covenants. The result was the creation of “residential security maps” that reflected their perceptions of the strength of real-estate investment in the St. Louis area.³¹

These maps were created for urban areas across the United States. The St. Louis map divided the City of St. Louis and St. Louis County into four subsets labeled “A” through “D.” “A” areas were shaded in green and were designated “best.” Mortgage lenders were encouraged to offer these areas maximum assistance through financial tools like government insured loans. “B” areas, designated as still “desirable,” were shaded blue, and “C” areas, designated as “definitely declining,” were shaded yellow. “D” areas, shown in red, were labeled “hazardous.”

While observing that these surveys “took due note of zoning issues and the age of housing stock,” Gordon illustrates through archived internal documents from the HOLC that racism was the true driver of a hazardous “D” rating:

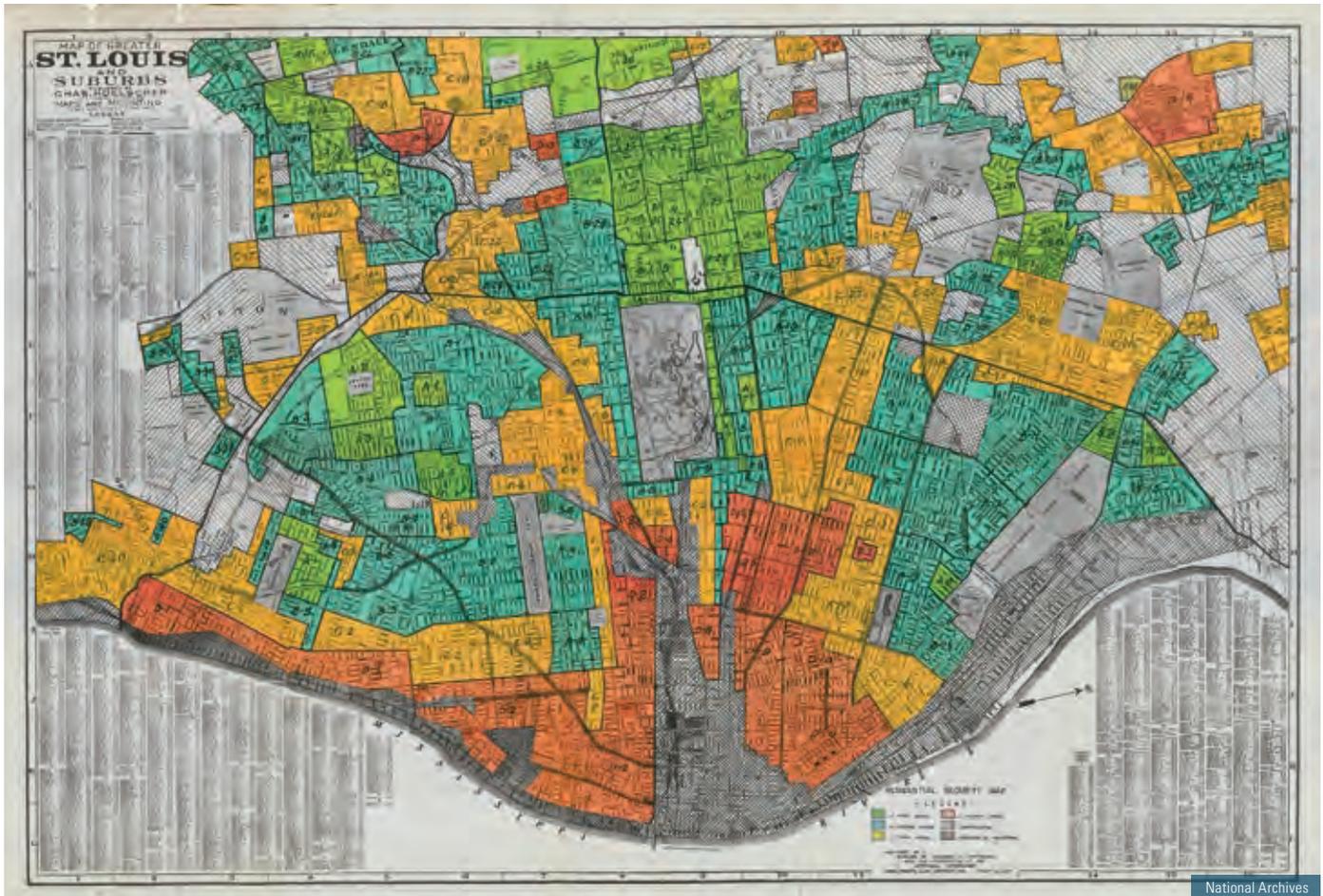
[T]he key to the rating system—was racial occupancy. The standard local area survey form prefaced its narrative description with required entries for local population, the “class and occupation” of residents, the percentage of foreign born and Negro residents, and the degree of “shifting or infiltration.” The most commonly noted unfavorable factors in C areas were “expiring restrictions [deed covenants] or lack of them” and “infiltration of a lower grade population.” D areas were almost invariably marked by “infiltration” or the presence of a “colored settlement” or “Negro colony”—and the summary judgment that “the only hope is for the demolition of these buildings and transition of the area into a business district.”^{4(p. 92)}

In St. Louis the racial motivations of the maps were made explicit. As Richard Rothstein writes in *The Color of Law: A Forgotten History of How Our Government Segregated America*, an appraiser in 1940 noted that suburban Ladue should be colored green, or desirable, because it had “not a single foreigner or negro” whereas the middle class suburban area of Lincoln Terrace was colored red because “it had ‘little or no value today...due to the colored element now controlling the district.’”^{30(p. 64)} However, neighborhood instability was not only defined by the presence of African Americans. In her 1969 book on racial policies and practices in real estate, sociologist Rose Helper detailed a “ranking of races and nationalities with respect to their beneficial effect on land values” that was employed in Chicago. Under the rankings Mexican Americans, southern Italians, Russian Jews, and Greeks were also among a list of least desirable ethnicities because of their alleged effect on housing values.³²

It is from these maps that the term “redlining” is derived.

Substantial areas of cities throughout the nation were divided by actual lines on a map. Outside these areas it was possible to receive home loan assistance. But those within the lines and shaded red received little federal assistance.

Figure 6. 1937 St. Louis Residential Security Map reflects the perceptions of the strength of real estate investment in the St. Louis region, ranked from “best” to “hazardous.”



In the City of St. Louis and St. Louis County, those lines were drawn in ways that would harm generations of African Americans at the most basic levels of housing and economic security.

A year after the creation of the HOLC, the Roosevelt administration formed the Federal Housing Administration (FHA) to help increase homeownership among first-time buyers. These potential buyers were promised very low down payments and amortization, with the federal government insuring their loans. As in the case of the HOLC, the FHA also needed to appraise the value of homes before agreeing to insure the loans. Through the *Underwriting Manual* that would be written for this purpose, the agency mandated segregation as a prerequisite for granting loans. Enforcement of residential segregation became a stated federal policy.³⁰ Rothstein quotes the manual as instructing banks to lend in areas that would aid in the “prevention of the infiltration of...lower class occupancy, and inharmonious racial groups.”³⁰

A Best
Areas that mortgage lenders were encouraged to offer maximum financial assistance

B Desirable
Desirable neighborhoods yet older homes expected to maintain stability

C Declining
Marked by “infiltration of a lower grade population”

D Hazardous
Marked by “infiltration” or the presence of a “colored settlement” or “Negro colony”

Redlining then and now

The Fair Housing Act of 1968 outlawed redlining. But the practice created persistently poor and segregated neighborhoods in St. Louis. Table 2 shows that redlined neighborhoods deemed “hazardous” more than 70 years ago remain inhabited by low-to-moderate income residents. Table 3 illustrates that those same formerly redlined neighborhoods have a high percentage of residents from racial and ethnic minority groups.

Table 2.

GRADES/INCOME	Low-to-moderate income	Middle-to-upper income
A - Best	12.16%	87.84%
B - Desirable	57.35%	42.65%
C - Declining	75.46%	24.54%
D - Hazardous	89.59%	10.41%

Source: Richardson J, Mitchell B, West N. (2016) Home Mortgage Lending in St. Louis, Milwaukee, Minneapolis, and Surrounding Areas. National Community Reinvestment Coalition.

Table 3.

GRADES/INCOME	Minority	White
A - Best	14.17%	85.83%
B - Desirable	50.26%	49.74%
C - Declining	58.04%	41.96%
D - Hazardous	68.84%	31.16%

Source: Richardson J, Mitchell B, West N. (2016) Home Mortgage Lending in St. Louis, Milwaukee, Minneapolis, and Surrounding Areas. National Community Reinvestment Coalition.

African Americans were thwarted at nearly every turn when it came to finding a place to live. Of the approximately 70,000 housing units built in the City of St. Louis and St. Louis County from 1947 to 1952, fewer than 35, or .05%, were available to African Americans because of FHA policy, restrictive covenants, or the policies and practices of the real estate industry.³⁰

Redlining hampered African Americans not just by limiting housing choice, but perhaps more importantly, by preventing them from building wealth through home equity.³⁰ In the absence of these lower interest mortgages, African Americans who did purchase property were often subject to higher,

predatory terms and interest rates. And the lack of a strong ownership stake in communities made it difficult to attract or retain people, businesses, and development, leading to significant disinvestment.

Redlining and the segregationist policies of the FHA endured throughout the 1960s. Between 1962 and 1967 only 3.3% of the 400,000 St. Louis area mortgages backed by the FHA went to African American borrowers.³³ In St. Louis County, the percentage of mortgages issued to African Americans in that time period was below 1%.⁴

The Fair Housing Act of 1968 outlawed redlining. But the practice caused enduring economic hardship to residents in neighborhoods, particularly in neighborhoods that had been designated “hazardous” in St. Louis. Tables 2 and 3 are drawn from an analysis of the long-term impact of redlining in St. Louis collected by the National Community Reinvestment Coalition.³⁴ Table 2 shows neighborhoods redlined more than 70 years ago remain inhabited by low-to-moderate income residents today. Table 3 illustrates that those same formerly redlined neighborhoods have a high percentage of residents from racial and ethnic minority groups. Disinvestment caused by redlining in St. Louis essentially created persistently poor neighborhoods that continue to be segregated and primarily inhabited by African Americans with low-incomes. In Chapter 3 we will discuss how the legacy of redlining has impacted present-day home lending.

Access to Housing



Of the approximate
70,000
housing units from
1947 to 1952

.05% were
available
to African Americans

Source: Rothstein R. (2017). *The Color of Law: A Forgotten History of How Our Government Segregated America*.



St. Louis Post-Dispatch



Missouri History Museum



St. Louis Post-Dispatch



St. Louis Post-Dispatch

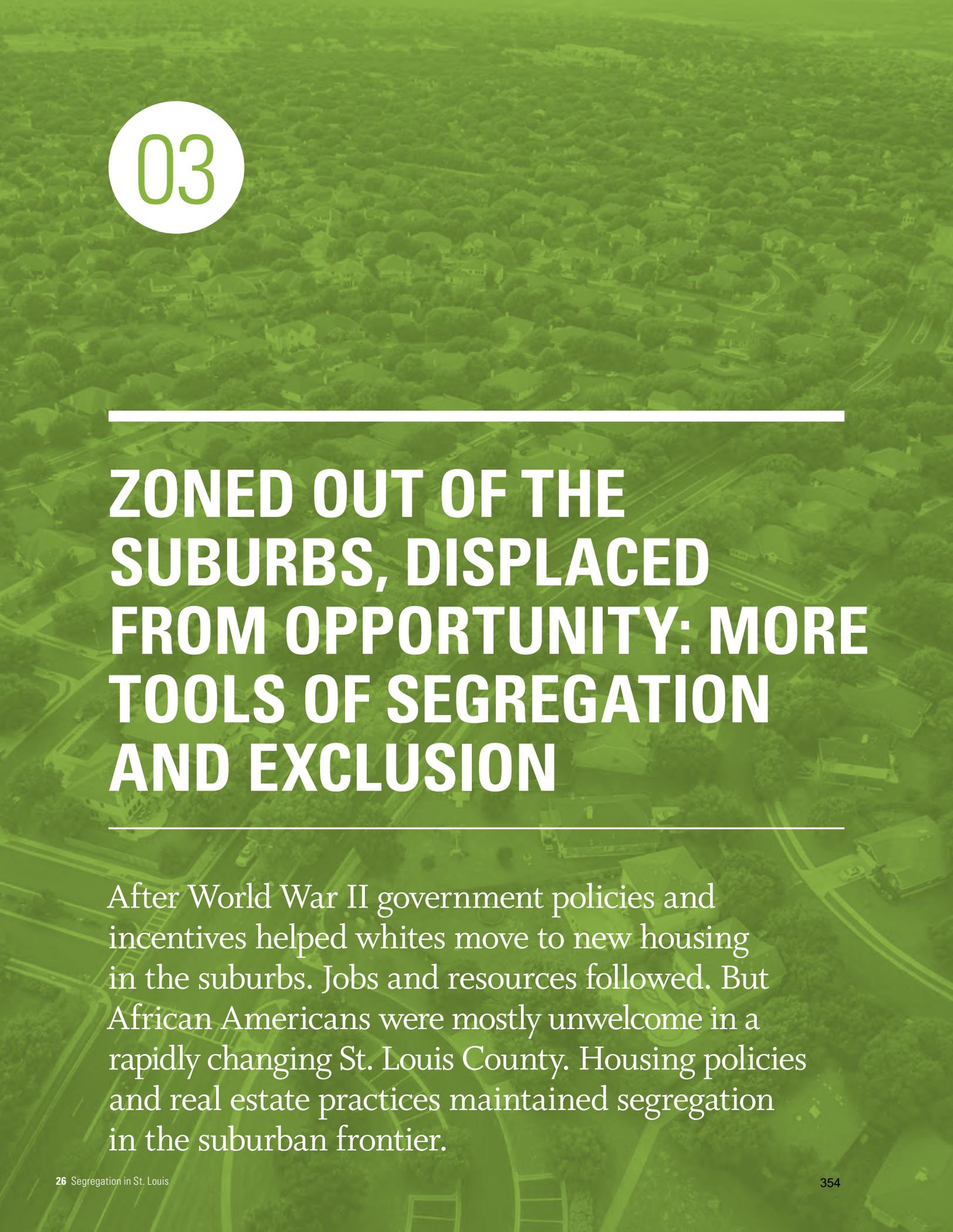
Once redlining was outlawed, actors in government and the housing industry turned to subtler methods to preserve residential segregation. We explore more tools of segregation in the next two chapters examining the growth of suburbia, exclusionary zoning practices, racially motivated federal financing programs, real estate steering, and various types of development and financing strategies in the St. Louis region.

Conclusion

The Great Migration brought an increasing number of African Americans to St. Louis through World War II. They encountered numerous housing policies and practices that excluded them from resources and economic opportunity. These included racial zoning, restrictive covenants, and redlining.

Final Thoughts

Many early segregation policies and practices were struck down by legal decisions and reforms, including the landmark *Shelley v. Kraemer* Supreme Court case originating in St. Louis. But segregation continued to characterize the regional residential landscape. As we will see in Chapter 3, post-World War II policies and practices created further housing barriers for African Americans in a period when working, middle-class whites prospered through new home ownership in the suburbs.

An aerial photograph of a suburban neighborhood, showing rows of houses, streets, and trees, all overlaid with a semi-transparent green filter. In the top left corner, there is a white circle containing the number '03'.

03

ZONED OUT OF THE SUBURBS, DISPLACED FROM OPPORTUNITY: MORE TOOLS OF SEGREGATION AND EXCLUSION

After World War II government policies and incentives helped whites move to new housing in the suburbs. Jobs and resources followed. But African Americans were mostly unwelcome in a rapidly changing St. Louis County. Housing policies and real estate practices maintained segregation in the suburban frontier.

The move to greener suburbs

By the middle of the 20th century another significant migration was underway, but it was very different from the Great Migration of African Americans to cities like St. Louis described in Chapter 2.

Starting in the late 1940s white city residents throughout the United States moved by the thousands from urban centers to newer, greener suburbs.

This massive movement was a difficult challenge for advocates hoping to improve housing and opportunity for African Americans. Instead of one political entity (i.e., the City), reformers in the St. Louis area were dealing with dozens of municipal governments, all expanding independently and competing for resources and residents.

Most suburban municipalities moved quickly to enforce racial segregation, using tools both old and new to accomplish this goal.

Chief among them was the practice of exclusionary zoning, or the establishment of policies that determine the use of land within municipal boundaries that have the effect of excluding particular groups of people from residing there. The new zoning mandates, with their emphasis on large-lot, single-family homes, were adopted within a decentralized

group of independent cities. Efforts by so many different municipalities and subdivisions were increasingly difficult to control in the way that fair housing advocates were able to legally challenge discriminatory practices in the City of St. Louis. Exclusionary zoning policies were an effective means of excluding the poor and African Americans from living in or near suburban towns—and as we will explore in later chapters, their effect remains potent even today for those with low-to-moderate incomes.

A growing, fragmented metropolis

Following World War II American suburbs grew rapidly in size and power, and their growth was fueled by federal and state policies. The suburban boom was facilitated by massive federal road and highway construction projects; federal and state housing subsidies such as low-interest mortgages primarily for whites through the FHA and the Veterans Administration (VA); new and efficient construction techniques; and ample cheap and developable farmland.³¹⁻³⁵

The City of St. Louis reached its peak population in 1950, and then declined at nearly the same rate that St. Louis County soared in population for decades thereafter.

Figure 7a. St. Louis County: Municipality by incorporation date.

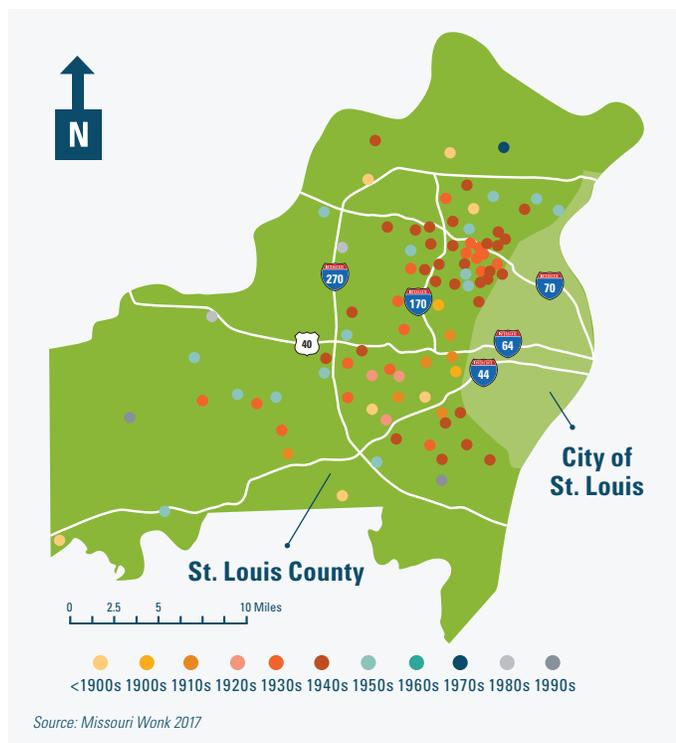
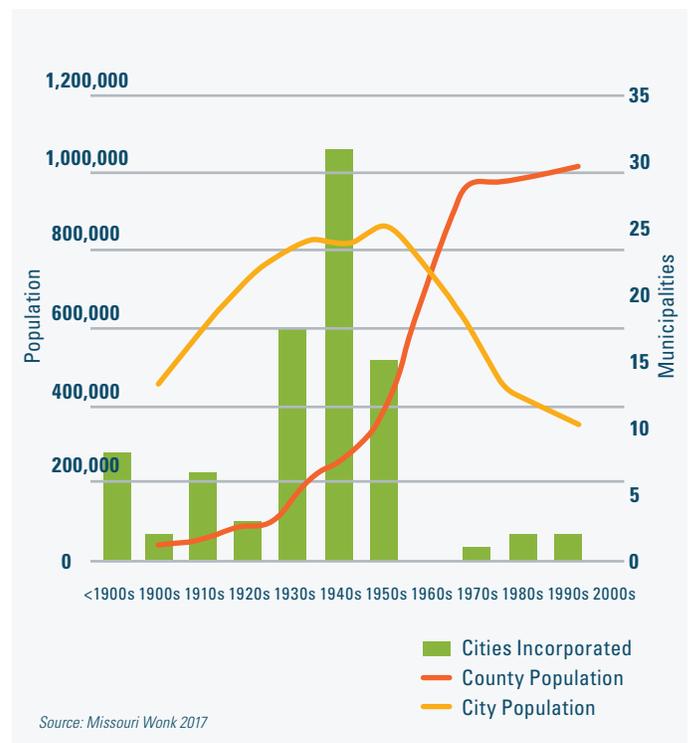


Figure 7b. St. Louis: Population and municipal incorporation by decade.



Before 1900 there were just six incorporated cities in St. Louis County. By 1940 that number grew to 35. By 1960 there were 95, each operating with independent authority over zoning and land use.

In the City of St. Louis and a few of the region's older, inner-ring suburbs such as University City, significant development had taken place prior to this intense suburban growth. These municipalities already featured a mix of residential property types, including single-family, duplex, and multi-family homes as well as retail and commercial infrastructure providing merchandise, services, and jobs. When zoning was employed in all of these established

cities, it took the form of so-called "descriptive zoning," where the zoning simply mirrored existing uses of land.

But further north, south, and west, in rapidly growing St. Louis County, large tracts of developable farmland presented a blank slate to dozens of newly-incorporating cities. The power to shape land use "from the ground up" gave city planners the tools needed to control the types of homes allowed, and by extension, the types of people allowed to live there. Each city, acting in its own self-interest, created land use policies that maximized potential property tax revenues and minimized infrastructure demands.

Figure 8. The evolution of St. Louis housing.



Multi-use



Multi-family



High-density single-family lots



Large single-family lot

As whites left the urban core, their housing changed through specific development tools and policies. Mixed-use neighborhoods with retail, apartments, and individual homes were staples of urban housing in the first part of the 20th century. Lower-income whites and African Americans were later encouraged to move into segregated affordable housing complexes, particularly as areas of the city were blighted and subsequently displaced African Americans. Middle class whites began buying detached homes in the city. After World War II, large-lot zoning coupled with low-interest mortgages not available to African Americans fueled the construction of larger, single-family homes that were unaffordable and inaccessible to low-income homebuyers and most African Americans.

The suburbs became places of power and resources that were purposefully insulated from the poor and racial and ethnic minority groups.

Source: Fishman R. *Bourgeois Utopias: Visions of Suburbia*. In: Fainstein S, Campbell S. (eds). *Readings in Urban Theory*. Oxford, Blackwell Publishing; 1996: 23-60.

These objectives were most easily met by mandating large-lot, owner occupied single-family residences. The prevailing logic was that other nearby cities or the City of St. Louis would provide the infrastructure and services. Gordon in *Mapping Decline* notes that:

“... none of these governments had any incentive to think about broader metropolitan goals or needs regarding commercial development, affordable housing, or regional infrastructure. Fragmented zoning, in this respect, came most directly at the expense of the City of St. Louis, which shouldered many of the costs of urban development even as the suburbs poached its population, retail trade, and employment base. But it also came at the expense of the suburbs themselves. All local governments bore the costs of administrative disarray and unmanaged sprawl. Suburbs engaged in often destructive competition to attract (or avoid) new residential or commercial development. And, over time, newer subdivisions and incorporations to the west were poaching not just the City but the older inner-ring suburbs as well.”⁴(p.129)

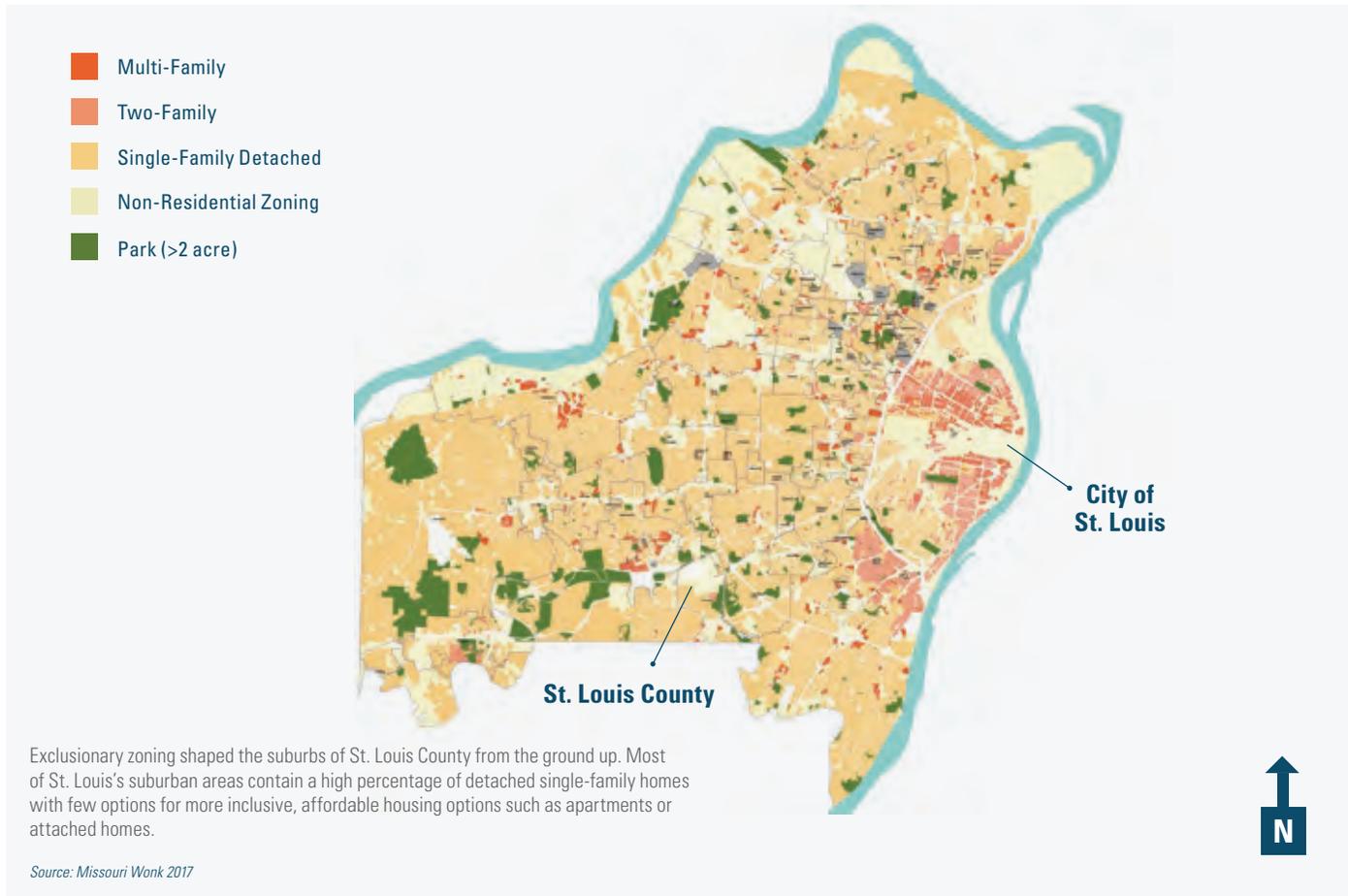
These suburbs had created, in the words of planning historian Robert Fishman, a “bourgeois utopia.” The suburbs became places of power and resources that were purposefully insulated from the poor and racial and ethnic minority groups.³⁶



The rift between the City of St. Louis and St. Louis County was clear in 1971 as the suburbs justified hoarding resources despite the economic drain on the City.

Source: St. Louis Post-Dispatch, July 23, 1971

Figure 9. City of St. Louis and St. Louis County parcels zoned for single-family housing.



The legacy of exclusionary zoning in St. Louis County can be seen today in Figure 9. The map created by researchers with Missouri Wonk provides a unique parcel-by-parcel look at zoning classifications for single-family, two-family, and multi-family housing in both the City of St. Louis and St. Louis County.

Missouri Wonk surveyed nearly all of the region's existing zoning requirements and calculated "county equivalent zoning," a novel tool that enabled them to standardize hundreds of different zoning classifications and lot size requirements present in the dozens of municipalities in our region.

Note the relatively few areas of suburban St. Louis County that contain land parcels zoned for potentially more affordable multi-family homes. Note as well the large swaths of far western St. Louis County that are almost exclusively zoned for detached single-family homes.

Indeed, during their survey of zoning ordinances, Missouri Wonk found the cities of Ladue and Grantwood Village

banned multi-family housing outright. Another 48 cities lacked specific zoning classifications for multi-unit housing. Developers seeking to build multi-family housing in cities without dedicated zoning must typically secure a zoning variance that can require formal hearings and resident input. The process does allow for the creation of multi-family housing, but it can make it extremely difficult for developers to secure the municipal approval they need to build apartments, condominiums, and other forms of higher density, affordable housing.

Of the city and county's approximately 614,000 housing units,³⁷ Missouri Wonk found 25.9% of them exist in some form of multi-family housing. However, the concentrations of that type of housing vary widely throughout our region. The distribution of multi-family housing across the region is uneven, with the vast majority of municipalities (73 of 92) having a smaller proportion of multi-family housing relative to all housing within their borders than the regional average. In other words, a relatively small number of municipalities have a disproportionate share of multi-family units.

Rise of zoning in St. Louis

As mentioned in Chapter 2 the concept of zoning was initially created in the early 1900s to protect and separate residential areas from “nuisance” industries such as junkyards, tanneries, and polluting factories. Courts at the time consistently held that this tool could not be used to protect property values or to preserve neighborhood characteristics.³⁸ The courts repeatedly ruled local zoning ordinances could only be enacted if they had “a real and substantial relation” to public health, safety, or welfare.³⁹

But as the suburbs rose in prominence and population, municipalities sought autonomy in dictating land use. They exerted pressure to expand definitions of nuisance and to create their own specific zoning classifications.⁴⁰ The newly incorporated municipalities had every incentive to exclude the poor and to prohibit types of development that might attract them.

And yet, their large-lot residential zoning left them highly dependent on property taxes and without other forms of tax revenue. This, in turn, gave them further incentive to keep out the poor who might cost municipalities more in terms of developing transportation, affordable housing, and other infrastructure. Meanwhile, poor and racial and ethnic minority families were left stranded in a struggling central city “where they compete in stagnating markets for jobs and housing,” Paul King noted in a 1978 review of judicial decisions on exclusionary zoning in the United States.⁴¹ King explained the stark economic rationale behind this tool:

“The suburbs have tried to avoid these urban problems, for which they are partly responsible, by instituting measures to prevent tax-draining activities from following those that pay their way. These measures attempt to exclude all land uses that do not generate more in real property tax revenues than they consume in expenditures for public services.”^{41(p. 459)}

Exclusionary zoning in the suburbs not only mirrored long-established policies that contributed to racial segregation in the City of St. Louis; it also nearly eliminated the possibility of African American homeownership in many of these emerging suburban cities. Later in this chapter we will explore other systemic factors that made it difficult for African Americans of any economic background to buy or rent housing during the early rise of the suburbs through the 1960s.

Exclusionary zoning shaped the housing landscape upon which all other segregation policies were built.



As early as 1952 planners realized that St. Louis’s suburbs were developing in a disjointed and illogical fashion, with each new city competing for resources to support their own essential services such as police and fire protection. This cover illustration of a report released more than 65 years ago by the St. Louis County Planning Commission hints at the fragmentation that continues to hinder our region and contributes to our long history of housing segregation.

Source: St. Louis County Planning Commission. (1952) *Let's Get Together: A Report on the Advantages of an Integrated Community*

Reformers referred to the circumstances in the suburbs as a “steel ring” surrounding the city proper, conspiring to “contain” the African American population of the region.⁴¹

George Romney, who served as the secretary of the U.S. Department of Housing and Urban Development in the Nixon administration, referred to forming suburbs as a “white noose” around African Americans living in cities.³⁰

This obviously did not go unnoticed by leaders in the Civil Rights Movement. In an official publication, the NAACP called the suburbs “the new civil rights battleground,” and urged reformers “to do battle out in the townships and villages to lower zoning barriers and thereby create new opportunities for Negroes seeking housing closer to today’s jobs, at prices they can afford to pay...”^{42(p. 305)}



Black Jack, MO A racially-tinged example of exclusionary zoning

In St. Louis County, the incorporation of some townships was precipitated by developers' plans to site multi-family apartments in areas that were then unincorporated. One notable and well-documented example is the "Park View Heights" plan from 1969, in which two regional Methodist churches co-sponsored a plan for the development of moderate-income apartments near the Black Jack subdivision in what was at the time unincorporated St. Louis County. The site chosen was undeveloped and was zoned by St. Louis County as R-6 (suitable for multi-family).

Public response by many nearby white residents was swift and negative. One contemporary account said organized opposition was "repeatedly expressed in racial terms... by leaders of the incorporation movement, by individuals circulating petitions, and by [the] zoning commissioners themselves." In his scholarship, Colin Gordon also cites an appeals court judgement observing that "racial criticism of [the proposed multi-family apartment] was made and cheered at public meetings."

It was in this environment that the current municipality of Black Jack was hastily incorporated, even while St. Louis County's Department of Planning voiced "[strong opposition] to the act of incorporation on fiscal, planning, and legal grounds."¹¹ Though challenged unsuccessfully in the courts, Black Jack immediately enacted ordinances to zone all residential parcels as single-family.



Paul Sableman



St. Louis Post-Dispatch

Source: Gordon C. (2008). *Mapping the Decline: St. Louis and the Fate of the American City*.

Exclusionary zoning and the forms it often takes

While all zoning seeks to exclude certain types of land use, civil rights activists began to present the case that the dominant pattern of the region's suburban zoning policy intentionally excluded African Americans and poor urban families.

In 1968, the National Commission on Urban Problems presented a report to Congress that identified three powerful exclusionary tools available to incorporated municipalities: exclusion of multi-family housing, "large lot" zoning, and prohibition of mobile or manufactured homes.⁴³

King's study of exclusionary zoning notes that each of these exclusions has "the general effect of. . . increase[ing] the cost of development and consequently the price of housing," and that "[e]xclusionary practices, particularly zoning, constitute one of the major factors responsible for limiting the dispersal of low- and moderate-income families into suburban areas."^{41(p. 459)}

Multi-family prohibition

Most of the wealthiest cities in St. Louis County have little, if any, affordable, multi-family housing, making it nearly impossible for lower-income families to find housing within their city limits. That is not by accident. Local leaders in many emerging suburban cities prohibited or strictly controlled the development of more affordable multi-family structures such as apartments, condominiums, or duplexes.⁴

Archived zoning and municipal documents illustrate the negative local attitudes toward developing multi-family housing:

Ferguson

A Ferguson city planner wrote in 1932, “No apartment buildings are now found within the city. This [proposed zoning ordinance] affords an excellent opportunity for controlling this type of housing.”^{44(p. 137)}

Richmond Heights

A 1941 ordinance for the City of Richmond Heights expressed the “intention of maintaining. . . an exclusive subdivision of single-family residences of substantial value.”^{44(p. 136)}

Ladue

A contracted Ladue city planner noted that “one of the major objectives of our proposed zoning ordinance is to protect and continue the spacious residential character now found within the city.”^{44(p. 137)}

Brentwood

Meeting minutes of the City of Brentwood’s zoning committee show it refusing the request of a developer for a variance for multi-family housing because, “the city is now occupied by single-family homes and every effort should be made to preserve this character.”^{44(p. 137)}

Note in Figure 10, two St. Louis County cities ban multi-family zoning outright. Only half, or 46 out of 92 surveyed municipalities, have zoning classifications for multi-family housing. However, as shown previously in Figure 9, St. Louis County overall has very few tracts of land zoned for multi-family housing. Even if a municipality has zoning classifications for multi-family housing, it doesn’t guarantee such housing will ever be developed. And the presence of multi-family housing does not always translate into affordability.

Figure 10. Municipalities and multi-family zoning in St. Louis County.

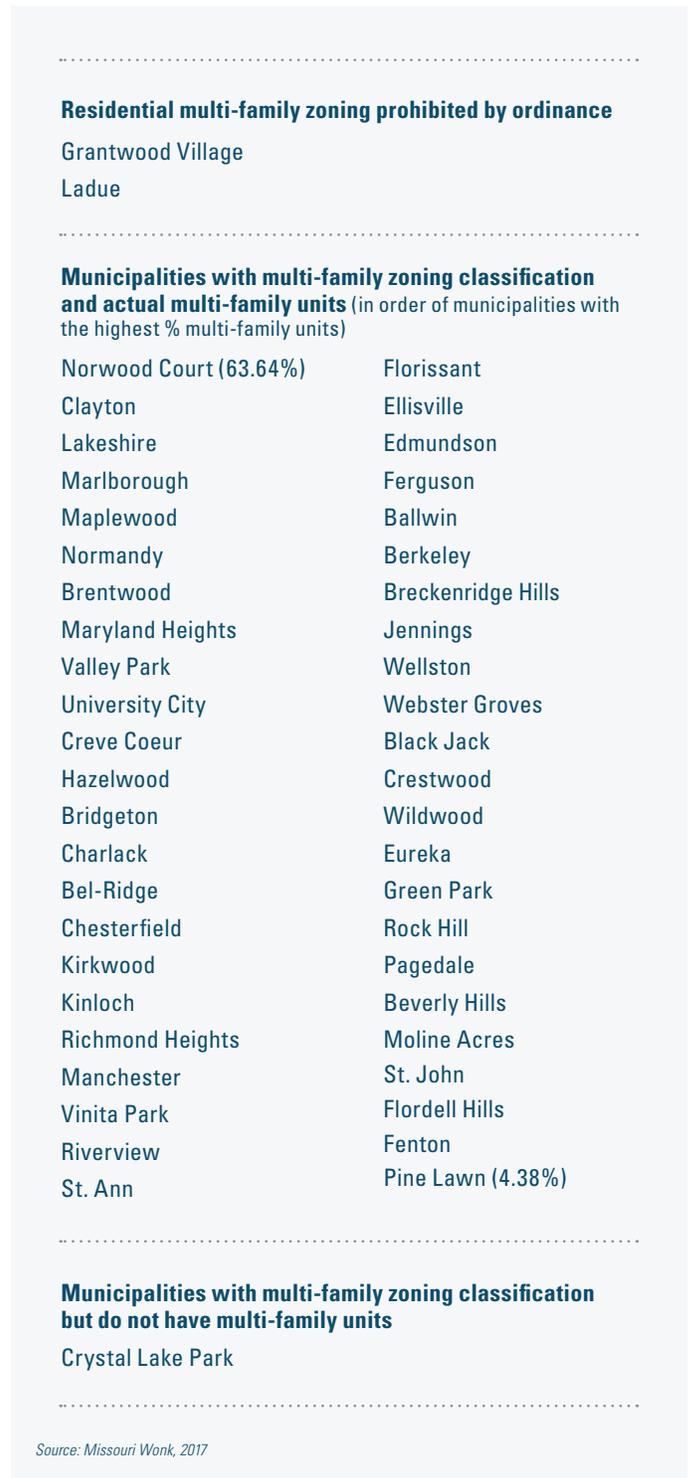
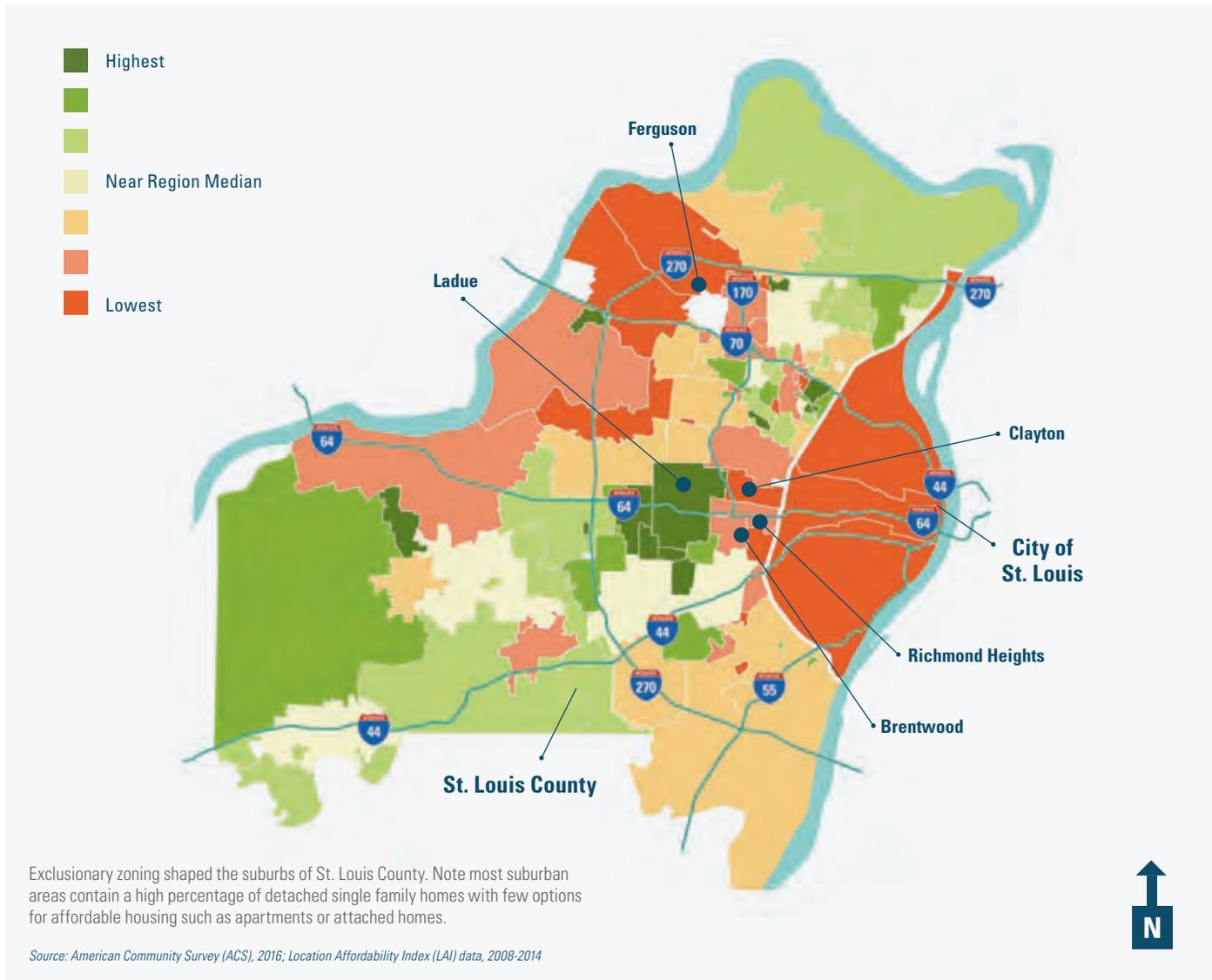


Figure 11. Percent detached single-family homes as of 2017.

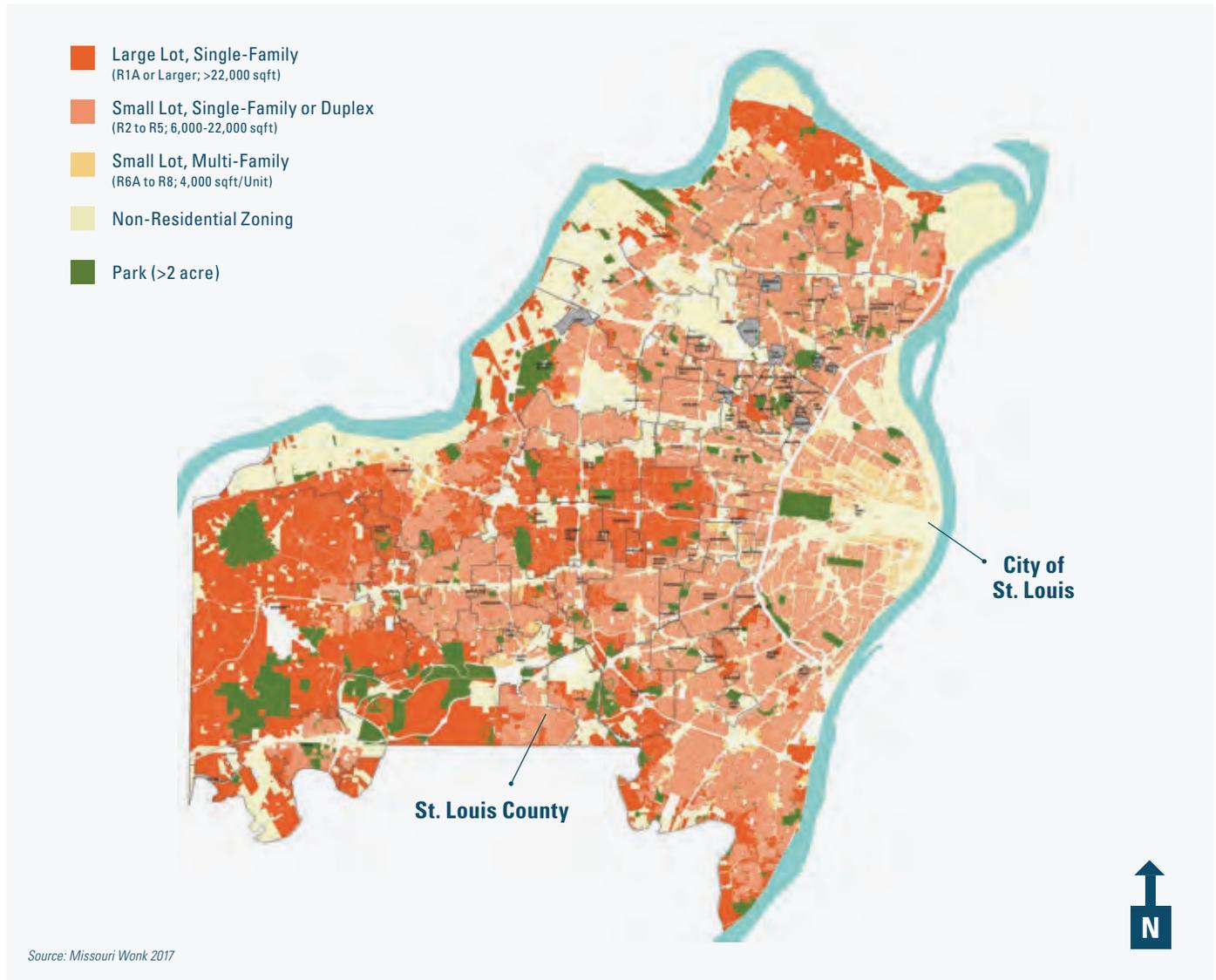


Large lot zoning

Emerging suburban cities also pushed to increase average lot sizes in their communities, a zoning policy that substantially inflated housing prices. A recent study of 274 subdivisions in mid-century St. Louis County found that less than 10% of lots were smaller than 5,000 square feet, the most common lot size standard in older, inner-ring suburbs.⁴ Ladue standardized lot sizes to require different parcels throughout the city to be a minimum of 30,000, 78,000, or 130,000 square feet. Only a handful of lots were allowed to be smaller at 15,000 and 10,000 square feet. None were zoned for multi-family residences.⁴

Incorporating municipalities with tracts of undeveloped land often created obstacles for multi-use residential zoning from the very start with a strategy called “wait-and-see” zoning. All unused land was automatically zoned for the “highest use” category, the most restrictive zoning classification. Any proposals seeking “lower uses,” such as multi-family housing or more densely populated single-family homes, would require strict review and formal action by the governing body to change the zoning.

Figure 12. County equivalent zoning in the City of St. Louis and St. Louis County.



Prominent urban planner Harland Bartholomew—a man who gained notoriety for his now controversial use of eminent domain in urban renewal projects such as the construction of the Gateway Arch—also championed larger housing lots. In 1941 he advised suburban Kirkwood on its zoning ordinances and urged the city to increase minimum lot sizes in several residential zoning classifications.⁴⁵ He noted that “the most important function of the zoning ordinance is to give [single-family, owner-occupied homes] the most protection possible and to encourage its further development in areas now vacant.”⁴⁶(p. 136)

Figure 12 illustrates another of the present-day manifestations of decades of exclusionary zoning practices in St. Louis County. The same standardized zoning classification used for type of dwellings in Figure 9 was also used to examine minimum lot sizes region-wide. The darkest red areas, found particularly in the western and central parts of St. Louis County, indicate places where housing lots are more than 22,000 square feet, roughly a half-acre in size. Areas with smaller lots dedicated to multi-family housing are shaded yellow. There are very few areas of St. Louis County with smaller lots zoned for more affordable, multi-family housing.

Restrictive covenants in the suburbs: Backed by the government

Exclusionary zoning in the suburbs wasn't just perpetuated by suburban elected leaders and the planners. It was also incentivized by the FHA in its underwriting of loans to suburban developers. Underwriting is the process of review that borrowers, properties, or projects undergo prior to the approval of a loan. In Chapter 2 we discussed how the Great Depression and later a housing shortage after World War II, led the FHA to underwrite new mortgages mainly for working-class, middle-class white buyers, but very few African American buyers.

Around the same time the agency also began backing low-interest loans to developers of suburban homes. Again, the federal underwriting of construction loans carried racial restrictions. In the 1930s and 1940s the FHA's underwriting manual warned against backing loans for housing projects for "inharmonious racial groups" and conversely promoted occupation "by the same social and racial classes."⁴⁶

Developers of whites-only subdivisions were vastly favored for construction loans to build single family, large-lot homes. Even though enforcement of restrictive deed covenants through the courts had been outlawed, post-war suburban developers often included discriminatory language in homeowner association policies prohibiting sales to African American buyers with the encouragement of the FHA.³⁹

Advertising in the 1950s for new suburban subdivisions in St. Louis frequently carried the labels "FHA Financed" or "FHA Approved," a sanitized term that essentially meant "whites only" housing.³⁰



"Mismatch of where the jobs were, and where the people needing these jobs were forced to live. . ."



Dr. Robert Fishman

In his interview for the film "The Pruitt-Igoe Myth: An Urban History" (2012) professor of urban planning, Robert Fishman, contrasts the experiences of African Americans in mid-century St. Louis with the concentrated ethnic communities of earlier years and points out the stark economic reality that faced African Americans in a segregated region:

The urban economy in 1949 appeared very strong. Not only were the populations of big cities peaking, but also their industrialization. So that it appeared that all you had to do was solve the housing problem, and there would be plenty of jobs within every big city. What nobody could see was that this was the peak period, and that the urban industrial economy was about to really fall off a cliff.

The American city has been, in the past, a wonderful mechanism for assimilation of immigrant and migrant groups. What happened after 1945 was that wonderful mechanism of opportunity began to fail. This economy still flourished, but it flourished outside the city, and as a result you had a mismatch between where the jobs were, and where the people who needed the jobs were living, or were forced to live. In the days of say the Italian and Jewish ghettos, these ghettos were close to those critical entry-level industrial jobs. The black ghetto, for the first time, was very far from where jobs were moving. They moved to the city as the black migrants did, and instead of finding themselves in the midst of this wonderful expanding urban economy they found themselves in the midst of an economy that was dying.

Source: *The Pruitt-Igoe Myth*. St. Louis: Unicorn Stencil LLC, 2011.

Qualified buyers in St. Louis

80,000 African Americans had sufficient incomes to purchase homes during the suburban housing boom

Source: Sexauer CF. *Catholic Capitalism: Charles Vatterott, Civil Rights, and Suburbanization in St. Louis and the Nation, 1919-1971*. Ph.D. Dissertation, Department of History, University of Cincinnati. May 6, 2002:219-220. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.

National access to FHA Loans for African Americans

2% of homes insured by the FHA since 1946 have been available to African Americans



Most of them were developed in the South for segregated African American housing

Source: U. S. Commission on Civil Rights. *Hearing before the United States Commission on Civil Rights: 1959*. Washington D.C.: U.S. Government Printing Office. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.

Though the FHA would eventually soften the wording of its underwriting policies for developers, discrimination continued in its loan insurance programs well into the 1960s.⁵

These policies essentially kept thousands of African Americans with resources to buy homes out of the suburban housing marketplace.

An FHA survey conducted in St. Louis in 1953 estimated that 80,000 African Americans had sufficient incomes to purchase homes during the suburban housing boom.⁴⁷ And yet, a 1959 national study found only 2% of homes insured by the FHA since 1946 had been available to blacks, and most of them were developed in the South for segregated African American housing.⁴⁸

The Fair Housing Act: New rights and protections

The Civil Rights Movement increased housing opportunities for African Americans and ushered in new rights and protections, including the prohibition of discriminatory real estate agent and landlord practices through the Fair Housing Act of 1968. Final passage of the landmark legislation was propelled by the unrest in dozens of cities across the country following the assassination of Dr. Martin Luther King, Jr. in April of that year.

However, the whites-only developments of earlier decades and other significant roadblocks continued to make it difficult for African Americans to purchase suburban housing even after the Fair Housing Act went into effect.

In 1970 Larman Williams, then an assistant principal in the former Kinloch School District, testified before the U.S. Commission on Civil Rights about his difficulties purchasing a home in Ferguson because he was African American.⁴⁹

“I called. And I called. And I called. And I called, and I got no return,” Williams said of his efforts to contact a real estate agent. “They could tell by my voice, I guess.”⁴⁹

The year 1968 saw Williams’ frustrated initial attempts at purchasing a home (he would later prevail), but it was also the year that another important Supreme Court decision on housing that originated in St. Louis was handed down. In 1965 Joseph Lee Jones and Barbara Jo Jones were barred from buying a home in a North St. Louis County subdivision near Florissant called Paddock Woods because of a builder’s covenant forbidding the sale of homes to African Americans. The interracial couple won the high court case, *Jones v. Alfred H. Mayer Co.*, about a month after the Fair Housing Act was passed. The Court held that Congress could regulate the sale of property to prevent racial discrimination.⁴



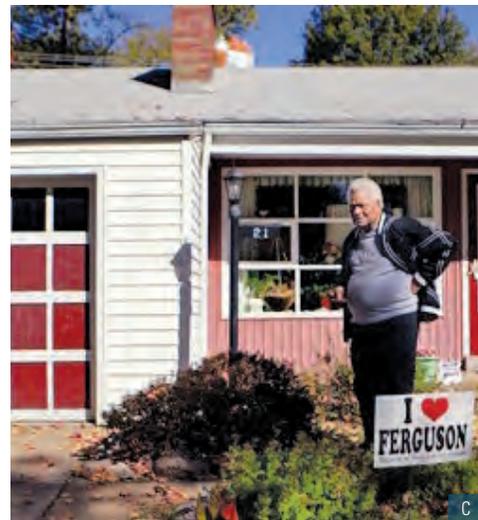
St. Louis housing reform

St. Louis continued to play a role in the national discussion around fair housing in the 1960s.

A. The Fair Housing Act was enacted in 1968 under U.S. President Lyndon B. Johnson. The law remains difficult to enforce without ongoing legal challenges.
Source: Wiki Commons

B. Joseph Lee Jones and Barbara Jo Jones were the successful plaintiffs in a federal Supreme Court Case alleging racial discrimination after the couple was denied purchasing a new house in North St. Louis County.
Source: St. Louis Post-Dispatch

C. Larman Williams, one of Ferguson's first African American homeowners, testified before a U.S. Commission on Civil Rights in 1970 on his difficulty buying the house (pictured) on an all-white street in 1968.
Source: Huy Mach, St. Louis Post-Dispatch



“We never sell to colored.”

Source: Gordon C. Mapping Decline: St. Louis and the Fate of the American City. Philadelphia, PA: University of Pennsylvania Press; 2008.

Racial steering

By the late 1960s, many of the entrenched legal protections encouraging residential segregation were challenged or overturned by legislation and litigation. But most professional real estate agents continued to selectively show homes or “steer” African American clients to just a handful of city neighborhoods or specific inner-ring St. Louis County suburbs.

Steering was further incentivized, ironically, under new legislation intended to help lower-income families purchase homes. After it was enacted in 1968, the Fair Housing Act established a new housing subsidy program referred to as “Section 235.”

Section 235 provided federal mortgage subsidy payments to lenders to assist low-income families unable to meet the credit requirements previously mandated by the FHA’s mortgage insurance programs.

Despite the program’s intentions, its effect was to preserve, and sometimes accelerate, patterns of racial segregation in the City of St. Louis and St. Louis County. The subsidies were passed through existing discriminatory private real estate institutions that continued to steer buyers into segregated neighborhoods.⁴

Section 235 was supposed to provide counseling programs for low-income buyers, but the programs went unfunded until the early 1970s.⁴ African American buyers were routinely shown and sold homes in neighborhoods in which they already lived, including the north side of St. Louis and the inner-ring suburbs of Pagedale, Normandy, and northern University City.

At the same time white buyers, some living in increasingly integrated neighborhoods, were steered by real estate agents to move to segregated, white suburban neighborhoods.

“We never sell to colored,” boasted one realtor in 1969. “When they ask for a specific house, we tell them there is already a contract on that house.”^{4(p. 87)}



In the early 1990s, officials in University City acknowledged that it was “common practice for real estate agents to steer blacks into neighborhoods north of Olive Street Road and west from Sutter Avenue to the Olivette city limits.”^{4(p. 8)}

Source: *St. Louis Post-Dispatch*, June 20, 1991

One black real estate agent noted the situation “seemed little more than a shell game moving people ‘from one substandard home to another’ so that realtors could collect a commission.”^{4(p. 104)}

A Civil Rights Commission investigation found recipients of the subsidies were “sorted by race” and frequently shown one house on a “take-it-or-leave-it” basis.^{4(p. 104)} Local realtors, public housing officials, and the local FHA office openly discussed the practice in St. Louis, the Civil Rights Commission found.

One review of Section 235 found racial steering in St. Louis locked about 75% of low-income African American homebuyers (about 800 buyers) into costly mortgages on deteriorating housing that they could not afford to maintain, let alone renovate. As one local mortgage company confided at the time, “Many of these [houses] should have seen their last owner.”^{4(p. 104)}

Also as part of the Fair Housing Act of 1968, the Office of Fair Housing and Equal Opportunity was created within the Department of Housing and Urban Development and was tasked with combatting racial steering.

The problem was clearly systemic. In the latter part of the 1960s aerospace manufacturer McDonnell Douglas, a major suburban employer in North St. Louis County, was struggling to find housing for some of its employees. The company was heavily recruiting African American workers—some 650 new hires in 1969. And yet, McDonnell Douglas found that these middle-class workers were routinely being steered to buy in Kinloch, an African American community with struggling schools and limited resources.⁵⁰

Evidence and testimony collected by the local chapter of the Association of Communities Organized for Reform Now and by a local grassroots coalition of black homeowners and renters called the Freedom of Residence Committee further documented the pervasiveness of this practice. Starting in the late 1960s, the Freedom of Residence Committee sent both African American and white volunteers into the real estate market to document racial steering. Volunteers posed as homebuyers and met with realtors to confirm the practice. In the 1970s, the U.S. Department of Housing and Urban Development began to document incidents of steering and continues to do so each decade.⁵¹

In the early 1990s homebuyers continued to grapple with coded messages that steered African Americans to the north of Olive Boulevard and whites to the south of Olive Boulevard,⁵² a roadway viewed as a dividing line between white and African American neighborhoods in the suburbs of University City and Olivette. The Metropolitan St. Louis Equal Housing Opportunity Council, the successor organization to the Freedom of Residence Committee, still utilizes auditors in rental and home buying markets, and they continue to find African Americans being steered by both realtors and property managers into North St. Louis and North County.⁵³

Development and displacement: Urban renewal, spot zoning, condemnation, and annexation

Though sweeping civil rights legislation had been enacted, barriers to integration in housing remained. Along with the ongoing challenges of racial steering, the Fair Housing Act also has had to compete with a variety of modern development tools and practices in the St. Louis region that have continued to displace African Americans in the name of progress. The policies, often utilized by cities competing to bolster their tax bases, have driven investment into wealthier parts of the region. Gordon believes development in the name of “renewal,” some of it large-scale and some directed at individual homeowners, ultimately displaced an estimated 85,000 people from 1950 to 1975 into areas of lesser opportunity. About 85% of the displaced were African Americans (personal communication, February 2018).

Urban renewal

The displacement of African American communities predicated on development and progress is part of a longstanding pattern in St. Louis history and continues to the present day.

The single largest displacement of African Americans in the region’s history occurred in the 1950s in the City of St. Louis under the banner of “urban renewal.”

The Mill Creek Valley neighborhood in midtown St. Louis had been home to African Americans since the start of the Great Migration. Its population grew quickly after World War II as many African American laborers from the South settled in the area bounded by 20th Street to the east, Grand Avenue to the west, Olive Street to the north, and the railyards to the south.



In 1956, St. Louis Mayor Raymond Tucker (left) overlooks Mill Creek Valley, a historic African American neighborhood in Midtown St. Louis slated for urban renewal. The demolition of the neighborhood just east of Saint Louis University displaced several thousand residents into low-income housing projects and deteriorating neighborhoods in North St. Louis and North St. Louis County and made way for Highway 64/40. Much of the remaining land languished vacant (right) until campus expansions at Saint Louis University and Harris-Stowe State University.

Much of the housing stock, consisting of row homes divided into apartments, did not meet standards of the day. After World War II more than half of the dwellings lacked running water, and 80% didn't have interior bathrooms.⁵⁴ Even so, by the early 1950s, the neighborhood was home to about 800 businesses and nearly 20,000 residents, 95% of whom were African American.⁵⁵

During this period St. Louis government officials and a group of corporate leaders called Civic Progress backed the increasingly popular concept of urban renewal, where poor neighborhoods were blighted and cleared for commercial and economic development with the help of bonds financed by both federal and state governments.⁵⁶ With the support of the local NAACP and the local press, \$110 million in bonds were approved to finance the project, which would bring an industrial park to midtown St. Louis.⁵⁶ More than \$11 million in city funds were used to bulldoze the 54-block neighborhood, which included 5,600 housing units and some 40 churches.⁵⁵

The St. Louis Chamber of Commerce endorsed the Mill Creek project, arguing that the move would hasten the "natural" movement of people to the suburbs.⁴ But the

reality was much different for the people who lived there. When work began in 1959, most African American residents moved to segregated, low-income housing complexes in the city, including the Pruitt-Igoe development in North St. Louis, or to substandard housing both in North St. Louis and rapidly transitioning inner-ring suburbs in North St. Louis County such as Wellston.^{56,57}

The Mill Creek Valley project



City funds were used to bulldoze a **54-block** neighborhood



5,600 housing units & **40** churches were destroyed

Source: Mill Creek Valley. University of Missouri–St. Louis.

Critics called the urban renewal project and others like it “Negro removal.”

Source: Gordon C. Mapping Decline: St. Louis and the Fate of the American City, Philadelphia, PA: University of Pennsylvania Press, 2008.

“As black families moved repeatedly to stay ahead of the urban renewal bulldozers, space in the city itself disappeared, and a wholesale movement to the northern and northwestern suburbs began,” Richard Rothstein observed.⁵

A federal audit later found few of the displaced families received relocation assistance, though money had been allocated for it.⁴ Some of the redevelopment was earmarked for new housing, but by the time work began on those apartments in 1961, only 20 original families still called Mill Creek Valley home.⁵⁴ Critics called the urban renewal project and others like it “Negro removal.”^{4(p. 206)}

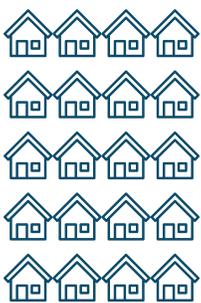
The project was never intended to create economic opportunity for the African Americans it displaced. Architects of the plan backed the creation of large-scale, low-income housing projects such as Pruitt-Igoe as a signature goal.⁵⁶ But Mill Creek Valley’s redevelopment further harmed existing services for African Americans in St. Louis. Based upon a review of city directories, it is estimated that more than half of the businesses and institutions that were forced to relocate had disappeared from the City of St. Louis by the mid-1960s. Some had moved to St. Louis County, but about 70% of them closed.⁵⁸

In their 2005 paper, Joseph Heathcott and Máire Agnes Murphy argue that the economic viability of the African American community in Mill Creek Valley was never considered in redevelopment plans.

“Their reward, in the minds of planners and officials, would be the gleaming new high-rise public housing projects already taking shape on the north and south sides of the city, such as the massive Pruitt-Igoe complex,” according to Heathcott and Murphy.^{56(p. 160)}

The southern part of the Mill Creek Valley project ultimately made way for Interstate Highway 64/40. The remaining reclaimed land did not draw the industrial economic investment that was planned for the area. In the mid-1960s the area was referred to as “Hiroshima Flats” because of its flattened and desolate landscape.⁵⁴ In the absence of other development, Saint Louis University began acquiring land in the 1970s and eventually expanded its campus eastward from Grand Boulevard to Compton Avenue, the bulk of which contains athletic fields, an indoor athletic facility, and campus buildings. Harris-Stowe State University, a historically black institution, expanded its campus on land east of Compton Avenue.⁵⁴

The Mill Creek Valley project



As urban renewal progressed only

20 original families still called Mill Creek Valley home in 1961

Source: O’Neil T. (2009). A Look Back: Clearing of Mill Creek Valley Changed the Face of the City.

Eminent domain

The Mill Creek Valley project was the most disruptive because of its size and its intentions to direct displaced African Americans into the type of high-rise public housing that is now considered a notorious failure throughout the country.⁵⁹ But similar development strategies and policies displaced African Americans both in the central city and in the suburbs.

In the late 1960s about 500 residents were displaced from the African American community of Pleasant View to build Interstate 55; they were given vouchers to relocate to Pruitt-Igoe.⁶⁰

McRee Town, originally a working-class neighborhood of row homes, was cut off from the adjacent Shaw neighborhood after the construction of Highway 44 in the early 1970s. The neighborhood suffered severe disinvestment afterward and became an area known for deteriorating low-income housing for mostly African American residents. In 2003 the nearby Missouri Botanical Gardens aggressively lobbied for a redevelopment project for McRee Town that utilized eminent domain. Botanical Heights, the new development built in its place, provided no low-income housing.⁶¹

In the early 1980s, much of the residential and commercial property in Kinloch, Missouri's first incorporated African American city,⁶² was bought out by the St. Louis Airport Authority for noise mitigation. Critics claim the authority was making way for a runway expansion across Interstate 170 that never materialized. Kinloch lost more than 80% of its population from 1990 to 2000.⁶³

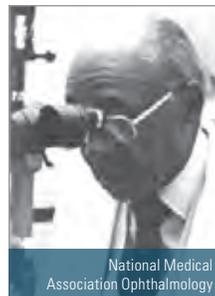
Spot zoning and condemnation

Displacement also occurred as a result of spot zoning, or the re-zoning of small parcels of land not in keeping with the zoning of the surrounding neighborhood. Though rare and now illegal, spot zoning to exclude an unwanted neighbor was sometimes employed to keep upwardly mobile African Americans out of white suburban neighborhoods in the St. Louis area.

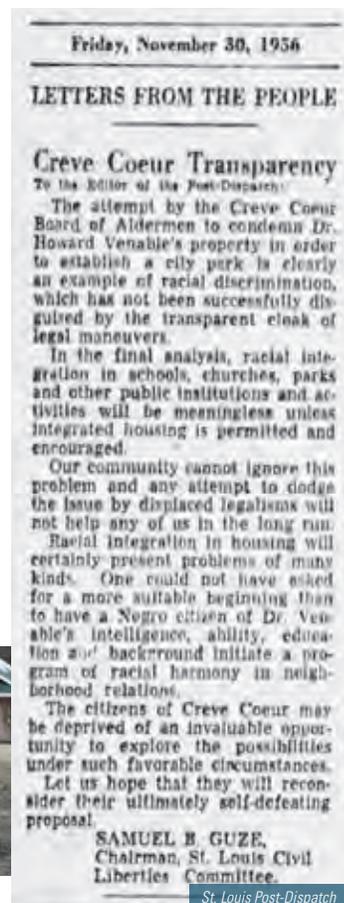
Perhaps the most egregious use of spot zoning occurred in 1956, when Dr. Howard Phillip Venable,⁶⁴ a prominent African American eye surgeon who practiced at the historic Homer G. Phillips Hospital, and his wife Katie, attempted to build a house on two lots in the suburban city of Creve

Dr. Howard Venable

In the 1950s, the esteemed African American physician was blocked from building a home in Creve Coeur by spot-zoning and condemnation.



National Medical Association Ophthalmology



St. Louis Post-Dispatch

Coeur. A hastily formed all-white citizen's committee pressured the Venables to sell their land, and the city refused to issue plumbing permits. The couple was undeterred and continued with construction. However, mid-construction, Creve Coeur successfully moved to condemn the property and rezone it as a small, 7-acre park with a playground, which remains to this day.⁶⁵

It wasn't just individuals who were targeted through spot zoning. Fifteen years after the Venables were blocked from living in Creve Coeur, the city eliminated a small African American neighborhood off of Ladue Road, just west of Lindbergh Boulevard, through aggressive enforcement of code violations and by refusing permits for remodeling.⁴ In 1971 the neighborhood consisted of small homes on tiny lots deeded before the city's zoning law required much larger ones.⁴ The then mayor of Creve Coeur said that "he personally did not want any colored in there."⁴(p. 213) The city began buying up lots in the neighborhood via an anonymous straw party.⁴ The area was eventually bought out and the residents displaced. It is now home to Malcolm Terrace Park.



Meacham Park is a historic suburban African American community dating back to the mid-1800s. The small city was annexed by Kirkwood in 1991. A significant portion of Meacham Park was later redeveloped into a large shopping center with tax incentives granted to the developers by Kirkwood officials.

Annexation and forced loss of neighborhoods

Historic African American neighborhoods in the suburbs were also annexed by adjacent cities and zoned out of existence.⁵ Elmwood Park in St. Louis County was settled after the Civil War by formerly enslaved people from nearby farms. It consisted of 37 meager homes and lacked paved roads or sewers. When the adjacent city of Olivette annexed part of the enclave in 1950 to “straighten its borders,” Elmwood Park residents had no say, nor were they given any of the amenities and services offered to its wealthier white residents.⁵

Instead, a large barbed-wire fence was erected to separate Elmwood Park from a nearby affluent subdivision. Unaware that they were now dependent on Olivette for services, residents received bills for back taxes and saw some of their homes auctioned off because of the debts.⁵ Yet, the neighborhood remained until about 1960, when Olivette applied for and received federal urban renewal project funds that enabled it to condemn the properties.

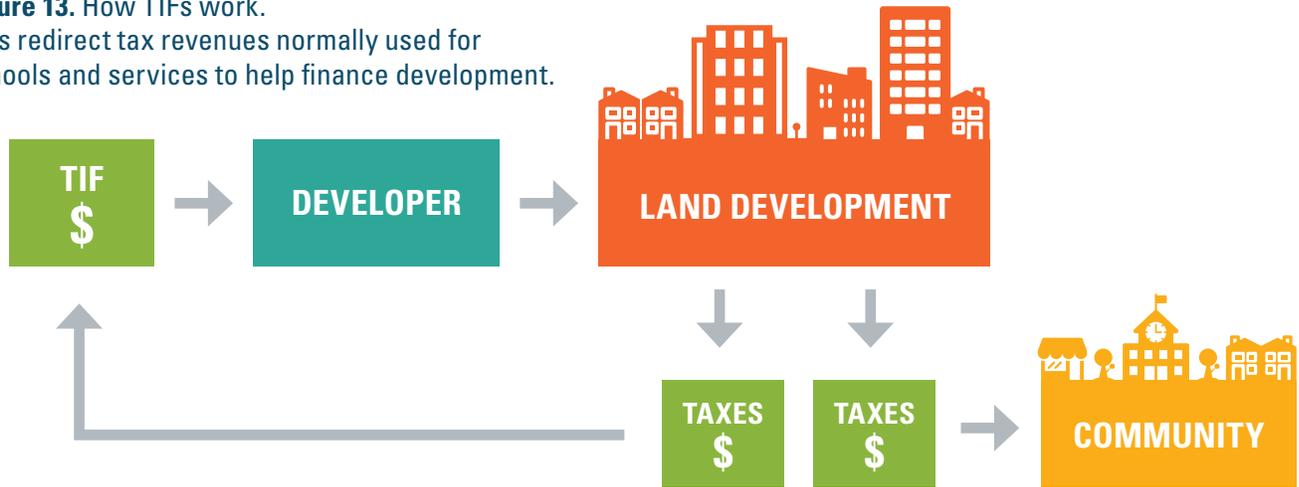
Elmwood Park was rezoned for industrial uses. Olivette took ownership of the properties through eminent domain and began charging rent to residents who had previously owned their homes outright.⁵ At the same time, St. Louis County moved to condemn homes in an unincorporated area bordering Elmwood Park and razed 170 homes for industrial development and more expensive housing.⁵ African American residents relocated to areas with less opportunity, including segregated public housing in the City of St. Louis and inner-ring suburbs such as Wellston and Pagedale.³⁰

The city of Clayton also eliminated a thriving downtown African American neighborhood dating back to the early 1800s. The city zoned the area for commercial uses and pushed it out of existence between 1950 and 1960 with the help of federal urban renewal project funding.⁶⁶ Losses included African American churches and a historic African American school. A hotel and various office buildings exist on the land today. The loss in long-term housing equity to many of these displaced African American residents cannot be overstated. Clayton, with a top-ranking school district, remains one of Missouri’s most affluent communities, with a median home value around \$600,000.

This pattern of displacement through annexation and re-zoning endures. Meacham Park, another African American neighborhood dating back to 1892, was annexed by Kirkwood in 1991.⁶⁷ The annexation was overwhelmingly supported by residents under the assumption that the neighborhood would retain its residential character and that Kirkwood would enhance services and conditions in the mostly low-income neighborhood of tiny homes.

But four years later, Kirkwood developed a plan that dedicated about two-thirds of Meacham Park’s landmass to a shopping center featuring Target, Lowe’s, and Walmart stores. Most of the homeowners in the new commercial footprint were bought out, and a few houses were taken through eminent domain. Though affordable housing was built in a remaining section of Meacham Park and about \$4 million in community improvements were dedicated to the neighborhood, its population had shrunk by nearly a third just four years after the annexation.⁶⁸

Figure 13. How TIFs work. TIFs redirect tax revenues normally used for schools and services to help finance development.



Use of TIFs and other development incentives

The fate of Meacham Park was facilitated by a popular development tool often used by competing municipalities in the St. Louis region to lure retailers and other businesses. Kirkwood granted \$17 million in tax-increment financing, commonly known as TIF, to developers of the commercial project that displaced a large proportion of Meacham Park.⁶⁹

TIFs essentially grant developers a portion of property, sales, or earnings taxes generated by the new development to pay for some of their construction costs and required community improvements.

TIFs and other forms of developer incentives, such as property tax abatement, are intended to be used in disinvested areas that would not be able to lure development otherwise. They are, essentially, meant to draw development to low-income neighborhoods and increase economic opportunity for their residents.

Proponents of the Meacham Park deal saw no issue with the use of TIF for the development.

“That was a city ghetto sitting in a suburban community,” said Herb Jones, mayor of Kirkwood from 1984 to 1992. “Now it looks like a normal neighborhood.”⁷⁰

Many residents of Meacham Park felt differently. They believed that their historic African American neighborhood was broken apart by the TIF and that it drove longtime families to relocate to areas of lesser opportunity. They argued that Kirkwood was not working in their best interests.

“I just wish that the African-American community [Meacham Park] of this City of Kirkwood had been embraced and respected and assisted in the improvement of their lives and their well-being, rather than being used, mistreated and disregarded,” one resident told a researcher. “It could’ve been a great thing because when the people in Meacham Park annexed, voted to have this area annexed, it was never their [the residents] intent to be manipulated into a situation where they would not gain and Kirkwood would, at their expense.”^{71(p. 83-84)}

Kirkwood was not the only suburban community to redevelop a historic African American neighborhood into retail properties to build its tax base. In the mid-1990s municipal leaders and developers in Brentwood saw the location of a thriving middle-class African American neighborhood as a missed revenue opportunity. The neighborhood, named Evans Place and originally called Evens-Howard Place, was located near the intersection of Interstate 64/40 and Highway 170, and was considered a prime retail area just a mile away from the Galleria shopping mall.⁶⁸

Evans Place had been in existence for 90 years. It contained 130 homes and 30 businesses and was home to about 800 people when it was displaced through a combination of home buyouts and TIF financing for the developers.⁶⁸ Many residents relocated to North St. Louis County. The neighborhood was initially created to house African American and immigrant families working in a nearby brick factory. Historically, it was one of the few middle-class communities in the St. Louis region in which African Americans could buy new homes. The area today is home to a Target and other chain stores.⁶⁸

A larger review of TIFs and other development incentives in the St. Louis region points to clear deviation from their original intent and economic harm to African Americans.

In general, most incentives in the St. Louis region elude high-need African American neighborhoods and are concentrated on wealthier, white ones.

One study estimates that 84% of TIFs granted between 2000 and 2014 in the City of St. Louis went to neighborhoods in the increasingly lucrative central corridor and downtown, places that are home to relatively little of the city's African American population and where assessed property value per square foot is much higher than areas that don't get incentives.⁷² Overall investment prompted by TIFs amounted to more than \$338 million gone to mostly white or commercial neighborhoods that likely could have lured investment on their own.

In March of 2018, the City of St. Louis Comptroller estimated tax abatement arrangements for developers cost the City \$29.6 million in the 2016 fiscal year, including about \$18 million in tax revenues that would have gone to St. Louis Public Schools.⁷³

As examples of just how stark this deviation from original intent can be, the following incentives have been granted with the goal of alleviating blight, a complex, variously defined term used to denote urban decay⁷⁴ and disorganization:

2012

In 2012, \$10 million in TIFs were approved for a high-end condominium complex containing an upscale grocery chain in the City of St. Louis's affluent Central West End.⁷⁵ Less than two years later a full-service grocery store shuttered on North Grand Boulevard,⁷⁶ leaving the high-need, predominantly African American Fairground Park neighborhood without a large supermarket. The store remains vacant. Though property tax abatement enabled the construction of smaller grocery stores about a mile south of the closed store, those incentives were dwarfed by the TIF granted in the Central West End.

2016

In 2016, city officials in affluent Clayton in St. Louis County granted \$75.6 million in real estate tax abatements over 20 years to help a Fortune 500 company expand its campus in an area described as the Midwest's second priciest office address, rivaled only by Wacker Drive in Chicago.⁷⁷

In 2016, City of St. Louis officials blighted property adjacent to a boutique hotel and thriving concert hall just east of the successful University City Loop area. The city approved 16 years of real estate tax abatement estimated at \$12.8 million for a 230-unit apartment building. Rents start at \$1,475 a month for a studio.⁷⁸

2017

In 2017, the City of St. Louis granted 15 years of real estate tax abatement to developers of a 39-story luxury apartment tower to be constructed on Kingshighway across from Forest Park in one of the region's most exclusive real estate markets. The City additionally granted a 50% sales tax reduction on building materials for the developer. Opponents argue that the incentives were granted despite submitted paperwork suggesting the developer's return on investment would be significant even without tax abatement.⁷⁹

There are examples of TIF funding that have been used successfully in areas of high need in the St. Louis region. This includes \$2 million in tax increment financing arranged by the nonprofit Beyond Housing and approved by the small North St. Louis County community of Pagedale.⁷² The TIF and other financing enabled the 2010 construction



James Byard, Washington University



of a grocery store and other amenities for a community in which the median annual income was below \$27,000.

It is important to note that the Pagedale TIF was unusual, and benefitted from a larger financing package that included a private donor.⁸⁰ Though TIFs are intended for lower-income areas, it is often difficult for communities in weaker retail markets to lure developers to a potential TIF because they are competing against wealthier municipalities that are also offering competing TIFs for other projects.

In 2011, the East-West Gateway Council of Governments, a cooperative encouraging coordinated development of St. Louis regional policy, wrote an extensive report about the detrimental effects of TIFs.⁸¹

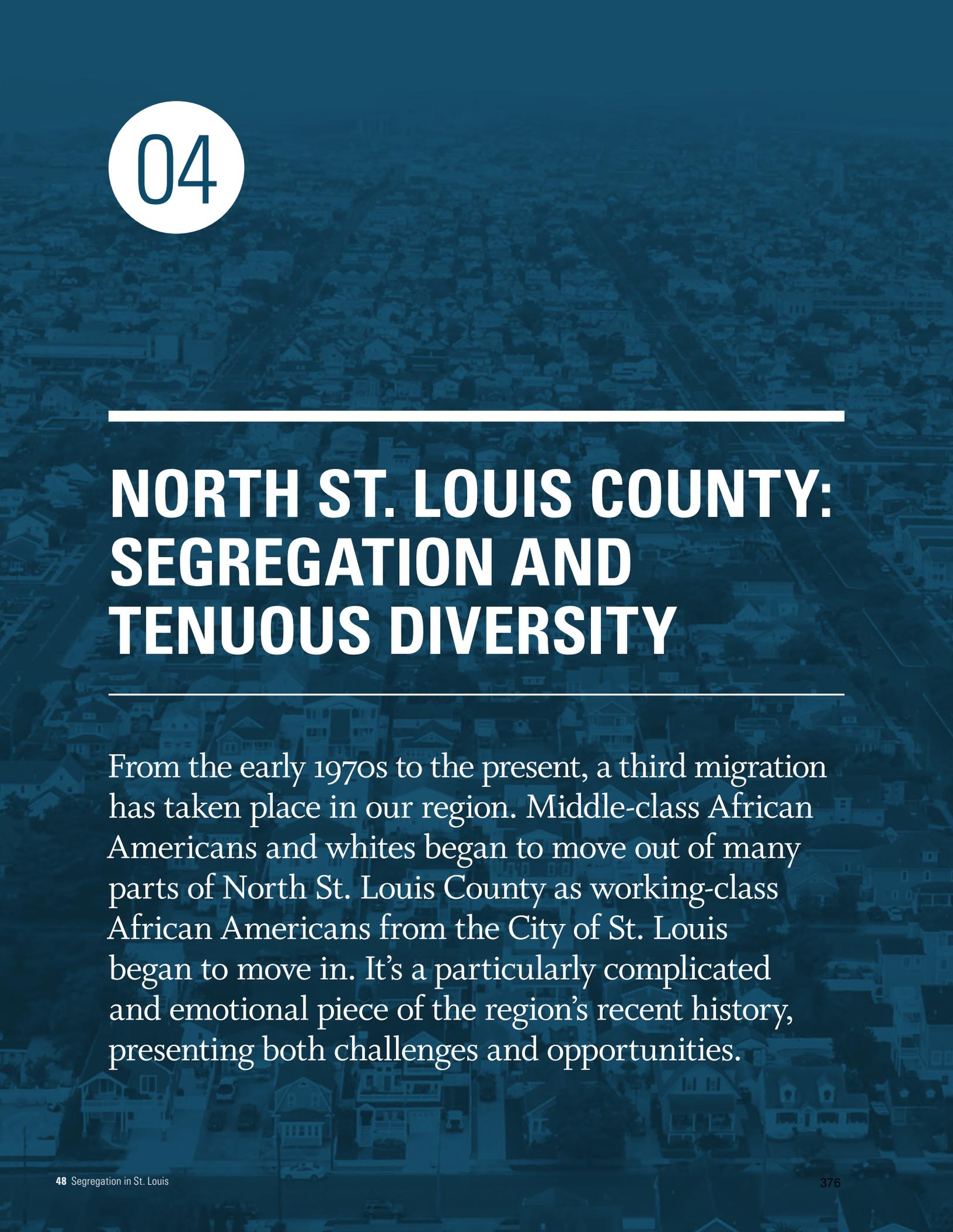
“The use of tax incentives has exacerbated economic and racial disparity in the St. Louis region,” the report read. “Historically, tax incentives to private developers are less often used in economically disadvantaged areas and their more frequent use in higher-income communities gives those jurisdictions what amounts to an unneeded, extra advantage.”⁸¹

Conclusion

The rapid rise of fragmented and competing suburbs coupled with exclusionary zoning shaped a segregated landscape in St. Louis County that actively discriminated against African American renters and homebuyers. Even as fair housing protections emerged during the Civil Rights Movement, racial steering kept many homebuyers and renters out of areas of opportunity in St. Louis County and further contributed to segregation. Urban renewal and more modern development tools continued to displace African Americans from established neighborhoods. The current use of development tax incentives has directed investment into wealthier communities and neighborhoods and bypassed areas with the greatest need for jobs, businesses, retail, and better housing.

Final Thoughts

The development of the suburbs and competition among the City of St. Louis, St. Louis County, and dozens of suburban municipalities contributed to pervasive patterns of segregation in our region. Many African Americans in our region remain isolated in disinvested areas without critical opportunities for upward mobility.



04

NORTH ST. LOUIS COUNTY: SEGREGATION AND TENUOUS DIVERSITY

From the early 1970s to the present, a third migration has taken place in our region. Middle-class African Americans and whites began to move out of many parts of North St. Louis County as working-class African Americans from the City of St. Louis began to move in. It's a particularly complicated and emotional piece of the region's recent history, presenting both challenges and opportunities.

Racially similar communities

Missouri Wonk calculated a “dissimilarity index” (Figure 14) to capture the present day impact of decades of policies and practices enforcing segregation in the St. Louis region. The dissimilarity index is a common measure of segregation. Specifically, it is a numerical comparison of the racial composition of an area relative to the overall racial composition of the larger geographic area in which it is located—in this case it is the City of St. Louis and St. Louis County.

Areas in red, orange, and darker yellow in Figure 14 represent places in our region where residents are more likely to live among neighbors who are the same race, with red representing the most homogenous, or racially similar, areas. Many of the factors to be discussed in this chapter have contributed to creating suburban communities in the west, southwest, and southern parts of St. Louis County that are almost exclusively white. Conversely, many areas in North St. Louis and North St. Louis County also score high on the dissimilarity index. These areas also reflect policies and practices that have increasingly forced many working-class African Americans into segregated areas with less opportunity.

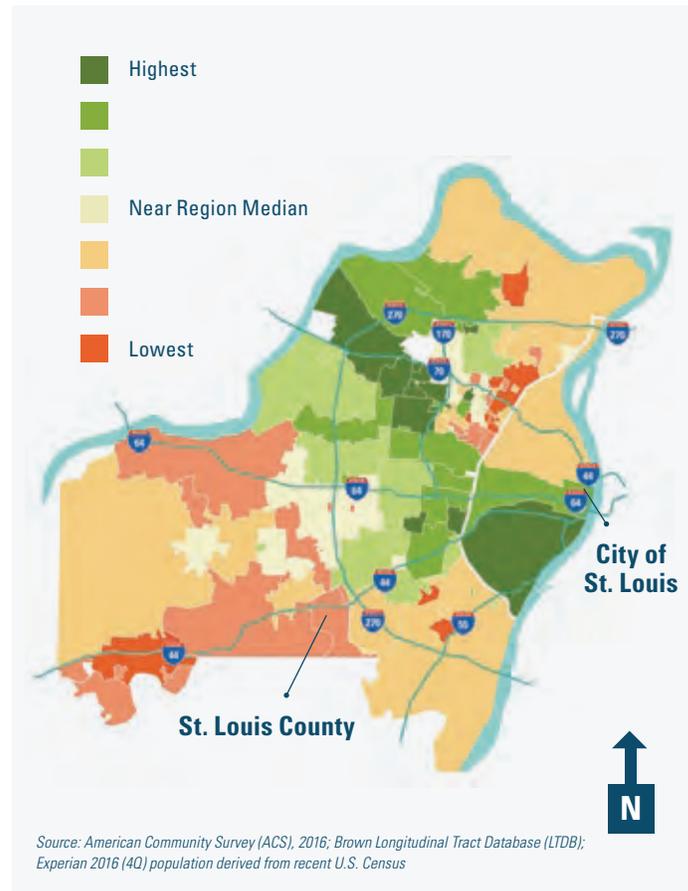
The green and lighter green areas of Figure 14 indicate areas of diversity, with dark green being the most diverse. Note the areas of relatively high diversity emerging from the southern half of the City of St. Louis and extending northwest through St. Louis County into communities such as Hazelwood and Florissant.

A third migration: Segregation of African Americans in inner-ring suburbs

Despite the challenges that we have reviewed, laws and protections have had some impact on increased housing mobility for African Americans in our region in the past 50 years. Todd Swanstrom, of the Public Policy Research Center at the University of Missouri-St. Louis, notes that middle-class African American home ownership and rental opportunities have increased in several St. Louis suburbs, particularly in Creve Coeur, Bridgeton, Hazelwood, Florissant, Bel-Nor, and Pasadena Hills (personal communication, January 2018).

Additionally, several low-income African American neighborhoods in the City of St. Louis have experienced increases in their white population, including parts of the West End, Tower Grove and South St. Louis. But this has also raised the risk of gentrification, which will be addressed in the next chapter.

Figure 14. Dissimilarity Index. In most parts of St. Louis people live in neighborhoods in which their neighbors are the same race or ethnicity.



These may be hopeful signs of increasing diversity in pockets throughout the region. On the surface, North St. Louis County, with 45 cities, appears exceptionally diverse.⁸² Data from the 2014 American Community Survey put it at 41.3% white and 52.9% African American.⁸³

Some scholars argue that this indicates a refreshing change that should be supported and maintained.

“Increasing in number and growing rapidly, diverse suburbs have replaced central cities as the places most likely to provide the potential benefits of integrated neighborhoods and schools to whites and nonwhites alike,” write scholars Myron Orfield and Thomas F. Luce.^{84(p. 1)}

Orfield and Luce go on to argue that American suburbs taken as a group are now more diverse than cities, and these diverse suburban communities could potentially carry tremendous political power if their diversity is supported and maintained.

But one recent national study by Daniel T. Lichter, Domenico Parisi, and Michael C. Taquino suggests that, for African Americans, the broad statistical increases in integration emerged from the continued depopulation of whites from certain neighborhoods, particularly within inner-ring suburbs and the decreased demand among whites for homes in these increasingly diverse neighborhoods.⁸⁴ The researchers argue that cities and suburbs overall have grown more segregated over the past 40 years, and persistent and intensifying racial disparities have emerged between white communities and those populated by people of color.⁸⁵

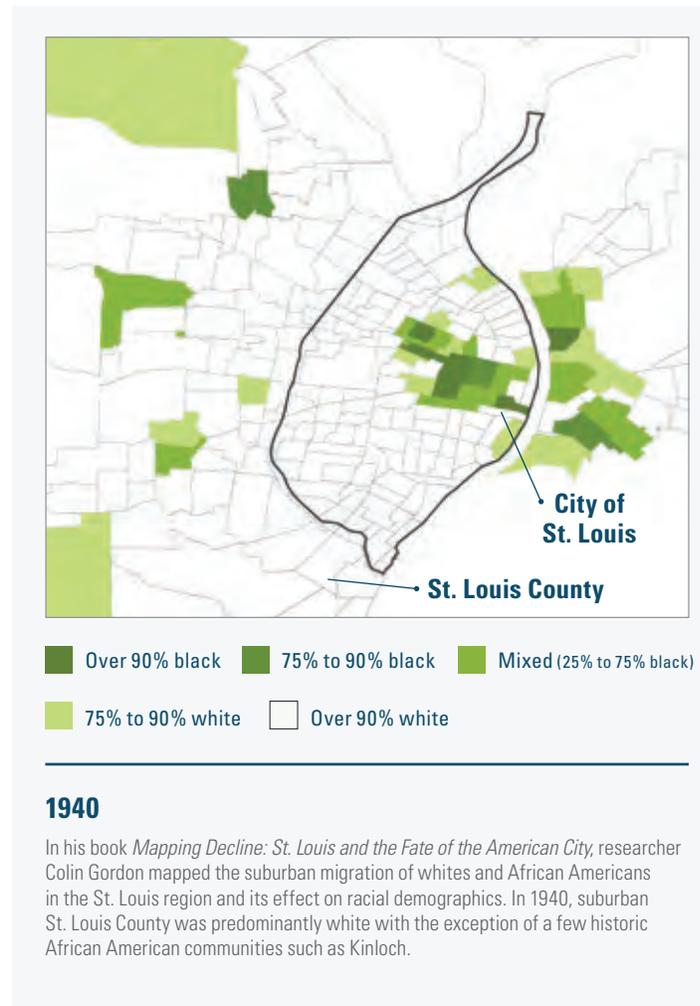
The study notes that “whites may be increasingly concentrating in places that are overwhelming white, especially at the [suburban] fringe,” and both whites and African Americans are increasingly separated in daily interactions.^{85(p. 845)}

John A. Powell, director of the Institute on Race and Poverty at the University of Minnesota Law School, notes that the “white suburban wall began to crack for middle-income blacks after the passage of the Fair Housing Act of 1968. As a result, middle-income blacks have begun to move to the suburbs in record numbers. However, they are often resegregated in the suburbs and remain isolated from the more powerful white suburbs that still capture most the opportunities and resources.”⁸⁶

Indeed, as more infrastructure is built to promote the growth of exclusionary, outer-ring suburbs, Powell argues, “It is hard to imagine an effective civil rights and social justice movement that promotes racial justice and addresses the negative consequences of concentrated poverty without addressing the fragmentation associated with sprawl.”⁸⁶

After Michael Brown was killed by a police officer in Ferguson in 2014, the relatively recent history of white and middle-class flight in North St. Louis County received national attention. Ferguson’s demographics were reflective of the hypersegregation and disinvestment affecting a large segment of its African American population. Though Ferguson appeared diverse at first glance, in reality the majority of African Americans lived in poor and segregated neighborhoods within Ferguson. Rothstein in “The Making of Ferguson” observed that Ferguson had “ghetto conditions we had come to associate with inner cities now duplicated in a formerly white suburban community.”⁸⁵ Those conditions included high-poverty segregated neighborhoods, lower performing schools, abandoned homes, and a sense of community powerlessness.⁸⁷

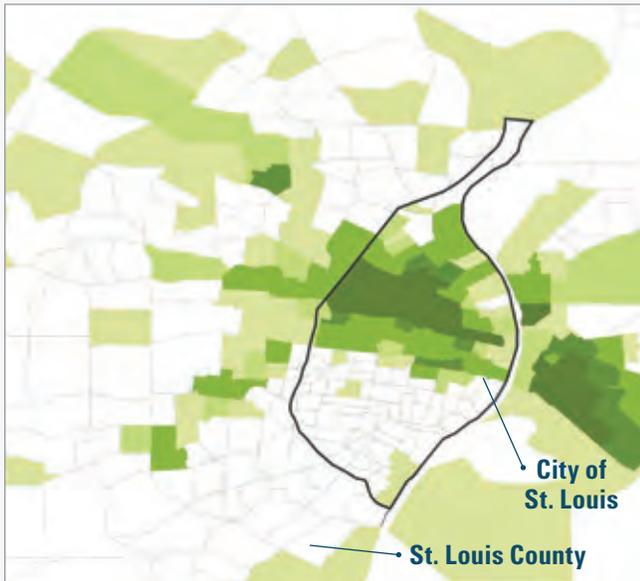
Figure 15. Racial makeup of the City of St. Louis and St. Louis County at three time points: 1940, 1970, and 2000.



It became clear that the demographic numbers did not tell a complete story about the isolation and segregation experienced by African Americans *within* Ferguson and other North St. Louis County communities.

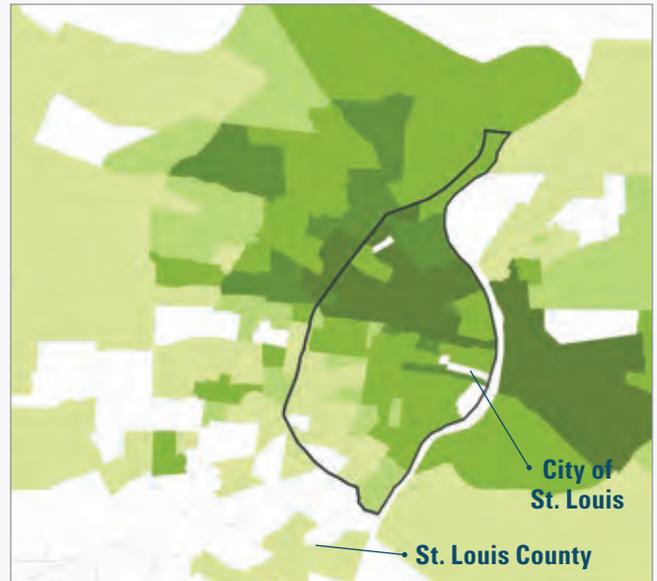
“Whites have left Ferguson, mostly for white suburban communities even farther from the urban core that is St. Louis. The racial composition of Ferguson went from about 25 percent Black to 67 percent Black in a 20-year period. Though one would be correct in saying that segregation decreased between neighborhoods in Ferguson, the change simply reflects massive white depopulation,” said Daniel T. Lichter, author of a 2015 study on macro-segregation.⁸⁷

These complicated changes within North St. Louis County in the past 50 years represent a third migration in the St. Louis region in which the middle class moved westward into outer-ring suburbs as low-income and working-class African Americans settled in the inner ring.



1970

By 1970, urban renewal projects, highway construction, and substandard conditions at the Pruitt-Iggoe housing complex in St. Louis were driving African Americans further into North St. Louis City and parts of North St. Louis County.



2000

By 2000, many whites had moved from North St. Louis County to western St. Louis County and St. Charles County, while African Americans had moved in great numbers from the City of St. Louis to parts of North St. Louis County. Some inner-ring suburbs such as Wellston and Pagedale experienced a rapid racial turnover.

Source: Gordon C. (2008) *Mapping Decline: St. Louis and the fate of the American City*.

Once again the migration has left behind many low-income African Americans in an area of increasingly disinvested suburbs.

It's a period of history that many residents, both white and African American, know first hand. Generations of middle-class white and African American families uprooted themselves from established communities in North St. Louis County as resources and new housing increased in the outer suburbs and St. Charles County, the latter of which experienced a tremendous boom in new home construction starting in the 1970s through the Great Recession. From 1990 to 2007, St. Charles County's population increased by 61.6%, with new residents relocating from both the City of St. Louis and St. Louis County.⁸⁸

The white migration west out of North St. Louis County is clearly documented in *Mapping Decline* through a series of maps illustrating white and African American migratory patterns from 1960 through 2000.⁴

"In a sense, the suburban color line had drifted west from the City limits to encompass much of near northeastern St. Louis County (Wellston, Bridgeton, Normandy, Jennings, Ferguson, Bellefontaine Neighbors) south and east of Lindbergh Boulevard," writes Gordon of the period from 1990 to 2000.^{4(p. 25)}

The above illustrations in Figure 15, also in *Mapping Decline*, compare white and African American demographics in the City of St. Louis and St. Louis County in 1940, 1970, and 2000. Note the rapid demographic turnover from white to African American along the northwestern border of the City of St. Louis. According to census data, by 2000, once nearly all white municipalities bordering North St. Louis had become more than 75 percent black, with the majority at 90 percent or more.⁴

Wellston 1940s to present



A. Wellston, circa early 1970s
Source: McWoods Family

B. Wellston Loop, circa early 1960s
Source: Linda Tate of www.wellstonloop.com

C. Wellston Loop, present-day
Source: Carolina Hidalgo of *St. Louis Public Radio*

D. Wellston street scene, present-day
Source: Whitney Curtis

E. J.C. Penney building, circa 1948
Source: *St. Louis Post-Dispatch*

F. J.C. Penney building, present-day
Source: Nancy Cambria



In the 1950s and early 1960s the St. Louis suburb of Wellston had a thriving retail center at the end of several trolley lines that particularly attracted nearby St. Louis shoppers because its stores were open on Sunday. A modern J.C. Penney anchored the shopping area. In the late 1960s and early 1970s Wellston experienced extreme white flight and disinvestment as African Americans were encouraged to move into Wellston. The once elegant Wellston Loop station remains standing in extreme decay, and the J.C. Penney is now an abandoned shell.

Much of this early migration of African Americans into North St. Louis County was fueled by the demolition of Mill Creek Valley starting in 1959 and then the 1972 demolition of the Pruitt-Igoe housing complex in the City of St. Louis, which consisted of 33, 11-story apartment buildings deemed uninhabitable by federal and state officials. Displaced residents of Pruitt-Igoe were given housing subsidies to move to Wellston and other inner-ring suburban areas. The migration also was occasioned by the demolition of African American communities such as Elmwood Park and Evans Place, which were discussed earlier.⁵

The migration of working-class African American families into once all-white St. Louis County communities had a rapid effect on suburban cities such as Wellston. In little more than a decade, Wellston's population went from almost completely white to entirely African American, and the city suffered extreme disinvestment.

From the 1950s until roughly around when the Hodiament trolley line was shut down in 1964, the Wellston retail area was a bustling place for people to gather. Its thriving commercial district along Easton Avenue (now Dr. Martin Luther King Drive) was sometimes referred to as the "Western Gateway to St. Louis." At one point the St. Louis County Bus Company ran seven bus lines to Wellston and served 25,000 people daily.⁸⁸

Today the Wellston Loop retail area contains mostly boarded up commercial buildings and vacant lots. A popular and architecturally significant J.C. Penney Department store shuttered in the mid-1970s. The building and the nearby bus and trolley station remain vacant and deteriorating in the center of Wellston.

Though racism and negative public attitudes toward integration played a role in the "white flight" out of Wellston and other cities in North St. Louis County, scholars of this period also point to the public policy, real estate industry practices, and other economic drivers of white and middle class residential patterns since World War II. Scholars such as Rothstein have said that our region has failed to make progress because of the myth that racism at the level of the individual was the only factor that fueled white flight.

"When we blame private prejudice, suburban snobbishness, and black poverty for contemporary segregation, we not only whitewash our own history but avoid considering whether new policies might instead promote an integrated community," Rothstein warns in "The Making of Ferguson."⁵

White homeowners in North St. Louis County had been enabled to buy their first homes through post-World War II Federal Housing Administration (FHA) loans. And yet, federal policy at the time excluded the vast majority of African Americans from obtaining them. In North County, many of these white homeowners began to experience unease beginning in the 1970s and 1980s as middle-class neighbors with spending power moved away and realtors steered whites away from their communities. Their concerns were not entirely about race, though.

For many, an economic calculus driven by public policy motivated them to cash in their equity and relocate to newer subdivisions further west—often to the other side of the Missouri River in growing St. Charles County, where the current population is more than 90% white and less than 5% African American. This movement was incentivized by federal and state transportation and infrastructure policy. More than \$500 million, plus millions more in land acquisition and other costs, was spent to complete the Page Avenue Extension into St. Charles County in 2014. The 20-mile stretch of divided highway, also known as Highway 364, was built to alleviate traffic congestion as St. Charles County grew in population.⁸⁹



Laura Brossart

Aimee VonBokel's great-grandparents lived in this now vacant North St. Louis duplex on Wells Avenue during the first part of the 20th Century. In her *St. Louis American* column, VonBokel chronicled the history of the house to explain the adverse economic dynamics of redlining and white flight and its impact on the African American community.

In a 2017 column in the *St. Louis American*, Aimee VonBokel, who is white, wrote eloquently about the causes of white flight, through the history of her now vacant and deteriorating ancestral family home on Wells Avenue in North St. Louis. It's a story that repeated itself decades later in North St. Louis County.

In her column VonBokel describes practices like redlining and racially motivated housing policies that eventually drove housing prices down in the neighborhood as it became increasingly poor and African American. It led her white grandfather to rent the house and buy a house in the suburb of Glendale, a place where home values have risen dramatically over decades, enabling families to accumulate wealth. Meanwhile the African American family that went on to rent and later own the St. Louis house gained no such wealth as it continued to depreciate in value.

As VonBokel describes it, "The story we uncovered was not a story of emotion, but rather, a story about money, and the rational, logical choices [her grandfather] made under circumstances that were beyond his immediate control."⁹⁰

After publishing her commentary VonBokel said, "There's just a lot of emotional tension that prevents people from speaking honestly about race. The result of racist housing policy is that we don't live near each other, we don't know each other, we don't speak to each other, we don't understand each other, and we don't even fully understand the policies and laws that got us here. There's a pretty massive learning curve" (personal communication, December 2017).

Though patterns of white and middle-class flight have been in St. Louis for many decades, no substantial public policy has been created to deter the migration of white and African American middle-class residents out of North St. Louis County.

The recession of 2007 and the bursting of the nation's housing bubble took a major bite out of financial gains in homeownership in North St. Louis County.⁹¹ Foreclosures hit African American households particularly hard; many had been targeted by the mortgage industry with predatory lending products. The situation continued to drive down housing prices and incentivized more middle class residents to move.⁹²

“There’s just a lot of emotional tension that prevents people from speaking honestly about race. The result of racist housing policy is that we don’t live near each other, we don’t know each other, we don’t speak to each other, we don’t understand each other, and we don’t even fully understand the policies and laws that got us here.”

Source: Aimee VonBokel, personal communication, December 2017

The continuing shift toward African American segregation in North County is particularly concerning when considered in the context of accumulating research about white and African American housing preferences. Overall, African Americans would prefer a 50-50 mixture of whites and blacks in the neighborhood in which they live, while whites have a preference for neighborhoods in which no more than 20% of their neighbors are black.⁹³ Not only does this sentiment influence white flight, but it also deters white homebuyers and renters from considering homes in increasingly diverse neighborhoods.

Michael Brown’s death, protests, and a militarized police response to those protests sparked numerous conversations and analysis about what happened and ways to bring heightened opportunity back to North St. Louis County.

This included the publication of *Forward Through Ferguson*, an exhaustive report with 189 calls to action to increase racial equity in the region. Though federal dollars have been earmarked for youth development,⁹⁴ and there has

been some public-private investment,⁹⁵ there has been little policy at the state or local level to stabilize housing or otherwise invest in North St. Louis County.

Richard Rothstein sums up the current situation as follows: “Whereas 20th century segregation took the form of black central cities surrounded by white suburbs, 21st century segregation is in transition—to whiter central cities adjoining black suburbs, while farther out white suburbs encircle black suburbs.”³⁰

Isolated and left behind, again

North St. Louis County's history of suburban zoning coupled with the lack of significant infrastructure now causes distinct problems for poorer African Americans left behind in segregated suburban cities that have experienced rapid disinvestment.

Smaller ranch homes in fragmented municipalities separated from retail and other services declined in value and condition and became unplanned low-income housing as middle-class whites and middle-class African Americans left. Retail and other jobs followed. North St. Louis County residents often find themselves in isolated neighborhoods with less access to social services and support agencies, poor transportation options, and declining schools and tax bases.

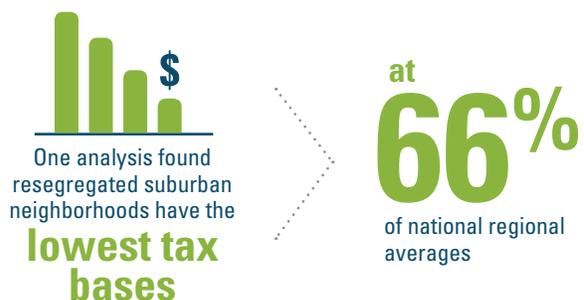
Those utilizing Affordable Housing Choice Vouchers in these suburban neighborhoods typically report a better quality of life than they experienced in older, deteriorating neighborhoods in the City of St. Louis that experience higher rates of crime and homicides, according to Molly Metzger, an assistant professor at Washington University specializing in housing policy and segregation (personal communication, January 2017).

However, the infrastructure and suburban-style housing in these neighborhoods pose great challenges for lower-income residents who do not own cars, cannot afford upkeep on single-family homes, and live geographically separated from important retail and service hubs.

"The suburban lifestyle works well for middle- and upper-class families, who can afford the multiple automobiles required in low-density suburbs characterized by widely separated land uses," writes Swanstrom.^{96(p. 9)} "The initial price of a home in an inner-ring suburb may be quite affordable, but this affordability ignores the operating costs of a home."^{96(p. 8)}

Many African American residents in highly segregated suburban areas also struggle with inequitable tax rates and services. Typically, their cities lack business and retail tax revenue, and are forced to tax lower-valued real estate more intensively to cover services.⁹¹

Segregated suburbs have smaller tax bases



Source: Orfield M, Luce T. *American's Racially Diverse Suburbs: Opportunities and Challenges*. 2012. https://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1056&context=imo_studies.

Research finds predominantly nonwhite suburbs are more acutely affected by meager tax bases. One analysis found resegregated suburban neighborhoods have the lowest tax bases, at just 66% of national regional averages.⁸⁴ And though median incomes and poverty rates may be nearly the same in segregated urban and suburban areas, research has found that urban, central cities have much stronger tax bases to provide services.

As already discussed, pockets of integrated municipalities remain in North St. Louis County and actually represent a national trend in which older suburbs overall are now among the most racially diverse communities in the nation. Swanstrom argues more efforts are needed to preserve them and prevent any possibility of "tipping" to entirely lower-income and African American due to continued middle-class movement into areas of greater economic stability (January, 2018).

Scholars Orfield and Luce argue these integrated suburban cities can leverage tremendous political power if their diversity is preserved to "ensure both the stability of their communities and the future opportunity and prosperity of a multiracial metropolitan America."^{84(p. 3)}

But they warn that stable integration does not happen by accident: "It is the product of clear race-conscious strategies, hard work, and political collaboration among local governments."^{84(p. 3)}



Conclusion

So where does this leave our region? St. Louis today is a metropolitan area that lives uncomfortably with a legacy of more than a century of laws and policies that have kept African Americans excluded from opportunity. These exclusionary practices have created a hypersegregated region.

Studies indicate that the St. Louis region remains among the 10 most segregated in the country.⁹⁷

With the reaction to the fatal shooting of Michael Brown in Ferguson followed three years later by the exoneration of a City of St. Louis police officer in the shooting death of Anthony Lamar Smith, St. Louis has become a place now roiled by intermittent conflict and protest. Issues of inequity and segregation underlie much of the discontent. Pockets of integrated neighborhoods exist, but systems and policies have not been put into place to preserve their diversity and keep them from transitioning to disinvested, newly segregated communities.

In the next chapter we will explore the contours of exclusion in contemporary St. Louis and hear firsthand the impact that modern segregation has on our region's residents.

St. Louis remains highly segregated



St. Louis

among the
10 most
segregated
metropolitan regions
in the country

Source: Logan JR, Stults BJ. *The Persistence of Segregation in the Metropolis: New Findings from the 2010 Census US2010 Project*, 2011.

Final Thoughts

St. Louis is a place stifled in its everyday life rhythms and future potential by segregation. How people work, shop, play, and learn remains separated at a grave cost to the region's overall well-being. And yet, there remains tremendous potential to embrace diversity as an asset within many communities.



HISTORY OF SEGREGATION AND HOUSING

This timeline highlights national, state, and regional events that perpetuate or combat segregation and its impact on housing.

SLFREE RACIAL ZONING ORDINANCE PASSES

St. Louis Real Estate Exchange successfully campaigns for a racial zoning ordinance to be placed on 1916 city-wide ballot.



EFFECT

African Americans prohibited from purchasing homes or residing on blocks with more than 75% white residents.

Photo Source: St. Louis Post-Dispatch

EMPOWER MISSOURI IS FOUNDED AS THE MISSOURI CONFERENCE ON CORRECTIONS AND CHARITIES

< 1900

1915

MISSOURI JOINS THE UNION AS A SLAVE STATE

DRED SCOTT V. SANFORD DECISION

Supreme Court case declared slaves and descendants of slaves were not U.S. citizens and could not sue in federal court.



1857



EFFECT

Court ruling frustrated abolitionists and increased tensions between the North and South.

Photo Source: Museum History Museum

MISSOURI LEGISLATION SUPPORTS SEGREGATION

Missouri Supreme Court rules that segregated schools are not in conflict with U.S. constitution.



1889



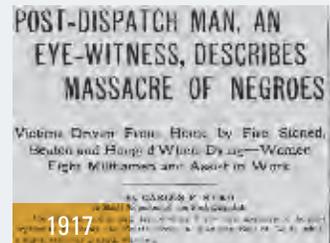
EFFECT

A law is passed ordering separate schools for African Americans.

Photo Source: Wiki Commons

EAST ST. LOUIS RIOTS

An estimated 100 African Americans are killed by white mobs during two days of terror following white police deaths.



1917



EFFECT

African Americans fled across the river to St. Louis for refuge.

Photo Source: Carlos F. Hurd, St. Louis Post-Dispatch

BUCHANAN V. WARLEY DECISION

Supreme court case successfully challenges racial zoning ordinances.



1917

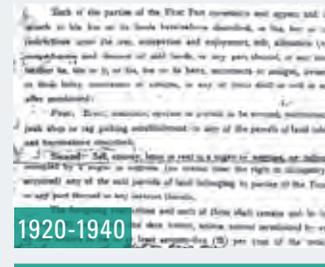
➔ **EFFECT**

Racial zoning found unconstitutional as a violation of the 14th amendment.

Photo Source: Missouri History Museum

DEED COVENANTS ESTABLISHED

Agreements created binding homeowners to restrict certain land use including race of occupant.



➔ **EFFECT**

These covenants prevented the sale of homes to a growing African American population in St. Louis.

Photo Source: Newstead Restrictive Covenant (April 1924), book 5896, 574-76, St. Louis Recorder of Deeds

THE GREAT DEPRESSION

1920

WOMEN GAIN THE RIGHT TO VOTE

1925

FIRST WINTER OLYMPICS

1930

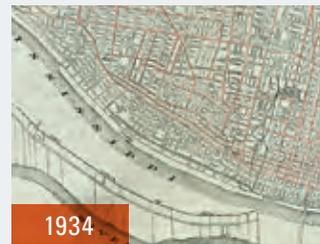
1935

“Segregation is that which is forced upon an inferior by a superior.”

—Malcolm X

FHA ESTABLISHED TO INSURE BANK LOANS FOR HOUSING

Federal Housing Administration makes funds available for massive surveying and evaluation of existing housing stock.



1934

➔ **EFFECT**

Residential security maps developed to assess whether housing in a neighborhood is a good or a bad financial risk, ultimately sustaining segregation.

Photo Source: Missouri History Museum

1940–1975 >

SHELLEY V. KRAEMER DECISION

Supreme court case successfully challenges racial covenants.



1948

➔ EFFECT

Racial covenants deemed a violation of the 14th amendment and made unenforceable by the courts.

Photo Source: Jason Purnell

PRUITT-IGOE OPENS

High rise public housing project welcomes its first residents.



1954

➔ EFFECT

Initially, project is praised as a success of urban renewal and equitable housing.

Photo Source: Missouri History Museum

1940

WWII STARTS

1945

1950

PORTION OF ELMWOOD PARK ANNEXED BY CITY OF OLIVETTE

TAX INCREMENT FINANCING (TIF) INITIATED IN CALIFORNIA

1955

ROSA PARKS ARRESTED FOR REFUSING TO GIVE UP HER BUS SEAT

STL IS REDLINED

Residential security map divides the city and county into four categories labeled A-D, with areas with expiring restrictions and increasing populations of African Americans labeled with a lower grade.



1937

➔ EFFECT

Mortgage lenders discouraged from offering financial assistance for purchasing homes in lower grade areas.

Photo Source: National Archives

FAIRGROUND PARK RIOT

A riot ensues after African Americans are allowed access to Fairground Park pool, one of the largest pools in the Midwest. African Americans were attacked with bricks and bats by an angry mob of whites.



1949

➔ EFFECT

Altercations lead to the injury of 15 people.

Photo Source: Laura Brossart

CIVIL RIGHTS ACT CREATES THE U.S. COMMISSION ON CIVIL RIGHTS

Mission is to inform the development of national civil rights policy and enhance enforcement of federal civil rights laws.



1957

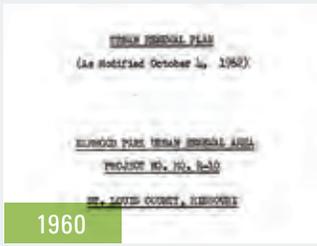
➔ EFFECT

Commission heightens awareness of civil rights issues to nation and sparks further legislation such as the Voting Rights Act of 1965.

Photo Source: United States Naval Photographic Agency

ELMWOOD PARK "RENEWED" BY CITY OF OLIVETTE

Olivette applies for and receives federal funds for urban renewal.



1960

➔ EFFECT

Elmwood Park is condemned and rezoned for industry and more expensive homes.

Photo Source: Brooks v. Land Clearance for Redevelopment (1966), RG 600, Supreme Court Case Files, Missouri State Archives

RUBY BRIDGES INTEGRATES WILLIAM FRANTZ ELEMENTARY SCHOOL IN NEW ORELANS, LA

THE U.S. BEGINS TO USE ZIP CODES

➔ EFFECT

Race-based housing discrimination and policies become illegal.

Photo Source: Wiki Commons



1968

INTERSTATE 44 COMPLETED, CUTS OFF MCREE TOWN FROM THE REST OF SHAW

Highway displaces a majority of the neighborhood and creates a physical barrier between neighbors.



1973

➔ EFFECT

Population declines and businesses begin to close.

Photo Source: Wiki Commons, Map data © 2018 Google

U.S. COMMISSION ON CIVIL RIGHTS HEARING ON USE OF FEDERAL URBAN RENEWAL PROGRAM IN ST. LOUIS COUNTY CONCLUDES

1960

MILL CREEK VALLEY RENEWAL BEGINS

GREATER ST. LOUIS FREEDOM OF RESIDENCE COMMITTEE FOUNDED

1965

INADVERTENTLY REINFORCES RACIAL STEERING

1970

DEMOLITION OF FRUITT-IGOE BEGINS

1975

JONES V. MAYER

Supreme Court determines that developers cannot deny family opportunity to purchase a home solely based on race.



1968

➔ EFFECT

This was later used as precedent for future housing discrimination cases.

Photo Source: St. Louis Post-Dispatch

FAIR HOUSING ACT PROHIBITS "REDLINING"

1968 federal act prohibits discrimination in the sale, rental, and financing of housing based on race, religion, national origin, or sex.



1968

➔ EFFECT

White Americans move out of the cities into sprawling suburbs.

Photo Source: St. Louis Post-Dispatch

UNITED STATES V. CITY OF BLACK JACK

Eighth Circuit Court of Appeals in St. Louis finds zoning ordinance invalid.



1974

➔ EFFECT

City of Black Jack ordered to allow development of low-cost housing.

Photo Source: Paul Sableman

“It is hard to argue that housing is not a fundamental human need. Decent, affordable housing should be a basic right for everybody in this country. The reason is simple: without stable shelter, everything else falls apart.”

—Matthew Desmond

1980

1985

1990

1995

MISSOURI PASSES REAL PROPERTY TAX INCREMENT ALLOCATION REDEVELOPMENT ACT

TIF incentives introduced as a tool for communities to redevelop blighted areas.



1982

➔ **EFFECT**

Enables cities across the state to finance redevelopment costs through property tax revenues generated after the land has been redeveloped.

Photo Source: Wiki Commons

METROPOLITAN ST. LOUIS EQUAL HOUSING AND OPPORTUNITY COUNCIL ESTABLISHED

KIRKWOOD ANNEXES MEACHAM PARK

Kirkwood promises to deliver better amenities to the historic black neighborhood that struggled to maintain services.



1991

➔ **EFFECT**

Two-thirds of the land is dedicated to development of a shopping center, and neighborhood population continues to shrink.

Photo Source: Clark Randall

MCREE TOWN REDEVELOPMENT CORPORATION GRANTED EMINENT DOMAIN

Board of Aldermen grant authority to condemn land and buildings of owners who refuse to sell.



EFFECT

Neighborhood demolished, and Botanical Heights neighborhood developed.

Photo Source: City of St. Louis

CITY OF ST. LOUIS AND NATIONAL GEOSPATIAL-INTELLIGENCE AGENCY ANNOUNCE A SITE IN NORTH ST. LOUIS CITY

The 97-acre site will be in the historic St. Louis Place neighborhood.



EFFECT

Remaining residents in the site area are displaced.

Photo Source: Laura Brossart

BOARD BILL 87 PASSES IN CITY OF ST. LOUIS

Aims to discourage landlords from illegally removing items and/or changing lock on tenants without proper legal procedures.



EFFECT

Landlords can face fines, time in jail or both for locking out tenants.

Photo Source: Rebecca L. Gorley of ArchCity Defenders

2000

SEPTEMBER 11, 2001

CIVIL RIGHTS ENFORCEMENT AGENCY IN CITY OF ST. LOUIS

Established by Ordinance 67119.



EFFECT

Gives citizens further access to report discrimination via agency investigating fair housing complaints.

ARCHCITY DEFENDERS AND ST. LOUIS EQUAL AND COMMUNITY REINVESTMENT ALLIANCE FOUNDED

COMMUNITY BUILDERS NETWORK CREATED

2005

BARACK OBAMA ELECTED FIRST AFRICAN AMERICAN PRESIDENT

SCHNUCKS CLOSES IN FAIRGROUND PARK

Maryland Heights based grocery chain announces it will not renew its lease in this North City location.



EFFECT

This area of high need loses food access.

Photo Source: Jasmine Burris

2010

MICHAEL BROWN IS FATALLY SHOT BY OFFICER DARREN WILSON

Ferguson protests highlight racial inequity in St. Louis County and the City of St. Louis, drawing national attention.



EFFECT

Acceleration of the #blacklivesmatter movement and formation of the Ferguson Commission.

Photo Source: Wiki Commons

2015

TEAM TIF BEGINS

BOARD BILL 260 PASSES IN THE CITY OF ST. LOUIS

Becomes illegal for a landlord to refuse a tenant's application because they are using a housing voucher.



EFFECT

Source of income becomes a protected class.



05

SEGREGATION IN ST. LOUIS TODAY

Daily life in contemporary St. Louis has been shaped by a history of segregation and exclusion—to the detriment of African Americans and the entire region.

“People sleeping in cars with children. That’s real.”

—*Kalila*, on the high rate of evictions in the region

How does the St. Louis region’s long history of segregated housing policy and practice affect us today?

The following chapter presents a series of maps showing various boundaries of segregation in our region that positively and negatively affect health, livability, prosperity, connectivity, and accessibility. Coupled with these maps are interviews with St. Louis residents existing within, and sometimes across, those boundaries.

Map data © 2018 Google

“If we had the same quality schools here, there would be peace of mind. We’d have a sense of community in our community.”

—*Brandy*, on the lack of quality schools in her neighborhood

“I think people don’t like to be reminded of what ails the city while they are in their protective bubble.”

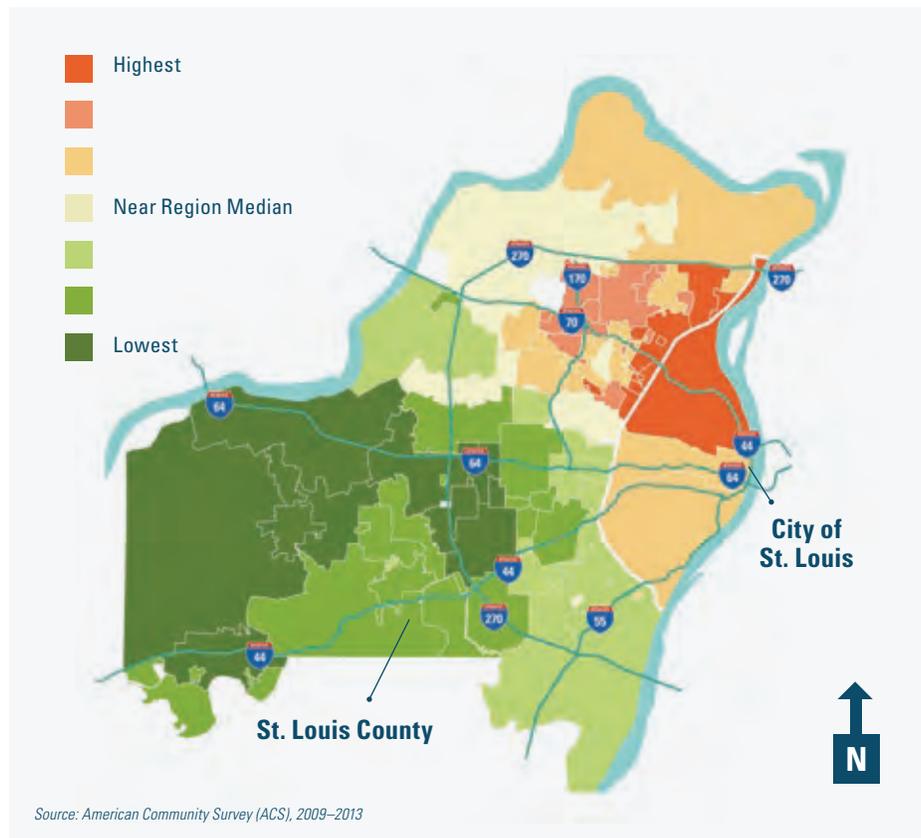
—*Tony*, on discussing race and inequity in the St. Louis region

The boundaries of exclusion

Just how separated are we by race and economics? Our team worked with analysts at Missouri Wonk to quantify regional exclusion using indicators with these traits: higher rental cost, housing values, and percentage of homes on larger lots; a lower percentage of African American population; and lower percentages of residents living below the federal poverty level and/or receiving housing assistance. An index combining these factors was developed, and each municipality in the St. Louis region was ranked by its level of exclusion. The results are shown in Figure 17. For the purposes of this analysis, the City of St. Louis was divided into northern, central, and southern partitions to aid in comparison. Municipalities shaded red or orange ranked the “most exclusionary,” meaning they remain inaccessible to most low-income and/or African American families in our region.

As Figure 17 shows, these exclusionary areas in the region are within the central corridor of St. Louis County, roughly along the route of Interstate 64/40 as well as most of far western St. Louis County. The second most exclusionary areas are adjacent to the most exclusionary, with most clustering in southwestern St. Louis County with the exceptions of Creve Coeur and Clayton. The third tier of exclusionary areas are mostly clustered in the southeastern portion of St. Louis County with the exceptions of Olivette, Richmond Heights, Webster Groves, Kirkwood, and Valley Park.

Figure 16. How do areas of St. Louis rank on a poverty index?



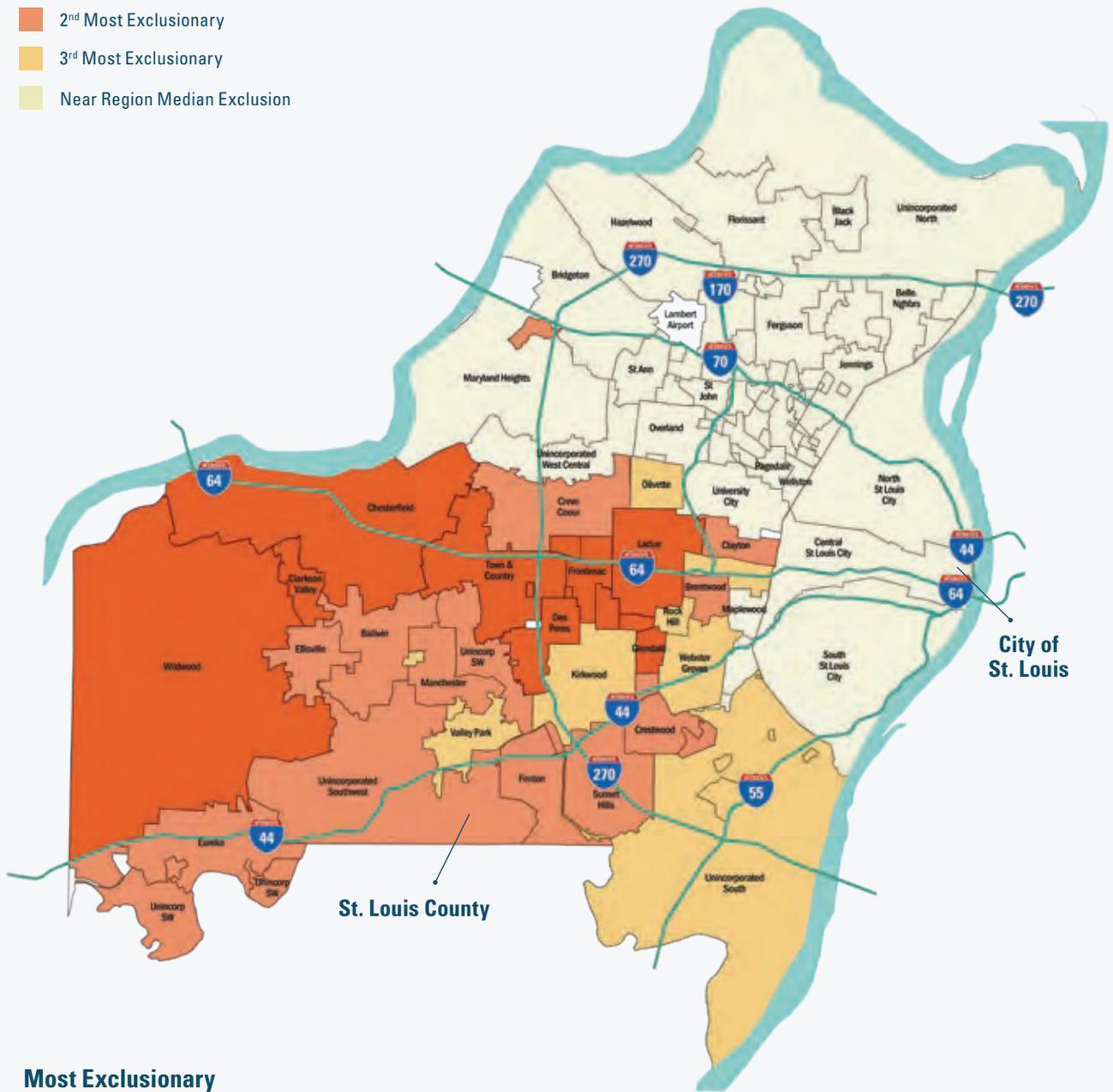
All areas within the City of St. Louis as well as most of North St. Louis County, and municipalities such as University City and Maplewood are either in line with the regional average or less exclusionary. Because the analysis is at the municipal level, our team was not able to depict areas *within* municipalities that are more or less exclusionary. This means that the map does not show whether there are parts of each municipality that are more or less exclusionary. It is also important to note that less exclusionary areas do not necessarily equate with areas of opportunity in terms of jobs, transportation, education, healthcare, and other resources.

Nearly all of the region’s most exclusionary communities have poverty rates that are significantly lower than the region average (Figure 16).

These exclusionary communities are often marketed by real estate agents as great places to raise families because of their strong schools. Newer suburban cities on the outer fringe of St. Louis County are also marketed to middle-class buyers for their inventories of new, larger, and more affordable homes. The long-term economic advantages to buying in these communities—if a buyer can afford it—are unmistakable, even luring buyers who may value diversity and understand the region’s history of race and segregation.

Figure 17. Which cities and regions in St. Louis are the most exclusionary?

- Most Exclusionary
- 2nd Most Exclusionary
- 3rd Most Exclusionary
- Near Region Median Exclusion



Most Exclusionary

- | | | | |
|---|--|--|---|
| <ul style="list-style-type: none"> 1. Warson Woods 2. Westwood 3. Clarkson Valley 4. Ladue 5. Des Peres 6. Huntleigh 7. Country Life Acres 8. Crystal Lake Park 9. Town & Country 10. Frontenac 11. Wildwood | <ul style="list-style-type: none"> 12. Chesterfield 13. Glendale 14. Ballwin 15. Fenton 16. Oakland 17. Sunset Hills 18. Creve Coeur 19. Champ 20. Manchester 21. Unincorporated Southwest | <ul style="list-style-type: none"> 22. Ellisville 23. Eureka 24. Clayton 25. Brentwood 26. Grantwood Village 27. Crestwood 28. Twin Oaks 29. Webster Groves 30. Olivette 31. Mackenzie 32. Kirkwood | <ul style="list-style-type: none"> 33. Unincorporated South 34. Rock Hill 35. Lakeshire 36. Winchester 37. Valley Park 38. Wilbur Park 39. Richmond Heights 40. Green Park 41. Bella Villa |
|---|--|--|---|



Source: Missouri Work 2017

Tony Messenger, the metro columnist for the *St. Louis Post-Dispatch*, is a prolific proponent of regionalism, social justice, and racial equity in his columns.

But he's often attacked on one short line in his biography. He and his family live in Wildwood. When Messenger and his wife relocated from Columbia, MO, to St. Louis in 2011, they chose to buy a home in the 11th most exclusionary municipality in the region according to our analysis. Wildwood, located within a 40-mile drive of his downtown St. Louis office, has a population that is more than 90 percent white. Less than 2 percent of its residents are African American.⁹⁸

Messenger said he and his wife found themselves in a situation common to many middle-class families who relocate to St. Louis. They encountered the double burden of finding affordable middle-class housing within a high-performing school district.

“When we first came to town, we had an interest in looking closer to the city,” he said. “But the houses that fit our lifestyle were two to three times more expensive than we could afford.”

Messenger said a dream home for sale in the city's Shaw neighborhood was too expensive, and it meant the family would likely incur private school tuition

costs for their two young children because of the poor performance of city schools at the time.

They settled in Wildwood because of newer homes that were more affordable and within a very strong school system. Their real estate agent was the one who suggested that it best fit their needs. And in a way, it does.

“We found a church nearby that we liked. And the great thing about Wildwood, it's got such great access to state parks and trails and the Meramec River. We've ended up enjoying it,” he said. “But I hate the commute, and I worry about my kids not experiencing the diversity I'd rather have them experience.”

Messenger makes a point of showing his white children his columns on inequity and racism. He walks his teenage son a mile from the *Post-Dispatch* parking lot to the Cardinal's games at Busch Stadium and talks about urban and equity issues they see along the way.

He says he has a lot easier time talking about racial inequity and social justice with his kids than his neighbors. One of the biggest trade-offs he encounters is the silence that many residents in mostly white suburbs adhere to regarding race and equity.

“When I'm at my kids' ball games in the suburbs, I always know the one or two parents interested in talking about the things I write about,” he said. “But I tend to avoid talking about those issues with anyone else. They're not interested in talking about it.”

Not long after they moved to Wildwood, Messenger took his daughter to a local café for a birthday breakfast. He was spotted by a state senator who posted publicly on social media that he was shocked to see him in Wildwood. Shouldn't he be in St. Louis volunteering at a soup kitchen, the senator wondered.

Messenger said attacks like that are designed to explicitly silence discussion in the suburbs about white privilege and equity. The politician was drawing a clear geographical boundary about where race and poverty can and should be discussed, he said.

“I think people don't like to be reminded of what ails the city while they are in their protective bubble, and I do that,” he said.

Tony Messenger's story illustrates our separation by race and class through housing market forces that drive where many African Americans and whites live. This separation makes it harder to openly discuss issues of racial equity and more difficult to establish the kind of empathy necessary to address it.



Life at Clinton-Peabody: Mice underfoot, bullets overhead

Christian Gooden, *St. Louis Post-Dispatch*

TONY MESSENGER
St. Louis Post-Dispatch

Jane Bradshaw was 18 months old when she fell down the stairs. A baby sitter wasn't paying attention. The toddler was in a walker and made her way to the top of the stairs. Cross the street.

Bradshaw crawled her climb. She had better things.

Today she lives on \$700 a month disability payments in the Clinton-Peabody public housing complex south of downtown.

She and her two children, 6 and 11, wake up nearly every night to the sound of gunfire.

"I need to move away from it," Bradshaw says. "It's not going to stop."

Just 1 1/2 blocks, Bradshaw and several of her neighbors walked east from the housing complex across Tucker Boulevard for a meeting at 8 p.m. to discuss problems with the place they call home. The big topic was mice.

In recent months of the 10-building complex operated by the St. Louis Housing Authority have been suffering through a massive mice infestation. On the 112 apartments in the complex, all serving low-income residents, at least 100 had mice problems as of a December survey by the city's health department. A follow-up inspection in February showed the number of infested units was down to 64.

Mice didn't bring Bradshaw to the meeting, Poverty did.



Tracy Boyd (left) and Elmer Williams listen in officials discuss mice and other issues at the Clinton-Peabody public housing complex. Before living there, Boyd was homeless.

— to other issues in a place like Clinton-Peabody. The housing complex used to have a tenant board to speak for the residents. But it dissolved last year because not enough people would serve.

The solution, state Rep. Steve Franklin says, is about the city and the surrounding community, putting time and money into making Clinton-Peabody a better place to live.

"It's about applying resources to a distressed community," says Franklin, D-St. Louis. Along with state Sen. Jennifer Harshbarger, D-St. Louis, and Rep. Wade Anderson, Clinton-Peabody residents are attending Franklin's hearing to talk and discuss community conditions.

"One year's not give him a bucket of cleaning supplies and say, 'This is the fix,'" Franklin says.

Last year at this time, Tracy Boyd, was homeless. The 32-year-old is happy for a bed over her back. She says things have gotten worse for the families who live on the streets of St. Louis since the city closed the Rev. Larry Rice's New Life, Evangelists Center.

Judney Smith has only been in the public housing complex for a couple of months. But he feels his own place is fine. Because the facility has radiator heat instead of electric baseboard heating, he says about \$200 a month on his energy bill, he says.

He could do without the night job, too.

"They start giving out about 10" months ago. Bradshaw would love to move her kids to a place where she didn't worry about bullets flying in the air at night, but she

Exclusionary communities are often marketed by real estate agents as great places to raise families because of their strong schools.

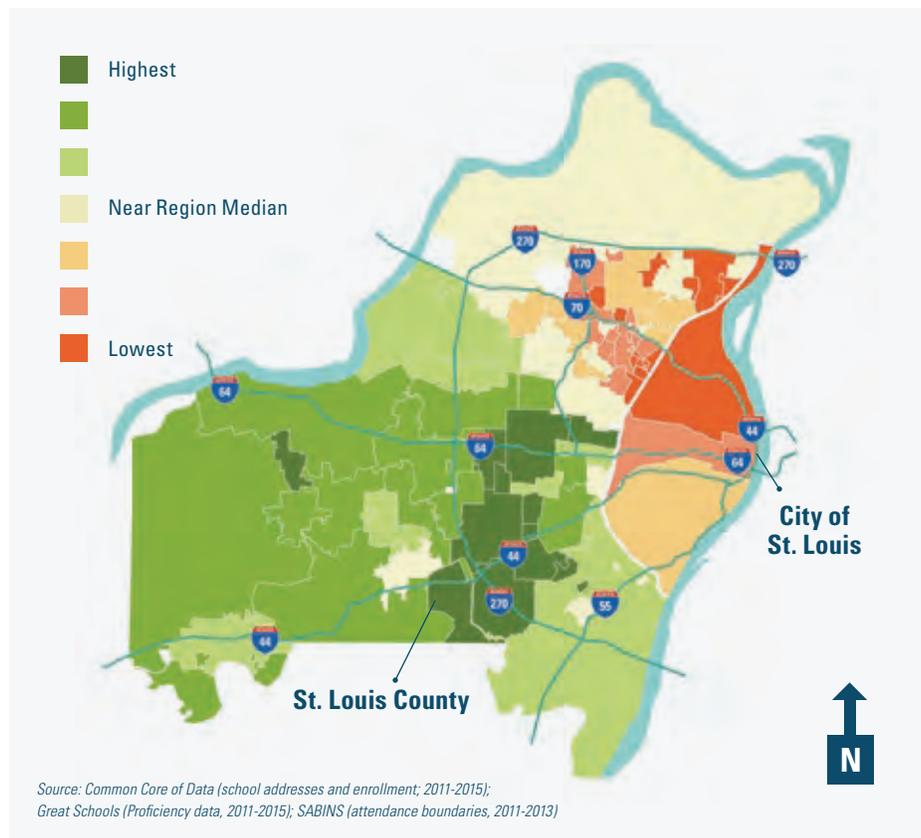
It's about the schools

Messenger's housing choice was driven by the size, newer construction, and affordability of the homes in the western suburbs of St. Louis and the presence of a quality public school district. The region's lowest performing schools exist in the very towns that experienced white flight and disinvestment (Figures 18, 16, and 14). They may rank as less exclusionary to African Americans and lower-income residents, but many residents have little, if any, equity in their homes. They often can't afford to move. And their children will likely be educated in underperforming schools without strong tax bases to support their districts. But the quality of schools does not exist in a vacuum. Very often dedicated educators are working hard to provide quality instruction to a student population that is facing significant social, economic, health, and other challenges. One of the more insidious consequences of economic segregation is that the children with the greatest needs often have far fewer resources at their disposal than children growing up with an abundance of opportunity.

The red, orange, and lighter orange shaded portions of Figure 18 indicate lower performing schools, while the greener shades indicate higher performing schools. Note that the highest performing schools typically exist in more exclusionary areas of our region (Figure 17).

So what are the actions families must take if they are unable or unwilling to buy housing in exclusionary communities but demand equal educational opportunities for their children?

Figure 18. Which St. Louis area schools have the highest and lowest proficiency ratings?



Darren and Brandy of South St. Louis have made educational opportunity a high priority for their three children.

Darren, who is African American, is a proud product of St. Louis Public Schools. But it hasn't been easy given that they live in a low-income area of St. Louis with underperforming schools.

When Darren was in 8th grade, his father woke before dawn one day to stand in line to enter an annual lottery. He won his son a coveted spot at Metro Academic and Classical High School, the state's highest performing high school with a national reputation for excellence.

When Darren and Brandy had their children, they expected to do the same

for them. But when the couple enrolled their youngest son in a feeder St. Louis magnet elementary school, problems arose immediately. The teachers and staff seemed disengaged. Disruptive and sometimes violent behaviors were common in the classroom and at the bus stop.

The couple eventually enrolled all of their children in the city's Voluntary Interdistrict Choice Corporation, otherwise known as the desegregation program or "deseg" for short. From the earliest years of elementary school their children were bused to schools in Kirkwood, more than 12 miles west on Highway 44.

Their oldest son has now graduated, but their younger children Kaleb and Aeden continue to attend high school and middle school in Kirkwood.

Last winter Darren and Brandy proudly displayed a Kirkwood Pioneer Cross Country sign on the small patch

of grass outside the family's brick ranch home. The house sits within earshot of Highway 55 in South St. Louis, a neighborhood south of Bevo Mill that has recently experienced several violent crimes.

At Kirkwood High School Kaleb made alternate to the 2017 state track championships. He plays the cello in the school orchestra. Both he and his younger brother have many friends at school. Almost all of them live in Kirkwood. Brandy and Darren know it's important to spend the gas money and travel time to ensure that their sons are involved with their friends and in many activities and programs through the school.

The desegregation program has been a blessing and a burden. Brandy said it was difficult to send her little boys off on a bus early every morning to go to school so far away. The couple felt like outsiders in the wealthier, less diverse school district.

There were early behavioral issues with their oldest son while attending elementary school in Kirkwood. The couple felt occasionally a teacher stereotyped their child as misbehaving because he lived in a lower-income area of St. Louis and his dad was black and his mom white—an assumption they believe would not have been made if he had been white and living in Kirkwood.

Class was also an issue: Darren is an electrician and Brandy is a waitress. Their older car and their city address were noticed. Families were sometimes aloof.

The couple decided to give living in Kirkwood a try to be closer to the schools. When their eldest son was nearing middle school, they put their house in the City on the market and



Whitney Curtis

leased a cramped ranch house on the outskirts of Kirkwood with a rent that maxed their budget.

But they never settled in. Kirkwood just never felt like home, Brandy said. Their home in the city didn't sell, so they moved back into it.

“We still didn't feel included even though we lived in Kirkwood,” Brandy said. “When we moved back we were like, ‘Thank God.’ The number one thing we felt was, this is our house. This feels like us. That never felt like us. But I felt sorry for the boys because we were so far away.”

Darren and Brandy are proud of the efforts they've put into making the desegregation program work for their boys. But Darren worries the boys try to minimize their racial identity among their mostly white friends. He wonders if they would stick up for themselves if a friend made a racial joke.

“I wish they had exposure to more kids with their same social background,” Darren said. “I think what they want is to be exposed to a whole variety of people with a variety of social and economic experiences.”

Brandy and Darren also know the significance of what it means to lack a high-caliber school in their neighborhood. There is a school



Whitney Curtis

within walking distance of their home. If it were of the same quality as a Kirkwood school, they know it would help their neighborhood. The value of their house has declined since they bought it, yet they've watched Kirkwood home prices soar in the past several years.

People don't sit out on porches in their neighborhood because of crime.

“If we had the same quality schools here, there would be peace of mind,” Brandy said. “We'd have a sense of community in our community.”

Darren and Brandy's story shows just how difficult it is for many working-class families in St. Louis to provide a quality education for their children while enjoying diversity and inclusion in their neighborhoods. Their story also demonstrates how lower-income neighborhoods suffer socially and economically because they lack the anchor of quality schools.

Affordable housing: Far from employment

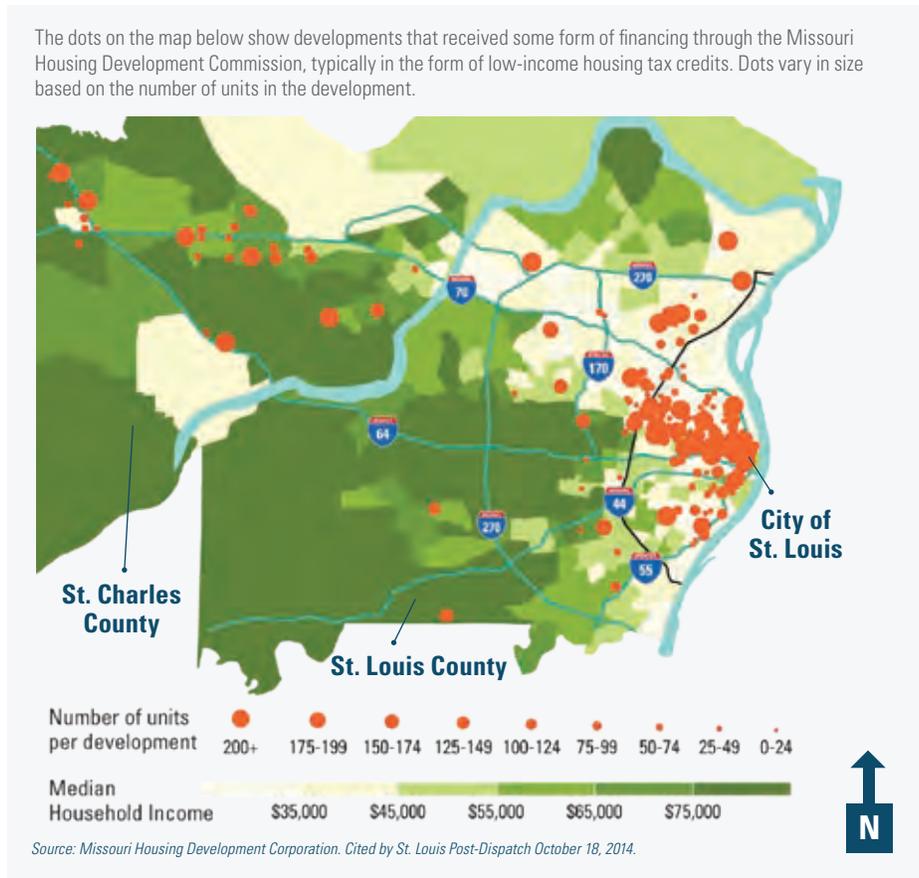
Figure 19 shows the location of high concentrations of affordable housing in the region. In the City of St. Louis and St. Louis County the highest densities of affordable housing exist in places characterized by high levels of poverty (Figure 16) and lower performing schools (Figure 18). The map further shows that low-income housing tax credits and other types of incentives to encourage affordable housing are rarely used in the region's most exclusionary municipalities (Figure 17).

Figure 20 shows the areas with the strongest and weakest access to jobs. Affordable housing in the central corridor of the City of St. Louis has strong job proximity. But note in Figure 20 that the highest density areas of affordable housing in St. Louis County are located in areas with poorer job proximity. This is particularly true in suburban areas of North St. Louis County that have experienced rising rates of poverty and increased segregation. These areas score the lowest on job proximity while also containing high densities of affordable housing.

Figure 20 also shows that some of the region's more exclusionary communities in western St. Louis County also have poor job proximity, requiring longer commutes to places of employment. But Figure 21 shows that residents in these communities typically have cars.

Figure 21 further shows that the majority of residents in areas with affordable

Figure 19. Where are the highest and lowest concentrations of low-income housing in the St. Louis region?



housing do not own cars that would enable them to easily commute to areas with greater employment.

The mismatch between the location of jobs, the placement of affordable housing, and low levels of car ownership place tremendous transportation stress on low-income residents in poor, segregated neighborhoods striving to earn a stable wage.

Shanette has struggled to maintain employment and support her children.

She's been hampered by limited affordable housing options, lack of proximity to jobs and job training, and few options for transportation. About five years ago, Shanette was living with her four children in a cramped North St. Louis County apartment. She was excited to find a larger house to rent for her family.

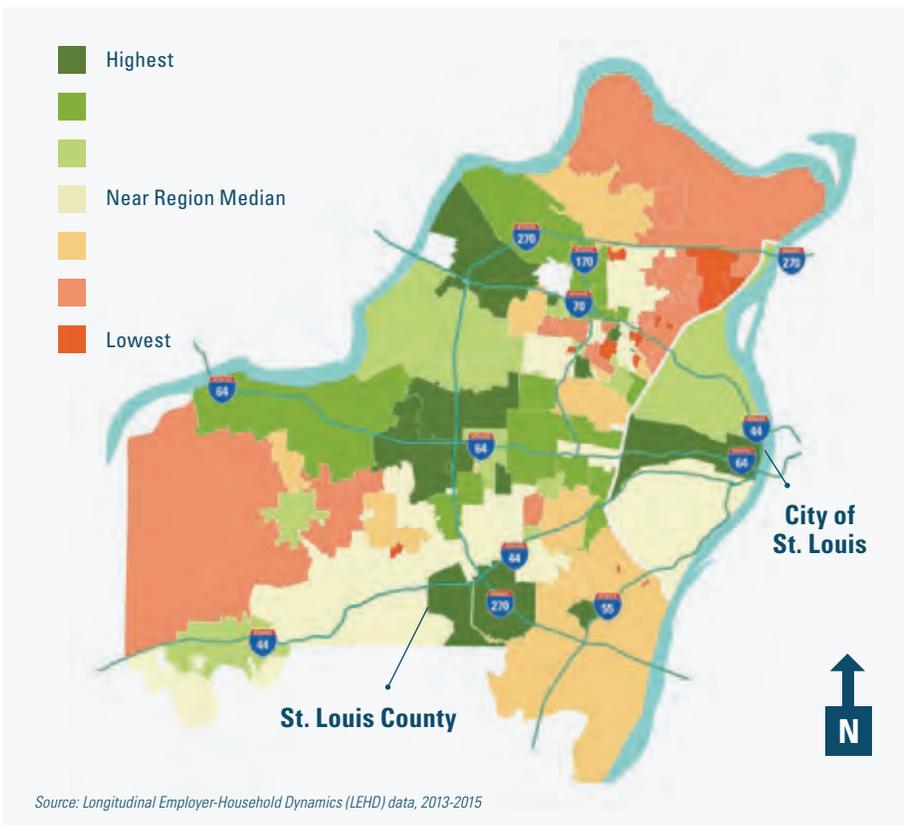
The little gray house on a cul-de-sac in Glasgow Village had a basement and a grassy backyard for the children and was in the same school district as her apartment. She was able to use her Section 8 Housing Choice Voucher to cover the rent. The landlord didn't require a security deposit.

But within a day or so of moving, Shanette was up against a significant challenge that she hadn't anticipated: a hilly walk between her house and the sole Metro bus stop in the neighborhood. Shanette could not afford a car.

Her neighborhood is located on the far northern border of the City of St. Louis. As Figure 19 illustrated, there is a significant concentration of low-income, subsidized homes in her neighborhood.

When Shanette lived in her former apartment, active bus stops on Chambers Road were located steps from her home. In her new house, any commute was a physical challenge.

Figure 20. Which areas of St. Louis have the best and worst proximity to jobs?



At the time of her move she was attending school 18 miles away in Earth City to become a dental assistant. Her new walk to the stop and additional bus transfers added up to a nearly two-hour commute each way. Shanette graduated from the dental program 18 months later despite health problems. But finding a job in the field without much experience or a car to get to far-flung dental offices was difficult. She ultimately could not use her training.

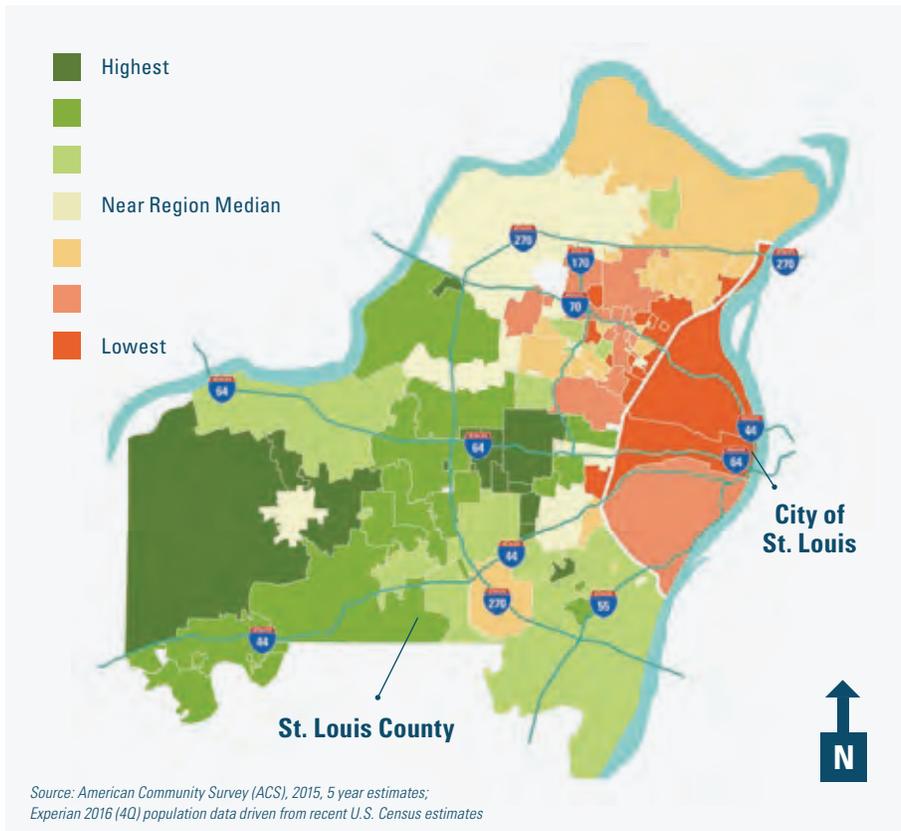
Shanette moved on to other employment, including a morning shift at a McDonald’s in Chesterfield in the winter of 2015. She would wake around 4 a.m. and then wait at the bus stop in the dark to begin her two-hour commute. The job did not last. Her son’s asthma began flaring up. Shanette was missing too much work while getting him to the doctor.

“Without transportation it’s a lot of burden, especially if you have multiple children,” Shanette said.

“As mothers, we do what we have to do. But it’s stressful. You have to leave your kids, and let them get on the bus while someone else is watching them,” she said. “You’re not there to watch them get on the bus or get them out the door.”

Shanette’s story shows how the region’s inventory of affordable housing is often isolated from places of opportunity, making it exceptionally difficult for working families to access critical job training and employment.

Figure 21. In which areas of St. Louis do households have the highest and lowest access to personal vehicles?



The public transit disconnect

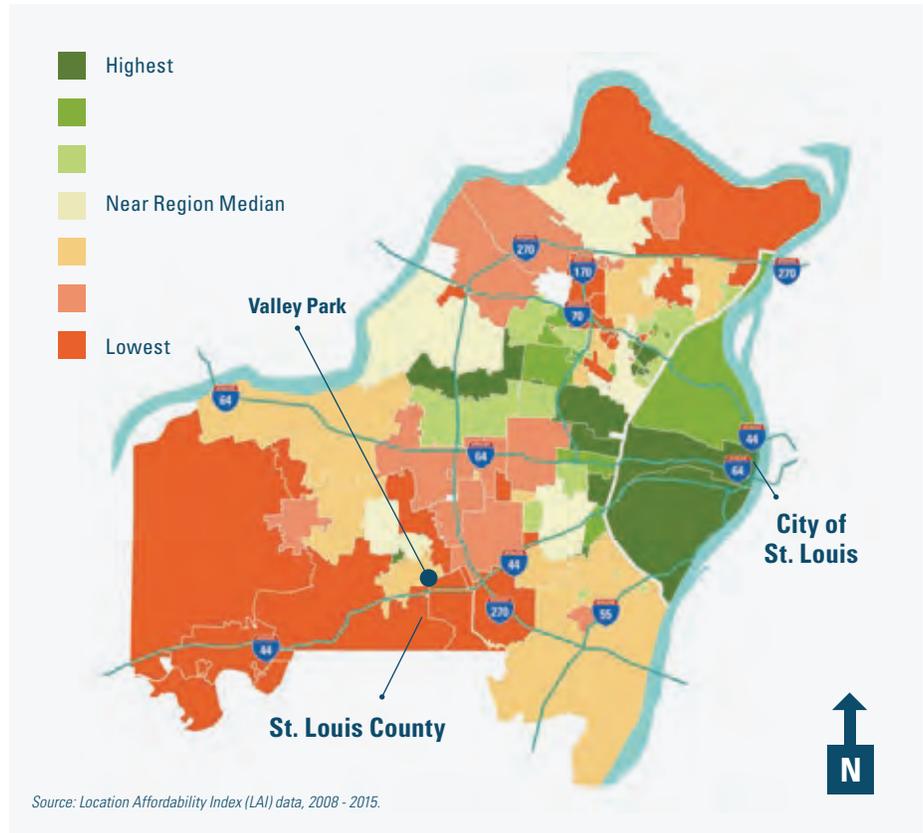
Shanette had limited job prospects due to health issues in her family, poor public transportation, and geographically limited choices for affordable housing.

Figure 22 shows the frequency of public transportation trips in the region for a single-parent family of three with 50% of the median income of a renter in the region. It again illustrates how areas with higher job opportunity remain inaccessible to many of the region's lower income residents. Note particularly how high transit usage for lower income residents is limited mostly to the City of St. Louis and a limited part of the central corridor St. Louis County, while some parts of North St. Louis County and far West County have very little transit usage by low-income residents.

In Figure 22, there is a tiny green spot of high transit usage in the Valley Park area of St. Louis County. The area is located north of Highway 44 and west of the 270 corridor. The area has affordable housing (Figure 19), higher performing schools (Figure 18), and moderate poverty levels (Figure 16).

This would seem to be an ideal place for those in search of economic opportunity for themselves and their children. But the situation in Valley Park also presents a cautionary tale about placing affordable housing in areas of higher opportunity that lack public transportation lines and infrastructure.

Figure 22. In which areas of St. Louis do lower-income households use public transit the most and the least?



LaTonya was 18 in October 2014, when *St. Louis Post-Dispatch* reporter Jesse Bogan met her at home in the Valley Park Apartments complex as she prepared for work.

Bogan was interested in reporting on the affordable housing complex because it is uniquely situated in an area of St. Louis County with a higher performing school district. Valley Park Apartments seemed like the antidote to a common problem: a key to integration and opportunity for lower income residents who are typically locked into affordable housing in impoverished, often highly segregated neighborhoods.

However, Bogan quickly discovered LaTonya's apartment complex is one of the most isolated from public transportation in the region. The closest bus line was located more than a mile away, and had limited service. Another was two miles away.

Lower-income residents in the Valley Park complex were using the transit but making long walks to the get to the bus stop. However, the bus routes were not helpful to LaTonya.

Bogan was shocked to discover LaTonya routinely walked along a narrow shoulder of Highway 141 to get to her job at a Burger King. The bus lines do not run up that highway. The highway has no sidewalks in places, including a long overpass. Every day LaTonya made the choice of walking under the overpass by homeless men who verbally hassled her or walking on the overpass squeezed between the fast lane and a concrete barrier.

A lack of transportation forced LaTonya to walk along this stretch of Highway 141 to get to her job from her affordable housing complex in Valley Park.

“I walked with her every step of the way, but for that piece on the highway where I said, ‘No, I’m not doing that,’” Bogan recalled.

Bogan said he instead walked the dirt path beneath the overpass where he was hassled by a homeless man. He met up with LaTonya on the other side of the bridge.

LaTonya was working the \$7.50-an-hour job to contribute to the household. She was going to high school part time as part of a work-study program. The risk of getting to the job was worth it to help support young children in her family.

Not long after, the family relocated to another affordable housing complex in North St. Louis County with a needed extra bedroom. LaTonya changed school districts.

On Jan. 27, 2015, the night before she was set to re-start school, LaTonya, and her boyfriend were struck and killed by a car while walking on a sidewalk in Wellston. Her mother, when contacted by Bogan, said the move to North County was originally a relief because her daughter would no longer have to walk such a treacherous route to work.

Bogan said during reporting he had sat down with Metro, the region’s transportation coordinator.



“It seemed like a no-brainer to me. I asked, ‘Why don’t you have transportation here?’ But Metro basically said, ‘If you put a stop there, you’d take it away from somebody else.’ To this day there is no stop there.”

“Transportation is a big deal out there for us,” said LaTonya’s mother Tonya. “I’m glad my daughter’s story and what she had to go through is getting out there. She was a good girl, she loved to work and go to school. She had big dreams.”

.....
LaTonya’s tragic story demonstrates how our region’s public transportation and infrastructure sometimes makes it exceptionally hard, and sometimes dangerous, for those in affordable housing in areas of opportunity to get to vital employment.

Food and retail access

Figures 23 and 24 illustrate how decades of disinvestment have left many of our region’s poorest and most isolated neighborhoods without healthy, affordable groceries or common retail needs.

Figure 23 specifically reflects data on access to retail employment in the region, but we also know that access to retail employment further reveals the proximity of retail.

It is clear that residents in North St. Louis and North County in particular lack these essential resources within walking or quick commuting distances. These are the same areas in which residents are more likely to lack access to personal vehicles (Figure 21).

Interestingly, the far western part of St. Louis County shows poor retail employment access while also being home to one of the nation’s largest retail strip malls in the Chesterfield Valley region of Chesterfield. However, the enduring lack of public transportation in the area, Chesterfield’s low-population density from large lot, single-family homes, and the large geographic area encompassing Chesterfield means that residents spend relatively more time traveling to access retail goods and services than in other parts of the region.

Figure 24 was constructed using proprietary marketing data compiled in 2011 by the Centers for Disease Control and Prevention. Though no new maps have been generated since then, it is important to note that a large chain supermarket along North Grand

Figure 23. In which areas of St. Louis do residents have the best and worst access to retailers?

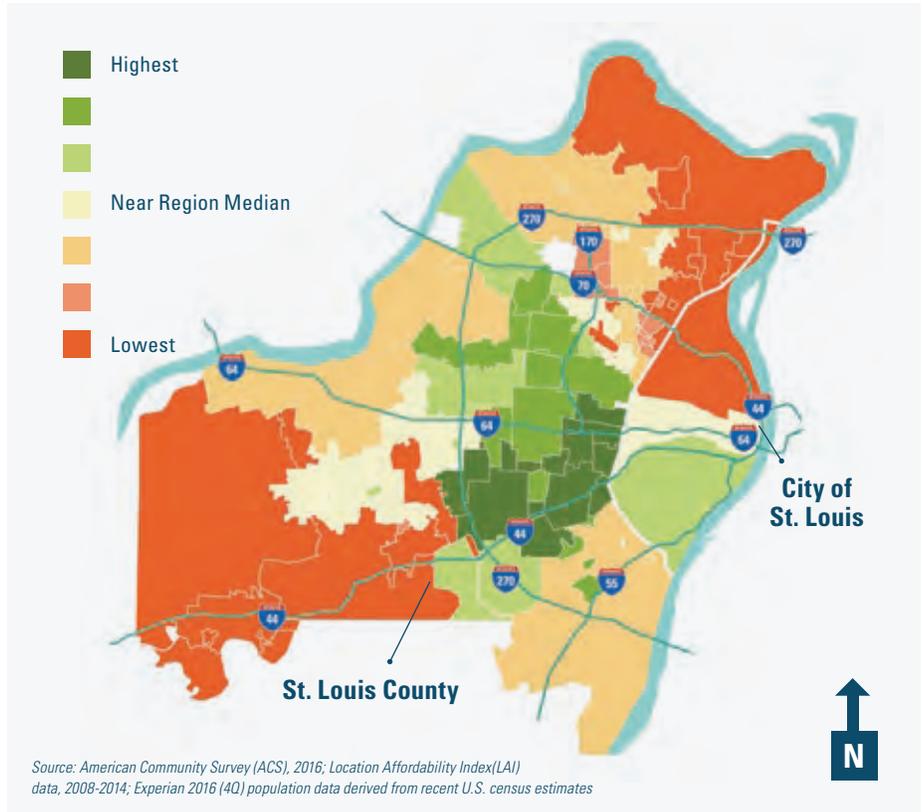
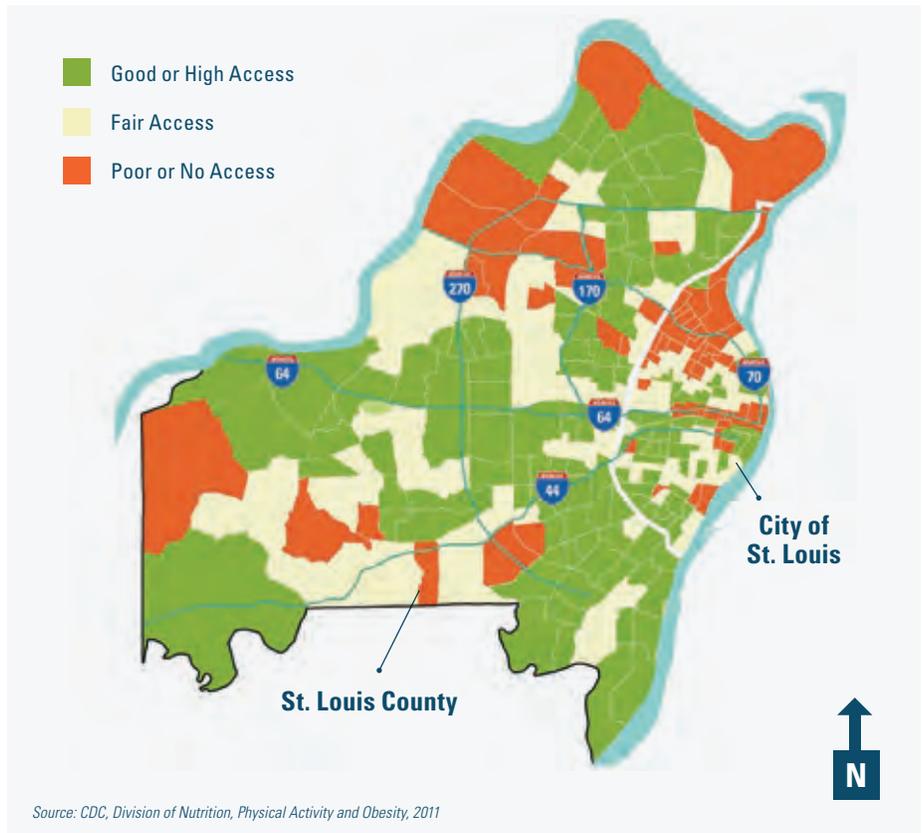


Figure 24. In which areas of St. Louis do residents have the best and worst access to food?



Boulevard in North St. Louis closed in 2014 and was not replaced. Surrounding low-income, mostly African American neighborhoods now lack a major supermarket within walking distance.

LaTosha, a mother of three who also helps care for a grandchild, spends substantial time commuting to obtain affordable, healthy food due to the lack of groceries in her North St. Louis neighborhood. She does not own a car.

Some mornings she wakes early to walk to a budget grocery chain. She has to come when the store first opens before quality items like milk and other dairy products run out.

“On certain days, if you don’t hurry up and get what you need at the store, you have very few items to pick from,” she said.

LaTosha lives just north of the Grand Center arts and entertainment district. A large supermarket is located on Lindell Boulevard about a mile and a half away. But the food there is not affordable, and she doesn’t always feel safe waiting for the bus.



Whitney Curtis

Sometimes she takes a bus to a food pantry about two miles down South Grand. But she said the produce is not fresh unless you arrive early on a certain day of the week.

“If you don’t hurry up and eat it quickly, it gets bad.”

What she’d like to see in her neighborhood is a Walmart Supercenter so she could shop economically and in bulk for the month. Instead, about once every six weeks, LaTosha prepares for a big shopping trip. She takes two buses to the Maplewood Walmart Supercenter seven miles away to get all of her shopping done. Then, because her daughter has a disability, she qualifies to use a Call-A-Ride to return home.

Under the rules of the door-to-door ride service, LaTosha said she was limited to three shopping bags on the van. But she’s since gotten creative.

“If you have a fold-up cart, they can’t turn you down. They can put the cart on the lifter for a wheelchair, and you can put how many bags you want in there. That’s what I do.”

It’s not always easy to plan ahead. When LaTosha came down with a bad cold, she needed cough drops. The nearby Family Dollar store was closed. She walked to a gas station. It was going to cost her about \$4 for a pack of four, a luxury she could not afford.

LaTosha’s story shows that it is exceptionally difficult for many working-class and low-income families in St. Louis and St. Louis County to obtain affordable household essentials and nutritious groceries in their neighborhoods. It can take hours on public transit to get to places that have affordable goods and services.

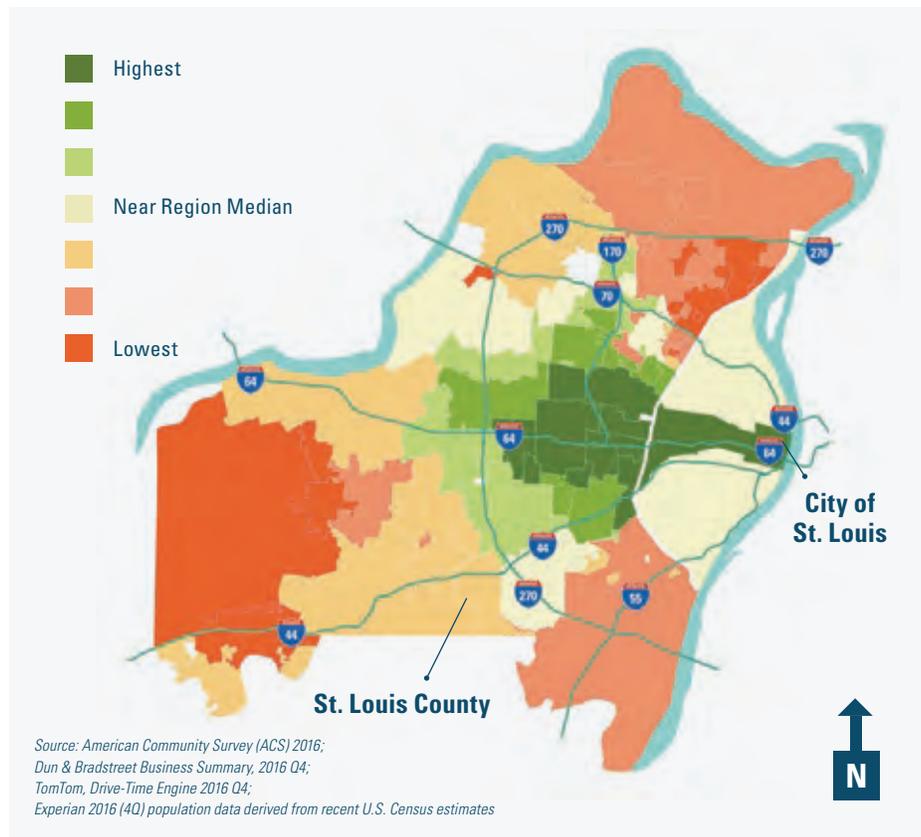
The medical gap

Medical care also is inaccessible for residents living in many of the low-income, African American neighborhoods highlighted in maps in this report. Figure 25 shows the accessibility of physicians in the region. Note from Figures 16 and 21 that physicians also typically don't have offices in the poorest areas in North St. Louis County, the same places where many residents don't own cars. This can make for long, difficult commutes on public transportation to get basic preventative and general medical care.

In 2016 *For the Sake of All* conducted a needs assessment in the Normandy Schools Collaborative as part of a cross-sector partnership to establish a school-based health center at Normandy High School. The school district covers 23 municipalities in North St. Louis County, most of them high-poverty and high-need areas. Surveys and interviews of students, parents, and staff found students were missing full days of school to take public transportation for routine visits to a doctor's office. In some cases, students were skipping medical care altogether or staying home to care for sick siblings who could not get to a doctor's office.

The assessment also found distinct medical needs for treatment of asthma and allergies, and more than a quarter of students reported needing behavioral health support due to poverty, trauma, and anxiety in their neighborhood, but they had poor access to such care.

Figure 25. In which areas of St. Louis do people have the best and worst access to physicians?



The Normandy Schools Collaborative footprint, as well as many other areas of North County and North St. Louis have many uninsured residents, as reflected by the red and orange shaded areas in Figure 26. However, even residents with Medicaid who live in close proximity to health care experience barriers, particularly when it comes to specialized care.

Alecia struggles with access to medical care for her two sons.

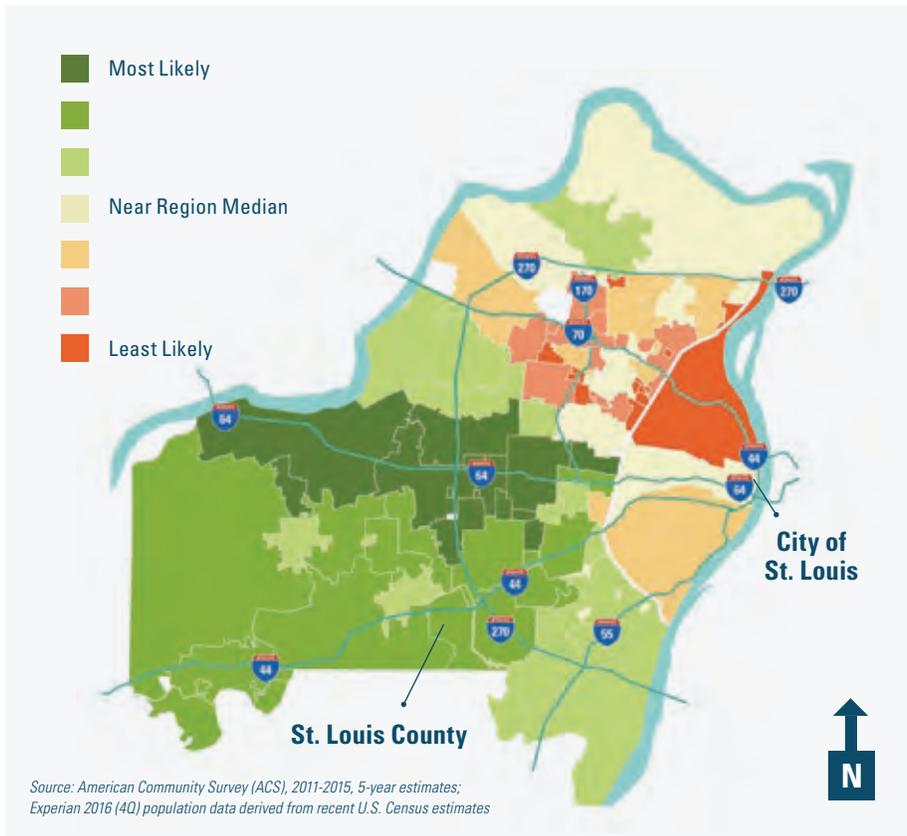
She lives with her two boys in an affordable housing complex on the eastern edge of the Central West End. There are two teaching hospitals within four miles of her home, and yet, the services her kids qualify for

under their Medicaid coverage are not all located within those medical facilities.

Alecia's oldest child, Ramonte, 14, has autism. Earlier this year, her 3-year-old son, Martins, also began showing signs of being on the autism spectrum.

When Martins turned 3, he aged out of the state's First Steps program that provided free speech and other therapies to help him with developmental delays. Since then he's had little in-school therapy beyond what his preschool teacher can give him while managing an entire classroom. He struggles with sensory issues that make him sensitive to bright lights, loud noises, and overstimulation. He has difficulty sitting still and often must take breaks in a quiet corner to calm down.

Figure 26. In which areas of St. Louis are people the most and least likely to be insured?



Alecia



The closest behavioral health provider for Martins is located 15 miles away in suburban Creve Coeur.

Alecia’s older son Ramonte also needs routine behavioral coaching and intervention for his autism. Yet the only outpatient behavioral facility that will accept Ramonte’s Medicaid insurance is 45 miles away in Wentzville, a suburb near the western edge of St. Charles County. Alecia does not own a car. Medicaid will only pay for ambulance rides to and from the facility, not cabs or other special transportation.

A special ride service to get her children to other medical services also has been spotty. Sometimes

the vans don’t show up. Alecia said she’s been let down six times in the past six months.

“We’re usually sitting there for 35 to 40 minutes past when they are supposed to come. So then I have to call the 800 number. They’ll say it’s on its way, or it got lost. Now mind you, I have a doctor’s appointment at 2, and now it’s 1:45. Now I have to reschedule.”

Alecia knows early intervention and regular services will help both of her boys overcome the challenges of autism. She’s even thought of moving to Wentzville for Ramonte so he gets the behavioral health care he needs, but it doesn’t seem possible.

“They have low-income housing,” she said. “But they do not have public transportation.”

Alecia’s story shows that health care that could make a profound difference in children’s development are not easily accessible or readily available for the poor, putting their futures at risk.

Clean air, housing, and health

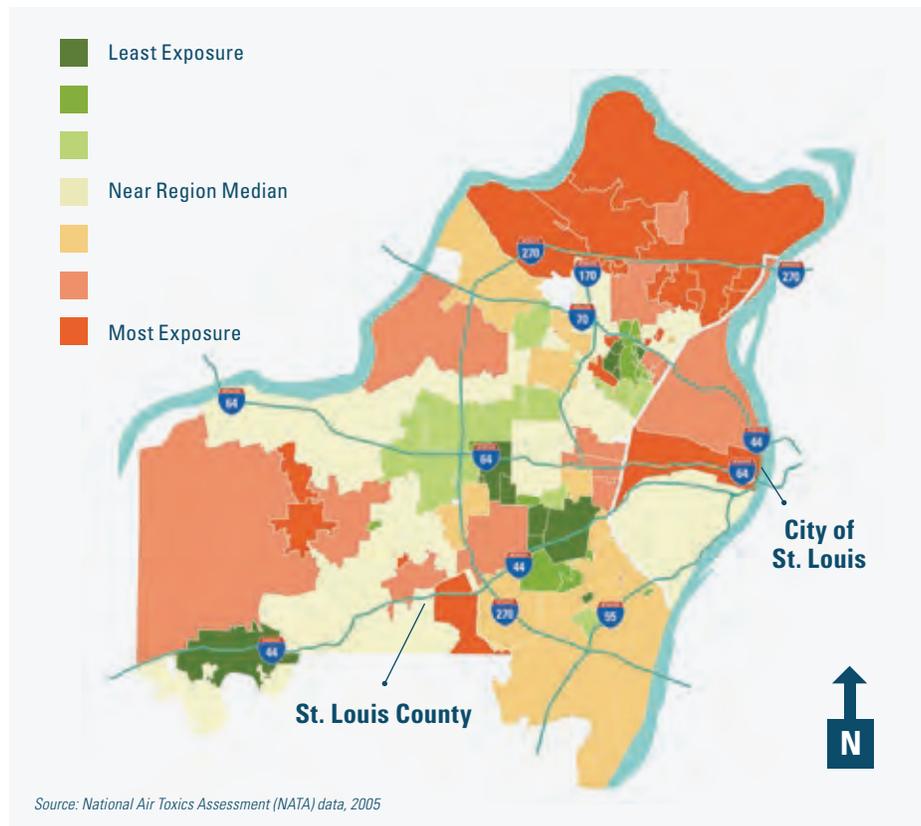
In Figure 27, areas shaded in red and orange show higher concentrations of air exposure to respiratory and neurological hazards in the St. Louis region. The map indicates that exclusionary areas of high opportunity and impoverished areas of low opportunity are exposed to environmental toxins.

For example, in Wildwood and Chesterfield, environmental health is poor primarily due to emissions from the Labadie coal-fired power plant in nearby Franklin County. The Environmental Integrity Project ranked the plant 20th in the nation for high emissions of arsenic, chromium, lead, and mercury.¹⁰⁰ The plant's owner, the state of Missouri, and the U.S. Environmental Protection Agency have come under criticism and faced legal action for not requiring "scrubbers," a pollution control that can significantly reduce toxic emissions from the smokestacks of coal-fired plants.¹⁰¹

In Jefferson County, just south of St. Louis County, two other coal-fired power plants also are operating without scrubbers along the Mississippi River.¹⁰²

Figure 27 also shows that nearly all areas of low opportunity and high African American population in the City of St. Louis and St. Louis County have average or below on environmental quality. In North St. Louis County and

Figure 27. In which areas in St. Louis are people exposed to the most and least environmental toxins?



parts of the City, much of this is attributable to more than a century of heavy industry along the Mississippi and Missouri rivers.

A secondary cause of poor environmental health is related to heavy urban traffic and diesel motors from buses compounded by decades of deteriorating and abandoned housing and factories within these areas.¹⁰³ Not only do decaying buildings release pollutants into the outside air, they cause health problems for adults and children residing within them.¹⁰⁴

Asthma is the most common among those health problems. It is a complex disease. Factors such as pollution, mold, household stress, tobacco and other smoke exposure, and allergies can bring on an asthma attack in which air pathways in the lungs swell and discharge mucus, making it difficult to breathe. Emissions from coal-fired plants lacking scrubbers also are considered a trigger of asthma.¹⁰²

Children in the City of St. Louis have asthma rates at twice the national average.¹⁰² Nearly 20 percent of all children in the City of St. Louis have been to the ER because of asthma, double the state average.¹⁰⁴ Though St. Louis has many programs to manage asthma in children, there are multiple local environmental factors that trigger asthma attacks. Poor air quality coupled with the poor quality of affordable housing overwhelmingly contributes to high incidence of asthma.

All three of Danielle's children have asthma.

They are 9, 8, and 6. In the fall of 2017 she was told by her children's physicians that her low-income apartment was triggering her children's asthma. But she had few affordable housing options and could not move. For nine years she has languished on a waiting list for a Section 8 Housing Choice Voucher, a subsidy that could help her afford to move to a better apartment.

Danielle lived two blocks north of the Wellston Loop. Wellston, one of the region's first inner-ring suburbs to experience white flight in the 1960s and 70s, is now one of the poorest cities in the nation.

Danielle's apartment complex was on a street with vacant buildings and boarded up storefronts that are nesting areas for rodents, which can migrate into homes. Both rodents and insects can trigger asthma.¹⁰⁵

Mice had eaten holes in the walls and flooring in Danielle's apartment. A cosmetic paint job by the property management company, new rubber floorboards, and quick fixes to seal the holes didn't get rid of the mice living in the walls and floors.

Bugs also were everywhere. Their pencil point droppings stuck to the top of pantry and closet doors. Powdery traces of white boric acid lined the apartment where the floor meets the wall to keep them at bay.

The pests put irritants into the air that could trigger an asthma attack.¹⁰⁵ The attacks started with pain and heaviness in her children's chests. Danielle was quick to act with inhalers and breathing treatments to minimize the attacks. But sometimes the kids would miss school; about a week every school year.

Theft and gunfire were common in her neighborhood. A bystander was killed in a shooting while walking on the sidewalk nearby. Danielle could not open the windows to air things out. Some were nailed shut.

“The kids are not allowed outside. Period,” Danielle said, so the yellow spiral slide in the small playground adjacent to the apartment complex went unused.



Colds in the winter also can cause asthma attacks.¹⁰⁶ Danielle knows to quickly get the children on steroids to better protect them from an attack. But the steroids cause them to become hyperactive, which added to the stress in the tiny apartment.

Danielle mostly gave up on cooking because she could not store much beyond frozen food and canned goods in the apartment. The mice and bugs got into everything. She relied heavily on take-out food at a nearby market. This also put a dent in her fixed income.

Danielle said her housing situation was stressful and disheartening. This, too, is hazardous because stress not only triggers asthma, but may increase the risk of depression.¹⁰⁷ Danielle had struggled with post-partum depression, which made it difficult for her to parent her children when they were younger. She had been on antidepressant medication in the past and was trying to take care of herself so she did not have another episode.

“It would be great to find someplace else so my kids and I can feel like we are in a home and be healthy and comfortable,” she said.

Just after Halloween last year she and the children went to Walmart and purchased a small Christmas tree. They decorated it in the front corner of their living room.

In December the property management company agreed to relocate the family to another apartment in North St. Louis after Danielle had a legal services attorney intervene. The children would have to transfer schools, but at least the apartment seemed better.

Three days before Christmas, it was moving day. The Christmas tree was gone. Clothing, bedding, and kitchen supplies were piled in its place. The kids dragged their clothes and toys down a flight of outside wooden stairs to a pick-up truck.

“I think people basically think people who are poor are supposed to have their kids live like this in these conditions,” Danielle said. “But it's not their fault.”

Danielle's story demonstrates how substandard affordable housing and surrounding environmental health risks are making many children in our region sick. This creates a cascade of setbacks for families, including serious chronic illness, regular school absences, housing insecurity, and increased household stress.

Substandard housing and infant-child health

Substandard and poorly maintained affordable housing can sometimes drive residents to make risky health decisions.

Sam and his family witnessed the situation firsthand while living at the Clinton-Peabody affordable housing complex just south of downtown St. Louis.

A mice infestation in the complex was causing mothers to sleep with their babies at night and not use cribs—an unsafe sleep practice for infants.

Sam is part of a group that is trying to get the African American community involved in tackling high infant mortality rates in the region, so he knew bed sharing was particularly dangerous. In St. Louis, African American infants are about seven times more likely than white babies to die of suffocation from unsafe sleep practices like bed-sharing. Several ZIP codes in St. Louis have infant mortality rates higher than state, national, and sometimes international averages, and those ZIP codes have predominantly African American populations.¹⁰⁸



Whitney Curtis

Sam was deeply committed to bettering conditions in Clinton-Peabody. He had even purchased an old bus to help fellow residents get to church and go shopping. He also used it to transport residents to community events and hearings on housing and poverty issues so that his neighbors' voices could be heard.

As local politicians and housing officials debated how to solve the mice infestation, living conditions in Sam's apartment worsened to the point that he and his wife Delois began shuttling their children to a relative's home so that they did not have to sleep there. The mice lived in the walls and squeezed into apartments through holes in the floor and in the walls near radiators, leaving droppings everywhere.

"Right now everyone who lives here is doing what's in the best interest for the children," Sam said. "They're using traps, washing things with bleach and

gloves, and all sorts of this, and all sorts of that. But from my personal situation, it is a no-win battle."

In December 2017 the family decided to pack up the bus and leave for temporary housing.

There was, however, a silver lining to living in Clinton-Peabody. A program at the apartment complex had enabled the family to accumulate savings in an escrow account. The family hoped to be able to use that money to put a down payment on a house in the City.

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Sam's story shows that conditions in some affordable housing in our region causes major family disruptions, hurts community connections, and puts infant health at risk.

Eviction: A spiraling descent into poverty

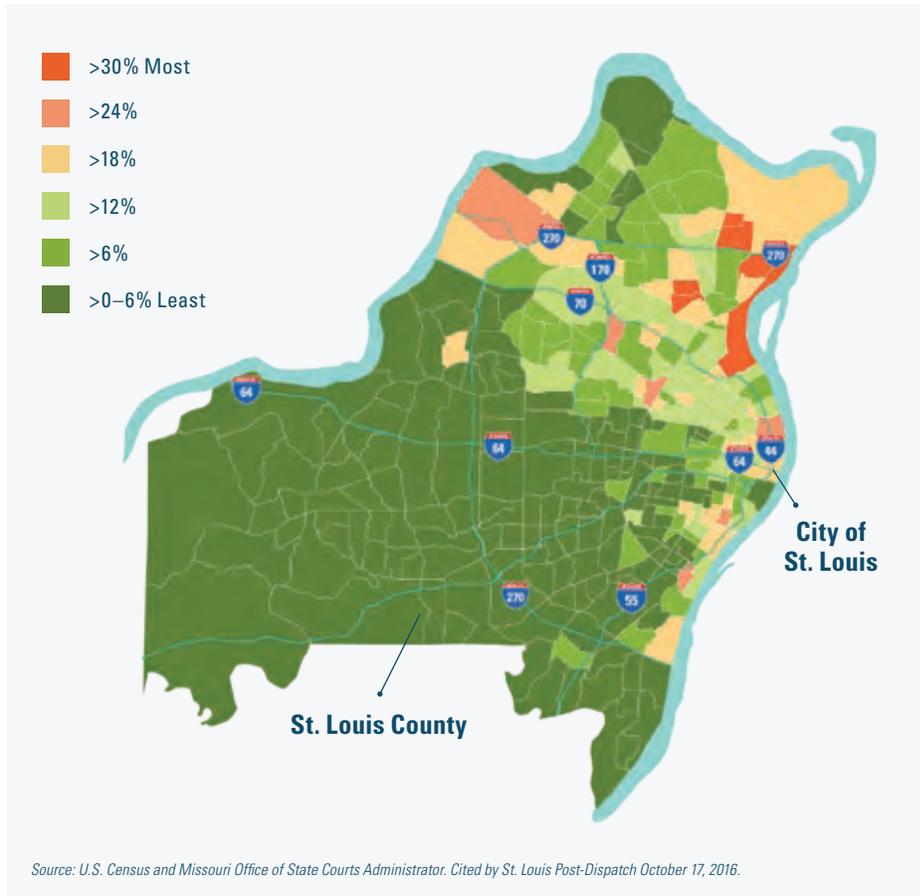
A 2016 analysis of eviction lawsuits in the St. Louis area by the *St. Louis Post-Dispatch* found eviction rates ranged as high as nearly 50% of housing units in areas of North St. Louis and North County.

Figure 28 shows the frequency of eviction and back-rent law suits in the region. Areas in our region that have endured white flight and poverty (Figures 15 and 16) also experience extreme housing instability. From 2013–2016, 16 to 48% of housing units in North County and North St. Louis had residents who were involved in the eviction process, according to the *Post-Dispatch*.

The *Post-Dispatch* analysis also found that, in 2015, nearly 16,000 lawsuits for back rent or apartment possession were filed against tenants in the City of St. Louis and St. Louis County. The report concluded that “years into the economic recovery” from the Great Recession, “thousands of households at the bottom rung of the rental market have yet to find stability.”¹⁰⁹

Eviction remains a major driver of increased poverty in highly segregated and disinvested communities. Once tenants gain an eviction on their court

Figure 28. In which areas of St. Louis areas are eviction lawsuits the most and least common?



records, most landlords refuse to rent to them. As the *Post-Dispatch* explained, “tenants then fall into a secondary housing market consisting of a smaller group of private landlords with relaxed or nonexistent screening policies, into apartments that are more likely to be substandard or situated in high-crime, high-poverty areas.”¹⁰⁹

“Evictions really do make people homeless. That’s not just something people say,” said Kalila Jackson, a lawyer at the Metropolitan St. Louis Equal Housing and Opportunity Council. “People sleeping in cars with children. That’s real.”¹⁰⁹

What’s particularly unsettling in St. Louis and elsewhere is the lack of legal representation and housing counseling available to tenants who must appear in eviction courts. In many cases, tenants don’t know their rights and show up to court without a lawyer. They are often encouraged by court clerks and officials to sign documents prepared by the landlord’s attorney, unaware that by doing so, they are consenting to an eviction. In St. Louis, as elsewhere in the country, the vast majority of residents in eviction court are African American women.¹¹⁰

Ciara's eviction was chronicled in the *St. Louis Post-Dispatch*.

Ciara appeared without a lawyer when she was summoned to eviction court in St. Louis in August 2016. At stake was her chance to remain in her subsidized apartment in a South St. Louis complex overlooking Interstate 55.

Ciara, a hotel housekeeper, said she made some bad financial decisions and had no financial cushion. She was three months behind on rent on the apartment she shared with her daughters, then 13, 8, and 6. Before she was called to the bench to talk with a judge, a lawyer representing the landlord called her name.

Ciara whispered with him on a wood bench in the courtroom and then agreed to sign a consent judgment with him.

The lawyer said she could go to the complex manager and arrange a plan to pay \$1,469 in back rent and fees. Ciara signed it.



Nancy Cambria, *St. Louis Post-Dispatch*

“I’m not evicted,” she said on her way to the elevator.

But a week later Ciara learned that eviction was imminent. The property manager wanted her out and was unwilling to establish a payment plan.

It was infuriating to Ciara because her employer had an emergency fund that would have helped her pay the rent—but only if she was guaranteed she would not be evicted.

The family moved in with Ciara’s mother in University City. They slept on air mattresses as Ciara scrambled to find an apartment she could afford through a website that advertised low rent apartments requiring little or no security deposit. They were mostly in poor neighborhoods. As she looked, the court garnished her wages for back rent.

Ciara wondered if she should go back to court to try to reclaim the back-rent being taken out of her paycheck. She wanted to argue that the complex was unsafe, poorly maintained, and infested with mice.

She did not know that by signing the consent judgment in the courtroom that day she had waived the chance to make that argument before a judge.

Ciara’s story is emblematic of many working mothers who are subject to eviction without proper legal representation. This puts them at grave risk of homelessness and steers them into an alternative housing market in excessively poor neighborhoods with highly substandard housing.

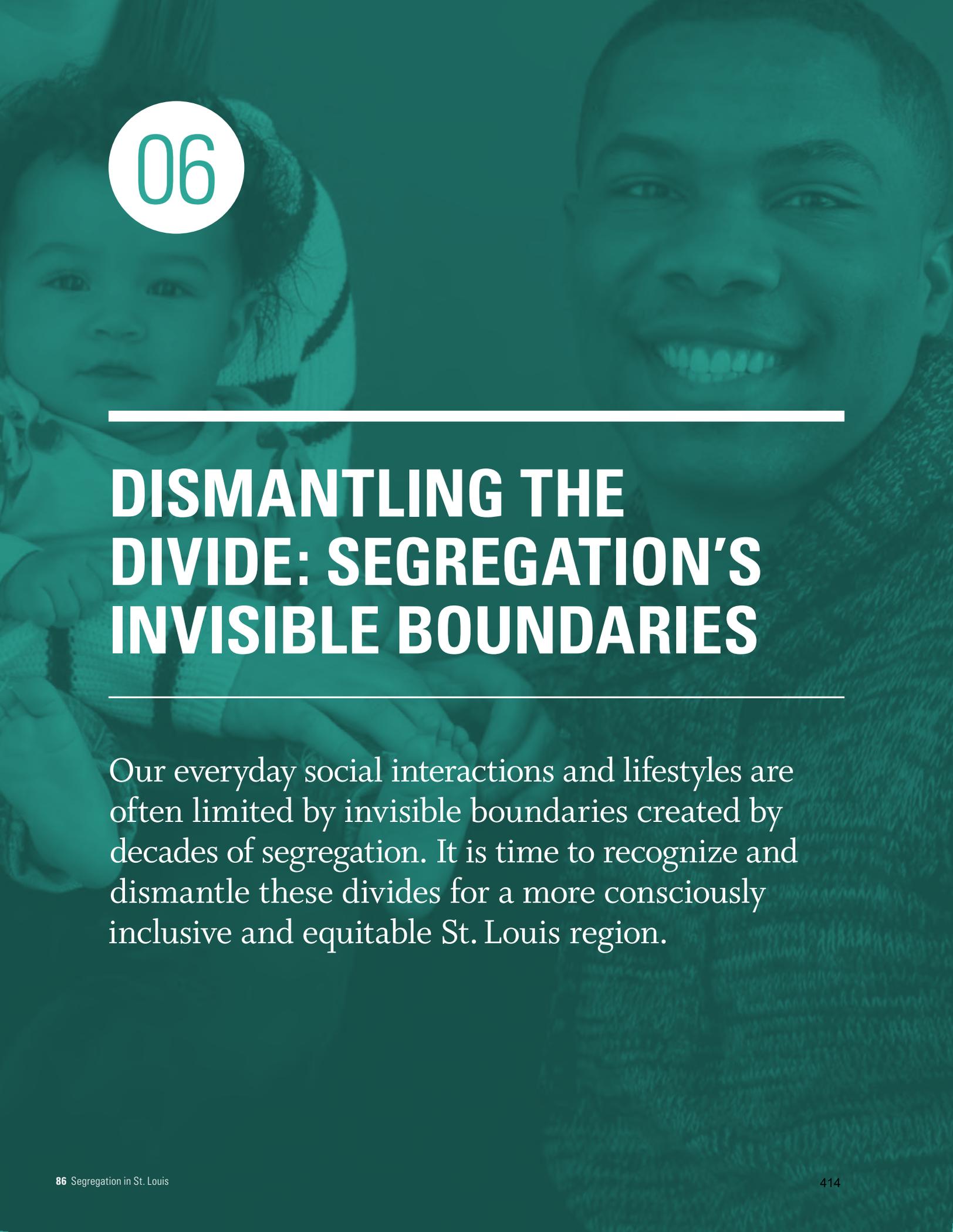


Conclusion

The configuration of neighborhoods in contemporary St. Louis is a result of policies and practices that have reinforced segregation for more than a century. This chapter shows that many neighborhoods with high rates of poverty and substantial African American population are often characterized by substandard housing and lack healthcare access, healthy foods, and retail outlets to obtain household essentials. These neighborhoods are also the most separated from areas with strong employment and educational opportunities. High eviction rates push residents into increasingly disinvested neighborhoods with even poorer performing schools and worse housing. All of this has very real consequences for children, families, and individuals in our region.

Final Thoughts

The personal stories shared in this chapter provide compelling evidence of the daily hardships created by segregation in our region. Many people press on and do their best with grace and resolve, raising families, working jobs, and making differences in their communities. But how much better could St. Louis be if these obstacles were removed so everyone had an easier daily experience and equal chances to succeed?



06

DISMANTLING THE DIVIDE: SEGREGATION'S INVISIBLE BOUNDARIES

Our everyday social interactions and lifestyles are often limited by invisible boundaries created by decades of segregation. It is time to recognize and dismantle these divides for a more consciously inclusive and equitable St. Louis region.



**“For that three hours
we were all together.”**

—*Shauna*, on the power of feeling included

**“Once they move in,
they begin to embrace
the diversity.”**

—*Christina*, on discovering the positives of diversity in a neighborhood

As we saw from the maps in Chapter 5, our history of residential segregation has created significant barriers that limit health and opportunity. These maps do not show the unseen social boundaries that people in our region encounter every day.

It’s much harder to illustrate those divides on a map because they involve the psychological separation of St. Louis residents by race and class. These invisible lines keep us apart and limit our understanding of one another. They often take a great emotional toll as well. In the stories that follow we examine ways in which people are crossing these difficult divides and sometimes finding ways to break them down.

Map data © 2018 Google

**“What would have
happened if people
hadn’t been afraid?”**

—*Kameel*, on the toll of white flight

GENTRIFICATION

Separated by gentrification

When we discuss racial progress in our region, we often point to the growth and resurgence of certain St. Louis neighborhoods that appear to reflect growing diversity. Some allude to the revival and extended growth of the Central West End, where middle-class whites and African Americans are moving into areas that were once predominantly lower-income African American neighborhoods. Or they look to Tower Grove, a once disinvested neighborhood that has experienced an influx of younger, middle-class families choosing to live in the City instead of the suburbs. The historic housing stock is often viewed as an asset for a city looking to bring residents and wealth back to the urban core.

Redevelopment often comes at the expense of existing working class residents, though. Affordable housing is typically not preserved when a neighborhood redevelops or gentrifies to meet the tastes and preferences of only its new, middle-class residents.

In April 2017 Thera was given 60 days to move out of her apartment of 15 years.

New landlords had more than doubled her monthly rent from \$340 to \$695. All six of the tiny row houses in the up-and-coming Benton Park neighborhood were being rehabbed. They were getting stainless steel appliances and white subway tiles in the kitchens.



Whitney Curtis

Thera, then 46, was on disability and living on a fixed income because of asthma and chronic obstructive pulmonary disease (COPD), a lung disease that often tethers her to an oxygen tank to breathe. Before her illness, she had worked for 13 years as an eligibility caseworker in a Missouri family assistance office, often helping families living in poverty. Thera didn't want stainless steel appliances. She just wanted to stay in her home.

But that was not an option.

“I honestly thought I was going to have to go back and move in with my dad,” Thera recalled. “They could have given us a little more warning to get together and decide what the best thing was for that building. They just didn’t give a crap. They do these things, these developers and these real estate companies, without even thinking who they are displacing.”

Thera said she watched her diverse neighborhood of mostly working-class families empty out and fill in with young white professionals, including tourists who were renting a growing number of apartments rehabbed into short-term vacation rentals. It bothered her, not only because she felt invisible to her newer, wealthier neighbors, but also because she felt that the neighborhood was losing its character.



Whitney Curtis

“I don’t want to live in an all-white area, and I never have. I like diversity, or having people around me that represent the rest of the world instead of the white microcosm.”

Thera said she lucked out when an \$800 inheritance came her way so that she could make a down payment on an apartment in the Tower Grove South neighborhood. Her only other options would have been to move in with her father or relocate in a poorer, more isolated area with more crime. She likes her new apartment, despite paying \$85 more a month, which is a hardship.

“It’s a pretty diverse neighborhood, too. But I don’t know if it will remain that way because people are buying things up.”

How much more powerful would our region be if everyone was included in our housing development plans—so that our neighborhoods thrived with different points of view and diverse identities?

Excluded from social networks

Chapter 1 discussed the importance of social networks for health, opportunity, and well-being. Social networks consist of friendships and connections in all aspects of life, be it in employment or in everyday social interactions. Those with strong social networks have better access to resources such as employment opportunities and health, financial, and other types of information. But St. Louis has invisible boundaries preventing people from feeling comfortable and connected to one another, even at some of its most beloved venues.

Sisters Shauna and Stephanie grew up listening to St. Louis Cardinals games with their grandfather on the living room radio.

Now in their 60s, they were raised in a middle-class African American family and lived in a diverse neighborhood in St. Louis near Union and Delmar Boulevards.

The 1960s were the heyday of the Cardinals. Shauna remembers seeing the last game Stan Musial played at Sportsman's Park on September 29, 1963, when she was seven.

The sisters moved away from St. Louis in the early 1970s to go to separate colleges. They pursued successful careers in engineering and theater

management. Both eventually settled in the New York area. Their love of baseball continued. They donned blue and headed to Yankees and Mets games. They loved the thrill of the crowd and the camaraderie of the game: high-fives and hugs.

“We’d go and we’d be in our team colors,” Shauna said. “When the team was successful, everybody celebrated together. For that three hours we were all together. We were all pulling together.”

When it was time to retire, the sisters chose to return to St. Louis. One of the factors that brought them back was their beloved Cardinals team. It was thousands of dollars cheaper to buy season box tickets for the Cardinals than the Yankees. For Shauna the thought of regularly attending dozens of games a season was a heavenly way to spend retirement.

In some ways it was. On May 26, 2015, Shauna caught a foul ball on the fly off the bat of Matt Holliday with her baseball glove. It qualified her for a Cardinals “honoring contract,” a prized document celebrating her achievement. It was the same game Holliday tied Albert Pujols’ record for reaching base in consecutive games.

But after three seasons, the sisters stopped buying season tickets. Shauna said the invisible boundary between her and the other nearly all white season ticket holders was palpable.

Early on, when a big play happened on the field, Shauna instinctively held up her hand for a high-five with the fans behind her, but she did not get a celebratory slap in return.

“They would look at you like, ‘What do you want?’” Stephanie recalled.



Whitney Curtis

The stadium friendships they expected with other season ticketholders didn’t materialize. Even though their T-shirts were the same, it became increasingly apparent that they weren’t socially connecting with other fans.

“I was spending a fortune on these tickets and getting a singular experience when I really wanted a collective one,” Shauna said.

Following an especially divisive election and the perception among many that openly racist behavior was on the rise, their slight discomfort at Cardinals games had become genuine uneasiness.

The sisters still love their Cardinals. They still go to games on occasion. Shauna, the engineer, follows the stats. But in all her calculations about retirement, she didn’t take into account an invisible color line within their Cardinal Nation.

What friendships and assets are we missing out on as a region if we continue to self-segregate ourselves from rich and rewarding social interactions?

The emotional boundaries of white flight

The history of white flight has also created intense emotional boundaries between people in our region. This history has also caused a sense of loss that is deeply felt but seldom expressed across racial lines.

Christine Schmiz and Cheeraz Gorman told their personal experiences of white flight through a fall 2017 “We Live Here” podcast on St. Louis Public Radio.

Christine is white. Cheeraz is African American. They had never met, but in the podcast they both mourned the North St. Louis neighborhoods that no longer resemble the places they remember as children. Both shared a powerful sense of loss and remorse.

Co-producers Kameel Stanley and Tim Lloyd said the fall 2017 podcast was one of the most popular they’ve produced on St. Louis.

“We’ve gotten a lot of feedback from people, especially locals who really said that it just resonated with them whether they were in Christine’s position or Cheeraz’s position,” Stanley said.



Carolina Hidalgo, St. Louis Public Radio

“This is the story of many people in St. Louis, and I would go out on a limb and say, it’s a story also happening outside of St. Louis. Anyone who has experienced life in a city that has declined probably has had these feelings. They are recognizing their own implicit role in society’s problems.”

Christine, now in her mid-60s, grew up in a small brick house in North St. Louis near the now demolished Sportsman’s Park. Cheeraz, a generation younger, grew up about a mile further north on Grand Boulevard in the College Hill neighborhood.

“We thought we were the coolest of all because we lived across from the baseball stadium on North Grand,” recalled Christine in the podcast. “The lights of the stadium shone in our bedroom.”

Christine said her childhood in the neighborhood was “somewhat magical,” with everything they needed within blocks of their house. The house was the first the family ever owned and was purchased jointly by her parents and grandparents, who combined their resources to make it work.

When Christine was a teenager in the mid-1960s, anxiety overtook the area as more African American families began moving into the area. Rumors spread that property values would fall.

“We were raised during that time in church where the priest would say everyone is equal, color doesn’t matter... until this whole thing about your property values,” Christine said. “They had this house, and the thought of losing your home—losing the value of your home—was really frightening.”

So, when she was 14, her family sold the house to a speculator for about \$9,000. Christine’s parents paid double for a house in an all-white subdivision in South St. Louis County. It was a hardship for her family, both financially and emotionally. Her grandparents moved to an apartment in the City. Christine lost her daily connection to childhood friends because the bus ride from her new house to her old neighborhood was impossibly long. Their family life grew more complicated. Her brother went to Vietnam. Her sister went through difficult times. In a way, Christine felt she had lost her life compass.

“I never felt like I belonged anywhere for a long time.”

Christine’s story was followed by Cheeraz’s. Cheeraz also explained the impact of white flight on her neighborhood a generation later. In 1969, her grandmother became one of the first black homeowners in College Hill centered around the historic North Grand Boulevard water tower. At first, people egged the home, but acceptance came. Cheeraz lived in the house until she went away to college and later went into advertising.

As a child, Cheeraz remembers a thriving neighborhood with shops, nearby jobs, and industry. Her neighbors were bricklayers, teachers, and auto workers. Everyone knew everyone else on the block. One of the family’s closest friends was a white neighbor.

“The whole thing of being white and black, and that being a tense relationship or contentious . . . did not even compute to me as a kid,” she said. “That tension didn’t even exist on this block or in the neighborhood when I was growing up.”

But as most of the whites and middle-class African American residents left, so did local jobs and resources.

“It was closer to the late 80s, early 90s when things started turning—when you could see the effects of the underground drug economy ticking up, and things started feeling a bit unsafe,” Cheeraz said.

During one of her visits home Cheeraz looked around at the abandoned buildings and empty lots where once



regal homes had been demolished. She felt loss. She wrote a long poem about it she later read at a local forum.

Christine happened to be in the audience and felt an immediate connection with Cheeraz.

In the podcast both Christine and Cheeraz visit their childhood homes on blocks with abandoned homes and weedy lots.

Christine’s old house looked smaller than it was in her memory. But the emotions were intense.

“I’m not a person who likes to go back,” Christine said. “It mainly now feels sad because I feel like it’s such a ridiculous waste.”

Cheeraz struggled to recite her poem out loud while standing on her childhood street in College Hill.

She was choked up. The neighborhood looked nothing like the caring village recalled in her childhood memories of security and promise.

“There’s something really blasphemous about taking away things that are precious to people. And I think people

don’t realize how precious buildings are, and environments are, and the memories that come to mind, and, you know, the things that happened.”

Cheeraz was asked what would have happened if people stayed.

“What would have happened if people hadn’t been afraid?”

“You might have walked through this world more whole... You would have had some great memories. You would have had some great friends who would have become adopted family members.”

“Yeah, you missed out on some really meaningful connections,” Cheeraz said.

How could we strengthen and unify our region by coming to terms with the human toll of our long history of housing segregation?

Crossing boundaries, building community

What does it take to change more than a century of ill-fated housing policy that has left too many in our region excluded, isolated, and disconnected?

In the next chapter we will explore numerous policy recommendations to build fairer, more equitable housing and opportunity for all residents in our region. It will take community action, and policy and systems change.

But it will also take a willingness for the people of St. Louis to more freely cross both the visible and invisible boundaries that segregate them and ultimately hold the region back.

We end this chapter with two stories highlighting personal ways people are breaking down these boundaries.

About a year ago, John was so pleased by his new North St. Louis County neighborhood that he began a special Instagram account tagged “Pasadena Hills” and started tagging real estate agents from around the region.



Whitney Curtis

The account highlights the architecture and the natural beauty of a historic neighborhood that was one of the nation’s first planned suburban communities in 1929.

“I thought, if we could really promote the area we could lure a lot more buyers here,” said John, who is white, and who purchased his home with his husband in 2015.

Once an all-white community, Pasadena Hills is 66% African American and 28% white.¹¹¹ John’s purchase in a community in which the majority of the population is African American bucks the trend reported in research that finds white homebuyers lose all interest in neighborhoods that lean beyond 40% black.¹¹²

John, a St. Louis native who has lived in Clayton and various neighborhoods in the City of St. Louis, said not enough people really understand the potential of North St. Louis County. Though he has friends who value diversity, he said they rarely consider looking at North County, even though crime is statistically less than in trending areas of the City of St. Louis, and homes are far more affordable.

A year ago, John hosted an open house for about 80 people in Pasadena Hills to show off the neighborhood at the request of Anthony Bartlett of STL Transplants. The organization has been working to break down barriers that prevent renters and homebuyers from finding homes in diverse neighborhoods throughout St. Louis.

Bartlett, who is not a real estate agent, works with local companies hoping to recruit new talent to St. Louis and retain employees considering leaving. The key, says Bartlett, is not only showing familiar areas like Tower Grove in the City, but diverse neighborhoods like Pasadena Hills, Bel-Nor, Bridgeton, Overland, Ferguson, Hazelwood, Florissant, and others that often go undiscovered by newcomers due to decades of stereotyping and racial boundaries.

Bartlett says younger adults and transplants coming to St. Louis both nationally and internationally know very little of that history and are demanding diversity and easy access to urban amenities. As Bartlett put it, the new generation of talent is, “running to diversity, not from it.”

And yet, “a lot of the newcomers to St. Louis find themselves in very remote, homogenous, and prairie pop-up types of suburbs,” he said.

“They are led to believe that only certain neighborhoods are an option. The new generation of talent 50 and under wants to be in areas that are diverse. They want to see people of different ages, backgrounds, and colors.”

Real estate agents Kevin and Christina Buchek said they are experiencing an increased interest in diversity among buyers as well. They’ve been promoting North St. Louis County towns like Bel-Nor, Pasadena Hills, St. Ann, Normandy, and Ferguson as strong places to live because of their diversity and their proximity to the City of St. Louis and nearby employers like the University of Missouri-St. Louis, Boeing, and Washington University.

The Bucheks both served terms as elected leaders in the town of Bel-Nor, one of the few places in the region where they say African Americans and whites have lived side-by-side for several decades. The small city is currently 48% African American, 46% white and 4% Asian.¹¹¹ Christina said African American homebuyers are more actively looking for diversity, and often seek out Bel-Nor. White homebuyers, however, often don’t put diversity at the top of their wish list, but are attracted to Bel-Nor because of its price point and its charming stock of older houses.



Whitney Curtis

“Once they move in, they begin to embrace the diversity, and they view it as a bonus,” she said.

Diversity became an added bonus last spring for Elle and Kevin, when they bought a 1930s home in nearby Overland, an area that offered them affordable, vintage housing.

Elle, who is white, was expecting their first daughter. She loved the house and immediately noticed the children playing in the street the day they were first shown the home.

Kevin, who is African American, had grown up in rural, mostly white St. Clair, MO. He said he was most attracted to the town’s close proximity to the City of St. Louis and the easy commute to their jobs. But now that their daughter is four months old, he sees further benefits.

“With our daughter, I think it will be great for her growing up in this area,” he said. “It’s not going to be a culture shock when she sees a different race because we live around all races: black,

white, Asian, and Hispanic. She’s going to be well-versed in that area. It’s exciting.”

Bartlett of STL Transplants, said it is important that residents like John, Elle, and Kevin speak up about the value of diversity in their neighborhoods to attract both St. Louis area natives and newcomers.

“By directing newcomers immediately off to Wildwood and other homogenous places, we’re losing out on a lot of people who otherwise could be the change makers in these diverse neighborhoods,” Bartlett said.

How much more would the region thrive if we intentionally viewed inclusion and diversity as assets in our neighborhoods?

INCLUSION

Starting young

Research shows that implicit racial bias —unconscious attitudes or behaviors that affect decision-making and behavior —starts as early as preschool.¹¹³

What if the region became more comfortable talking about equity and race during childhood to reduce or prevent bias from taking root?

Betsy decided to address the possibility of implicit bias with her own children three years ago through a group called We Stories.

The non-profit seeks to prevent racial bias by coaching parents to talk with their kids about race and equity through children's literature. At the time the Clayton resident was expecting her third child and had a toddler and a preschooler.

"I always considered myself to be anti-racist," she said. "If you told a racist joke at a party, I was the one who would say something."

But as a white woman, the relative newcomer to St. Louis felt she wasn't truly addressing racism as well as she could. She was aware that there were uncomfortable divides in St. Louis and that they were the result of decades of habits and perceptions that weren't being challenged.

"I did notice that there was a line, and that some white people that I knew were not willing to cross it. It was a geographical line and also



Whitney Curtis

a demographic line," she said. "It was as if people were told the same thing over and over again: 'You can't live north of Delmar or live in the Central West End.' And people just passed it on rather than fully experiencing it or understanding it themselves."

When she learned "implicit bias" forms in children as early as age 5, she knew she had a chance to make an impact with her children through We Stories.

"Here was an opportunity to mitigate that in my kids," she said.

At bedtime Betsy lies in bed with her kids and reads to them. There are the usual classics like Dr. Seuss. But now there are also picture books featuring children of color and age-appropriate topics regarding equity and fairness. The books are all recommended by We Stories. Parents who are in the program become a part of a reading community where they share thoughts and ideas about talking about race with young children.

There are two favorite books in the family repertoire right now.

One of them is *Please Baby Please* written by film maker Spike Lee and his wife Tonya Lewis Lee.

"That one is just really cute," Betsy said. "It has very few words, with a lot of rhythms and repeats. My daughter just read it to the baby tonight. Well, not read it, she knows it by memory."

Another is *Ron's Big Mission*, about Ron McNair, an African American astronaut who died in the *Challenger* explosion. But the book focuses on Ron's early childhood in the 1950s, when he held a protest in his segregated local library to win the right to a library card.

"It was really more explicitly about social justice and racism, and it helped to spur some conversations. We still go back to that book two years later," she said.

Betsy knows this is still an experiment. It's hard to tell whether the books and conversations will stick with her children. But she did get a hint at a recent conference with her son's kindergarten teacher. The teacher had asked students what they would like to change about school or home.

"He said, 'I want to change the rules. I want to make sure they're fair for everybody—both black and white.' So, okay, I think, something about this is working."



Betsy said We Stories has changed the way she views St. Louis. It's changed the way she talks to her children. And it has changed the way she spends her philanthropic money and volunteer time.

“It’s about breaking the cycle and getting out of the bubbles that we live in,” she said. “We end up isolating ourselves in these pockets of St. Louis, and I think that is to everyone’s detriment. We need to get more comfortable talking about how we are different and how we are the same, and then we can work together to force change.”

How would our region transform if our children were nurtured to understand and embrace racial differences and overcome the boundaries that keep us apart?

Conclusion

The St. Louis region continues to grapple with substantial racial divides that have limited our social networks and our opportunities for friendship, empathy, and understanding.

But there are growing efforts to break down these invisible boundaries. In Chapter 7 we explore recommendations and highlight activities already underway to dismantle these divides. With community involvement and support, St. Louis can break through those boundaries and thrive as a more inclusive and unified region.

Final Thoughts

More than a century of housing segregation in the St. Louis region may have divided us, but it no longer has to define us. Specific strategies can dismantle the divides between us to create a stronger, healthier, and more prosperous region.





07

RECOMMENDATIONS

A long history of housing segregation remains a significant barrier to prosperity and well-being for many African Americans and low-income families in our region. But it could be different. It is time for St. Louis to break free of the boundaries that separate us and limit our region's potential.

For over a century, African Americans in the City of St. Louis and St. Louis County have endured housing policies and development strategies that have trapped generations of some families in segregated and disinvested neighborhoods.

Despite the Civil Rights Movement, despite landmark U.S. Supreme Court housing decisions originating in St. Louis, and despite the Fair Housing Act of 1968, segregation continues to persist nationwide.¹⁴ In St. Louis, impoverished mostly African American communities continue to exist within miles of great wealth among predominantly white communities.

Disinvestment in low-income and African American neighborhoods has led to significant inequities in access to quality, affordable housing in areas of opportunity; employment and health care; strong schools; nutritious food and essential household goods; effective public transportation; and critical social networks.

Exclusionary zoning and its accompanying lack of affordable housing in wealthier suburbs make it nearly impossible for working-class African American families and struggling families of all backgrounds to move to areas of opportunity in our region. The situation has left children and families behind in impoverished neighborhoods where they must cope with environmental health hazards and debilitating trauma caused by poverty and crime. Despite the resilience and ingenuity of families seeking better opportunities, many avenues to opportunity are blocked. Skewed development incentives also prevent critical investment from helping these neighborhoods improve into areas with more opportunity.

In 2014 *For the Sake of All: A Report on the Health and Well-Being of African Americans in St. Louis and Why It Matters for Everyone* found factors such as quality and length of education, lack of economic opportunity, and isolated and segregated neighborhoods harmed African Americans' health and well-being.¹ The report found African Americans suffer from chronic diseases and other illnesses at much higher rates than white St. Louisans living in different neighborhoods. Life expectancy among predominantly white and black neighborhoods less than 10 miles apart can vary by as many as 18 years.¹

This report builds upon these prior findings, showing that affordable housing is a key factor determining the health and well-being of the entire region. It illustrates the ways in which our region is racially and economically divided by a lack of affordable housing in areas of opportunity. Racial boundaries established through years of policy and practice influence where people feel safe and included. As a result,



James Byard, Washington University

African Americans sometimes feel less safe or welcome at community events like St. Louis Cardinals games or in specific neighborhoods in the St. Louis region. Similarly, whites and African Americans deeply mourn the loss of once vital St. Louis neighborhoods that have declined due to flight and disinvestment.

White, middle-class families often give up on living in more diverse urban areas because they lack quality schools, forcing them into a segregated suburban housing market in distant areas of St. Louis County and beyond. Once there, longer commutes and traffic jams are the norm for families dependent on highways and cars to get to work. Suburban life, with its larger lots and lack of walkable downtown areas, causes residents to shop and access services in strip malls, reducing community life. Vibrant, diverse communities in North St. Louis County face uncertain futures due to a lack of financial and community incentive to keep middle-class families of all racial groups in these neighborhoods.

Despite decades of scholarship, litigation, and legislation to address the mechanisms that have enabled segregation, many policies and systems remain that perpetuate the region's divisions.

The problem of segregation can be solved. New policies, programs and incentives, and better enforcement of current policies can reverse the effects of more than a century of damaging housing policy. We can reshape our communities to be more diverse, inclusive, and prosperous for everyone.

1 AFFORDABLE HOUSING

a Create an Affordable Housing Trust Fund for St. Louis County

The Problem:

In the past three decades, smaller single family homes and older apartment complexes have morphed into unplanned and sub-standard low-income housing in many parts of North St. Louis County and some parts of South St. Louis County.⁹⁶ Many of these deteriorating homes are isolated from public transportation. They also require expensive upkeep that landlords will not make due to the declining value of the properties. Tenants and homeowners cannot afford to make repairs and improvements on their own, and the financial risk of investing in the area results in an inability to obtain loans for repairs. Mortgage lending, particularly in areas that were once redlined, remains minimal.³⁴ This contributes to an unstable renter and homeowner market, with continued deterioration of homes and neighborhoods affecting the well-being of residents. Efforts to spark development of low-income housing in wealthier areas lack local incentives and often face significant resident resistance in the form of NIMBYism (Not in My Back Yard).

The Strategy:

Encourage St. Louis County lawmakers and officials to establish an Affordable Housing Trust Fund either through the re-allocation of existing resources or the establishment of new sources. Consider a voter campaign to establish a small sales tax to generate revenues for the trust fund. Earmark resources for a variety of projects, including development of new mixed-use housing in areas of economic opportunity; a fund for home and rental improvements; assistance for utility and other housing expenses; and expanded transportation infrastructure to connect existing affordable housing to areas of economic opportunity.



In St. Louis: Affordable housing funding

A coalition of community nonprofits was recently established to advocate for increased funding of the Affordable Housing Trust Fund in the City of St. Louis. In 2016 the trust fund, though not fully funded, helped restore 47 affordable, energy-efficient homes in the historic Fox Park and Tower Grove neighborhoods of St. Louis for recent Bhutanese refugees rebuilding their lives in St. Louis. According to Community Builders Network of Metro St. Louis, affordable housing trust funds have been proven to stabilize communities, increase property values in low-income areas, reduce crime rates, build wealth, and remediate lead exposure.

b Comply with voter-mandated regulations to fully fund the Affordable Housing Trust Fund in the City of St. Louis, and increase contributions to the fund

The Problem:

In 2002, City of St. Louis voters approved an annual \$5 million appropriation to an Affordable Housing Trust Fund.¹¹⁵ The trust fund enables non-profit housing organizations to secure grants and low-interest loans to build new homes, repair or modify rental homes for people with disabilities, and provide rent, mortgage, and utilities subsidies to keep people in their homes. Despite the law, the trust fund has not been fully funded since the 2011 fiscal year.¹¹⁵ New sources of revenue that could fund it have been diverted to other development projects, including a failed initiative to build a professional soccer stadium.

The Strategy:

Build a broad coalition to appeal directly to the St. Louis Board of Aldermen about the intent of the trust fund and its potential impact on reducing homelessness, neighborhood instability, child trauma, poor educational outcomes, and crime in neighborhoods most in need of resources and interventions.



In Detroit: Greenlining mortgage-lending

The Detroit Home Mortgage Initiative enabled banks to grant second mortgages to homebuyers to bridge the “appraisal gap,” a situation in which a house’s listing price is higher than its appraisal. Detroit has experienced a 25% increase in new home mortgages since the inception of the program.

C Create a Greenlining Fund, enabling high loan-to-value lending to help low-income families obtain mortgages for home ownership and combat the legacy of redlining

The Problem:

From the close of the Great Depression into the 1940s the Federal Housing Administration graded urban neighborhoods in terms of mortgage risk through the mapping of American cities. Red areas marked neighborhoods that were home to mostly African American residents. They were ranked with a “D,” indicating that they represented the highest risk for banks and other lenders.^{4, 30} African Americans wanting to buy homes in their “redlined” neighborhoods could not get bank mortgages and were subject to predatory lending that emerged in place of federally backed home loans. African Americans were unable to build equity in their homes in these neighborhoods. This hobbled their ability to accumulate wealth. Working-and middle-class whites in the post-World War II era were given many lending incentives to buy affordable homes while African Americans and other ethnic and minority groups were not. Even though redlining was outlawed by the Fair Housing Act of 1968, many of today’s areas of racially concentrated poverty in St. Louis exist within the original redlined areas.³⁴ Maps of current-day mortgage lending show little, if any, lending happening in those neighborhoods. The Delmar Divide did not occur by accident. African American home ownership remains exceptionally low in these neighborhoods.³⁴ In many cases, tenants are paying total rent on devalued houses that far exceed the potential sale price. Yet, they are unable to secure bank mortgages to purchase homes in their current neighborhoods because sale prices exceed appraised values.¹¹⁶



The Strategy:

Support the St. Louis Equal Housing and Community Reinvestment Alliance (SLEHCRA) and others in efforts to establish a Greenlining Fund supported by the banking and philanthropic community. The fund would foster homeownership for lower-income residents in redlined areas by issuing mortgages in excess of the appraised value of the home. Greenlining would enable renters to break free of high rents on depressed homes and build equity in home ownership. Home ownership stabilizes neighborhoods and is attractive to outside investment.

d Increase affordable housing options in areas of opportunity

The Problem:

Most affordable housing in the City of St. Louis and St. Louis County exists in impoverished communities disconnected from jobs, quality schools, and other vital resources. The situation makes it harder for poor families without cars or efficient transportation to gain and maintain employment. This leaves too many families isolated in disinvested neighborhoods vulnerable to generational poverty. Efforts are being spearheaded by Missouri's current governor to significantly cut or cap the state's use of Low-Income Housing Tax Credits, a critical incentive to develop affordable housing.¹¹⁷

The Strategy:

Mobilize fair housing advocates and others to convince state lawmakers to maintain Missouri's existing Low-Income Housing Tax Credits. Issue incentives to entice landlords and developers to create significant affordable housing in areas of opportunity through the acceptance of Housing Choice Vouchers and other supports. Provide further incentive for Low-Income Housing Tax Credit projects to be built in areas of opportunity, and reduce or eliminate the requirement for community approval for project proposals. Support organizations like Ascend STL Inc., an organization that works with families to help them secure affordable housing in areas of better opportunity. The organization's Mobility Connection program partners specifically with families who participate in the Housing Choice Voucher Program to help them utilize Housing Choice Vouchers in neighborhoods in which less than 10% of families live below the poverty level.

e Eliminate housing discrimination based on source of income in St. Louis County

The Problem:

Currently, landlords and property owners in St. Louis County can refuse to accept tenants who pay their rent with a Housing Choice Voucher.¹¹⁸ This steers most low-income renters into impoverished areas of clustered affordable housing in St. Louis County and severely limits their access to communities with jobs, quality schools, and other resources.



In Memphis, Chicago, and New York City: Protecting users of housing choice vouchers

Source of income anti-discrimination laws have been enacted in many cities and some states around the country. Urban areas with such laws include Memphis, Chicago, Washington, D.C., and New York City. A 2011 report prepared by Lance Freeman of Columbia University for the U.S. Department of Housing and Urban Development found greater utilization of housing choice vouchers in areas with such protections in place.

The Strategy:

Propose a "source of income" law in St. Louis County that forbids landlords or property managers from rejecting rentals to tenants who receive housing subsidies or other supports. Provide greater enforcement and education on a similar law passed in the City of St. Louis.

2 EQUITABLE DEVELOPMENT AND ALLOCATION OF RESOURCES

a Support efforts in the City of St. Louis and St. Louis County to reform TIF and other public tax incentive programs to ensure optimal community input, transparency, and implementation

The Problem:

Tax increment financing (TIF), tax abatement, and other economic development tools are often misused in St. Louis to finance development in already thriving areas.⁸¹ These areas are typically wealthier, predominantly white neighborhoods, most notably in the central corridor of the City of St. Louis and St. Louis County. For example, a new apartment building housing an upscale grocery chain in the Central West End was given a TIF incentive⁷⁹ around the same time that a local chain supermarket pulled-out of the high-need Fairground Park neighborhood about four miles to the northeast.⁷⁶ Not only do many African Americans in our region lose out on the opportunity for investment in their neighborhoods, they remain separated from new employment opportunities. In some cases, these incentives have been used to displace historic African



Nationwide: A watchdog for TIF transparency

The use of TIFs and other development incentives is being scrutinized nationwide. Good Jobs First is a national policy resource center promoting accountability regarding economic development. It encourages “smart growth” to prevent suburban sprawl that can lead to segregation. The organization has a “subsidy tracker” enabling grassroots groups from around the country to access data on development incentives nationwide. Good Jobs First further provides “best practices” regarding development, fairness, and job growth for working families.

American neighborhoods existing amid wealthier communities. Kirkwood, for example, approved \$17 million in TIF financing for a shopping center that includes a Walmart and a Target.⁶⁹ This development displaced the majority of residents in Meacham Park, an African American neighborhood dating from the late 1800s.

The Strategy:

Support the community engagement, education, and policy advocacy of Team TIF, which encourages a tiered approach to housing and development tax incentives so that they are used in neighborhoods that need them most. Incentives also should be regulated to prevent the reduction of affordable housing and the displacement low-income residents.

- b Motivate businesses, philanthropies, and others in the private sector to support a regional Community Reinvestment Fund. The Fund would equitably invest in all neighborhoods dealing with economic hardship via grants, low interest loans, and tax abatement**

The Problem:

Decades of inequitable housing policies and practices have led to disinvestment in neighborhoods in St. Louis, leaving mostly African American residents with a cascade of

burdens. They include deteriorating housing, environmental hazards, vacant buildings, limited educational opportunities, lack of local businesses and employment, and crime. Residents often lack resources to address these problems and draw investment to their communities. Though some specific St. Louis area neighborhoods have rebounded in the past three decades, they have had the support and investment of well-resourced private partners such as hospitals and universities in their footprints.

The Strategy:

Support the efforts of Invest STL to create a unified Community Reinvestment Fund backed by the private sector in St. Louis to commit to projects in disinvested neighborhoods lacking strong anchor institutions to invest and foster progress. The fund would provide technical support, foster community engagement, and support innovative grassroots solutions that focus on a neighborhood’s strengths and needs.



In St. Louis, Cleveland, and New Orleans: Public-private partnerships for investment

Cleveland, Portland, Washington D.C., New Orleans, and Oregon have developed public-private partnerships to fund local community development organizations with comprehensive neighborhood improvement plans. The national organization Urban Strategies, Inc. has used a similar funding model to spark community development in neighborhoods throughout the country, including the construction of a community-focused child care center in the Murphy Park neighborhood in the City of St. Louis.

- c Establish a Community Benefits Agreement policy in the City of St. Louis and St. Louis County that gives neighborhood residents legal leverage to demand particular neighborhood improvements and remediation from developers**

The Problem:

Developers of large-scale projects value low-income neighborhoods for their sometimes cheaper land and depressed housing values, which enable them to quickly accumulate larger tracts of land. Residents are easily displaced through buy-outs or eminent domain, and the final development product does little to enhance the surrounding neighborhood. Sometimes, developers and city planners target pockets of affordable housing within up-and-coming neighborhoods for re-development, which can lead to the displacement of lower-income residents. The residents often move to more isolated affordable housing in areas of less opportunity.

The Strategy:

A Community Benefits Agreement policy in the St. Louis region would empower local residents to negotiate with developers on specific neighborhood improvements and mitigations to be done in conjunction with a proposed development in their neighborhood. Residents would have the power to sign off on a negotiated contract with a developer, legally binding the company to fulfilling the agreement.



**In cities nationwide:
Creating community benefits agreements**

Community benefits agreements first started in Southern California but have since been promoted in Atlanta, Boston, Denver, Los Angeles, Miami, Milwaukee, Minneapolis/St. Paul, New York City, San Diego, Seattle, and elsewhere. In Los Angeles, a community benefits agreement was negotiated prior to the construction of the Los Angeles Sports and Entertainment District, a large multipurpose project that included the Staples Center arena. The agreement stipulated mandatory creation of living wage jobs in the entertainment district as well as construction of some affordable housing and seed money for additional housing projects.

3 HOUSING AND NEIGHBORHOOD STABILITY

- a Diminish the spiraling damage to lower income children and families from evictions and illegal lockouts by building support and infrastructure to provide housing services, legal representation, and better tenant protections**

The Problem:

Evictions from rental housing plague low-income families in the St. Louis region, particularly among poor, African American communities.¹⁰⁹ They post a red flag on an individual's credit and rental history, regardless of whether the circumstances behind the eviction were fair or not. Families facing homelessness through evictions are typically forced into a secondary rental housing market of substandard homes in areas of very low economic opportunity, poor transportation options, and underperforming schools, all contributing to deepening poverty and inequity.¹⁰⁹

Those summoned to eviction court in both the City of St. Louis and St. Louis County rarely come with legal representation.¹⁰⁹ During the process most are steered by court administrators to sign on-the-spot documents presented by the landlord's attorney without a clear understanding that those agreements prevent them from arguing a case before a judge and still result in an eviction.

Illegal lockouts also create problems for renters in the City of St. Louis and St. Louis County.¹¹⁹ In these cases, landlords or property managers do not take required legal action to evict a tenant, but instead replace locks or padlock rental units. Tenants, unaware of legal recourse, face immediate homelessness and often lose all of their possessions. Police officers are often uncertain about whether they can intervene.

The Strategy:

Build a preventative, community-based social service support system with housing and utility assistance programs that includes onsite social workers, housing placement specialists, and attorneys to assist with housing matters *before* an eviction lawsuit is filed by a landlord. The program would help mediate disputes between landlords and tenants and reduce the risk of evictions and homelessness.



In St. Louis: School-based eviction prevention

In the wake of the Great Recession, the American Recovery and Reinvestment Act released temporary funding in 2009 through the U.S. Department of Housing and Urban Development to prevent homelessness. The City of St. Louis utilized \$8.2 million in funds to create a program called Hope Is Moving In. The program partnered with local agencies to send housing caseworkers into four geographically diverse public schools and a downtown charity to better engage residents at risk of eviction and homelessness and match them with assistance. The program was not sustained through federal funding, but was considered a model for the prevention of evictions and homelessness.

Require that the existing Legal Services of *Eastern Missouri Landlord Handbook*¹²⁰ be provided by landlords to tenants at the beginning of each lease term to ensure that tenants have current information about their legal rights.

Create tenant self-help materials to be placed on court websites and in local courts so that tenants can raise affirmative defenses and counterclaims in response to eviction lawsuits filed by landlords. Such self-help materials and forms are already available to landlords.

b Protect tenants by eliminating unfair local nuisance ordinances which disproportionately put domestic violence survivors and people of color in low-income or transitional neighborhoods at greater risk for eviction, homelessness, and poverty

The Problem:

Nuisance ordinances have been passed in parts of St. Louis County and have been on the books in the City of St. Louis.^{121, 122} The ordinances vary but are intended to stabilize neighborhoods and deter crime such as drug dealing out of houses. Properties can be deemed a “nuisance” after several police calls are made to the same property.¹²¹ Landlords are then at risk of losing

their rental license unless they evict the tenant. In some cases, tenants evicted from nuisance properties are prohibited from renting in that jurisdiction for a specific period of time.

But nuisance ordinances can often be discriminatory. They may particularly harm domestic violence survivors who must call the police or other authorities for protection.¹²¹ Nuisance ordinances can also unfairly affect tenants dealing with high crime in their neighborhood or who are caring for relatives with behavioral health issues that are difficult to manage. In general, nuisance ordinances discriminate against renters who are more likely to need emergency services, more likely to have police or criminal legal system contact, and less likely to have legal representation in housing matters.

The Strategy:

Mobilize to remove existing nuisance ordinances from the books. Discontinue the practice of proposing and passing these laws.



In St. Louis, New York, and Pennsylvania: Fighting discriminatory nuisance ordinances

In 2016 the U.S. Department of Housing and Urban Development issued legal guidance on local nuisance ordinances, warning of their potential to discriminate against domestic violence survivors and others in need of emergency services in violation of the Fair Housing Act. The American Civil Liberties Union has filed lawsuits in Florida, Missouri, New York, and Pennsylvania arguing nuisance laws discriminate against vulnerable tenants and victims of crimes, including domestic violence survivors.



c Establish “Consciously Inclusive Communities” to unite neighbors in focused action to make their communities welcoming and accessible in terms of income and racial and ethnic diversity to build ties that support human development and connection

The Problem:

Our long history of segregation continues to hold back the St. Louis region. Restrictive racial covenants and exclusionary laws and policies brought middle-class white neighbors together to keep African Americans and lower income residents out of their communities.⁴ The legacy of these policies and practices has created a St. Louis so thoroughly separated that its divides are palpable to recent transplants and visitors. Though there are established and emerging diverse communities such as University City, Maplewood, Creve Coeur, and small enclaves in North St. Louis County that stand as exceptions, inclusion has not been a regional priority. Vibrant communities provide opportunities for *all* residents to flourish and capitalize on

the creativity and connection that everyday interactions across difference facilitate. Thoughtfully executed, such communities could also serve as a much-needed answer to the social isolation and sense of disconnection in our contemporary society. To the extent that they are multi-generational, they could also provide an opportunity for older adults to remain engaged as they “age in place” in the context of a supportive community.

The Strategy:

Mobilize residents in areas of opportunity and in neighborhoods that have the capacity to rebound from prior population loss or disinvestment to become “Consciously Inclusive Communities,” where individuals and families from different racial and ethnic, economic, and generational backgrounds commit to inclusion and cooperation. Encourage vital personal connections and shared decision-making to increase understanding, with the shared belief that compassionate and welcoming communities enhance health, wellness, and life satisfaction for everyone.



Nationwide: Co-housing for inclusive communities

Residents often lament the loss of daily interaction and friendship in their neighborhoods due to the demands of the modern world. For some, this has led to an increasing interest in cooperative housing arrangements that are intentionally multi-generational and emphasize stronger neighborhood interaction and community ties. One way to achieve this is through co-housing, in which neighbors may have a shared gathering space for meals and agree to other types of supportive activities. According to *The New York Times*, there are 165 co-housing communities in the United States and another 140 in planning stages. It would be a powerful influence in St. Louis if such communities focused on inclusion and racial and economic diversity.



Conclusion

Change is possible. There are multiple organizations that are already working to enact these recommendations to improve access to affordable housing, break the boundaries of segregation, and increase opportunity for all residents in our region regardless of income or race.

These include ArchCity Defenders, Ascend STL Inc., Community Builders Network of Metro St. Louis, Empower Missouri, Invest STL, Metropolitan St. Louis Equal Housing Opportunity Council (EHOC), Team TIF, and many others. Several of these organizations partnered to produce this report. They share a vision of a stronger, more inclusive place that ultimately will break free of the segregation that has harmed our region. They envision a united St. Louis that will be a stronger, healthier, and more economically successful place for all those who call it home. They need our support in making that vision a reality.

Final Thoughts

We hope this report presents the information that the people of the St. Louis region need to understand our history, our present challenges, and the action needed to move forward.

GLOSSARY OF TERMS

Annexation

The act or an instance of annexing, or adding to something larger, especially the incorporation of new territory into the domain of a city, country, or state.

Dissimilarity index

A measure of segregation that describes how evenly neighborhoods or regions are integrated. It can be understood as the proportion of one racial or ethnic group that would need to move from a neighborhood in order to have a more even distribution of groups in an area.

Eminent domain

An exercise of the power of government or quasi-government agencies (such as airport authorities, highway commissions, community development agencies, and utility companies) to take private property for public use.

Exclusionary zoning

A residential zoning plan whose requirements (as minimum lot size and house size) have the effect of excluding low-income residents.

Fair Housing Act

Legislation enacted in 1968 (and amended in 1974 and 1988) providing the HUD Secretary with fair housing enforcement and investigation responsibilities. A law that prohibits discrimination in all facets of the home-buying process on the basis of race, color, national origin, religion, sex, familial status, or disability.

Federal Housing Administration (FHA)

Provides mortgage insurance on loans made by FHA-approved lenders throughout the United States and its territories. FHA insures mortgages on single-family, multifamily, and manufactured homes and hospitals. It is the largest insurer of mortgages in the world, insuring over 34 million properties since its inception in 1934.

Federal Poverty Level

A measure of income issued every year by the U.S. Department of Health and Human Services. It is adjusted for inflation and is used to determine eligibility for federal and state benefit programs like the Supplemental Nutrition Assistance Program (SNAP; commonly known as food stamps) and, Medicaid.

Gentrification

The process of renewal and rebuilding accompanying the influx of middle-class or affluent people into disinvested areas that often displaces poorer or long-time residents.

Great Migration

Refers to the massive internal migration of African Americans from the South to urban centers in other parts of the country between 1916–1970.

Greenlining

Efforts aimed at increasing investment in neighborhoods which have been redlined or are otherwise disadvantaged.

Home equity

The monetary value of a property or business beyond any amounts owed on it in mortgages, claims, liens, etc.

Hypersegregation

When a race/ethnic group is highly segregated in multiple ways, no matter how segregation is conceptualized or measured.

Implicit bias

Refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

Office of Fair Housing and Equal Opportunity (FHEO)
An agency within the U.S. Department of Housing and Urban Development whose mission is to eliminate housing discrimination, promote economic opportunity, and achieve diverse, inclusive communities by leading the nation in the enforcement, administration, development, and public understanding of federal fair housing policies and laws.

Predatory lending
The practice of lending money to a borrower by use of aggressive, deceptive, fraudulent, or discriminatory means.

Racial steering
Deliberately guiding loan applicants or potential purchasers toward or away from certain types of loans or geographic areas because of race.

Redlining
The practice of denying a creditworthy applicant a loan for housing in a certain neighborhood even though the applicant may otherwise be eligible for the loan. It has its origins in the mapping practices of the Home Owners' Loan Corporation in the 1930s.

Restrictive racial covenants
A covenant acknowledged in a deed or lease that restricts the free use or occupancy of property.

Social mobility
The ability of individuals or groups to move within a social hierarchy with changes in income, education, occupation, etc.

Spot zoning
The rezoning of a small parcel of land within the limits of another zone that is illegal when not done in accord with a comprehensive zoning plan or when arbitrary or discriminatory.

Tax abatement
An amount by which a tax is reduced.

TIF or tax increment financing
A tool that allows cities to borrow against future tax revenue in order to finance or encourage development in the present day.

Urban renewal project
A project planned and undertaken by an LPA [Local Public Agency] in an urban renewal area with federal financial and technical assistance under Title I of the Housing Act of 1949. A project may involve slum clearance and redevelopment rehabilitation and conservation, or a combination of both. It may include acquisition of land, relocation of displaced site occupants, clearance of site, installation of site improvements, rehabilitation of properties, and disposition of acquired land for redevelopment in accordance with the Urban Renewal Plan.

U.S. Department of Housing and Urban Development (HUD)
Established in 1965, HUD's mission is to increase homeownership, support community development, and increase access to affordable housing free from discrimination.

White flight
The departure of whites from places (such as urban neighborhoods or schools) increasingly or predominantly populated by racial or ethnic minority groups.

METHODOLOGIES

What follows are descriptions of data sources and methodologies used by Missouri Wonk to create specific maps and indices in Chapters 3 and 5 of the report.

The zoning analysis in Chapter 3 lays the foundation for examining the region’s zoning policies. It represents a comprehensive study of zoning in City of St. Louis and St. Louis County. The description of the zoning analysis outlined in this section presents the data sources and methodology used to develop a new “County Equivalent Zoning” classification applied to parcels throughout the St. Louis region.

The indices presented in Chapter 5 provide context for segregation’s impact on the region. They also illustrate wide disparities in access to basic needs and amenities that are critical to healthy living. In some cases, the indices in the chapter were recommended for inclusion by the Department of Housing and Urban Development’s Affirmatively Furthering Fair Housing guidelines. The researchers and authors felt strongly that other measures were important for the region to consider as it grapples with the impacts of segregation. This section further describes these indices and details the data sources and approaches used in their calculation.

Zoning analysis included in Chapter 3

Missouri Wonk conducted a survey of residential zoning ordinances for the City of St. Louis, St. Louis County and each of the County’s municipalities.² After conducting an in-depth review, Missouri Wonk determined that a few municipalities follow closely, or have inherited outright, the County’s “R-1” through “R-8” zoning classification system and closely match its lot size and use classifications. However, many zoning ordinances have come to deviate from this standard, in both zone naming and in lot requirements. With several hundred unique zoning classifications among St. Louis County’s municipalities,

the difficulty in making an “apples-to-apples” comparison has hindered the efforts to analyze differences between and among them. For instance, how would a Ladue single-family “C” zoned lot compare with a Town & Country property with a SL classification? What would be its equivalent in Sunset Hills?

Working from the zoning classifications contained within the City of St. Louis and St. Louis County Assessors’ databases³ and utilizing zoning classification information within municipalities’ and the County’s zoning ordinances,⁴ Missouri Wonk recoded the zoning classifications of residential parcels in the region and assigned each a “County Equivalent Zoning” classification. This new classification standardizes the lot-size metrics to the existing St. Louis County zoning classification system, which allows lot-size and density to be compared across the region. St. Louis County’s residential zoning classifications are listed below.

St. Louis County Residential Zoning Classification

ZONE	SIZE (SQ. FT.)	TYPE
R-1	43,560	Single-Family
R-1A	22,000	Single-Family
R-2	15,000	Single-Family
R-3	10,000	Single-Family
R-4	7,500	Single-Family
R-5	6,000/unit	Duplex
R-6A	4,000/unit	Multi-Family
R-6AA	3,000/unit	Multi-Family
R-6	2,000/unit	Multi-Family, 4 Story
R-7	1,750/unit	Multi-Family 200’ Height
R-8	500/unit	Multi-Family 200’ Height

This County Equivalent Zoning classification allowed for the creation of Figures 9 and 12 contained in Chapter 3.⁵

² Missouri Wonk made several attempts but was unable to obtain zoning ordinances for the municipalities of Champ, Calverton Park, Kinloch, Cool Valley, Country Club Hills, Flordell Hills, Charlack, Mackenzie, and Hilldale.

³ Missouri Wonk utilized the Assessor’s Rolls dated December 2016 for the City of St. Louis and June 2016 for St. Louis County. The County’s parcel data can be purchased from the County’s GIS Service Center: <http://data-stlcogis.opendata.arcgis.com/>. St. Louis City’s parcel data is available free of charge at the following link: <https://www.stlouis-mo.gov/data/parcels.cfm>.

⁴ Ordinances are frequently amended, and as a result, current or future ordinances may be different than what was utilized in the analysis. Missouri Wonk obtained the referenced ordinances throughout the 2016 calendar year and utilized the information as provided by the municipality at the time it was obtained. Following the analysis, voters of Vinita Terrace and Vinita Park elected to merge, and voters in Mackenzie will decide upon the disincorporation of the municipality in April 2018.

⁵ The figure classifies large lots as those with a CEZ classification of R-1 or R-1A. However, for purposes of calculating the Exclusionary Index in Chapter 4, a “large lot” is defined as a parcel with a CEZ classification of R-1, R-1A or R-2.

Indices included in Chapter 5

The Index of Exclusivity (Figure 17) illustrates the lack of inclusivity of a neighborhood and its housing. It includes six indicators: the percentage of rental units with a rental cost below the regional median rental cost, the percentage of owner-occupied housing with a housing value below the regional median housing value, the percentage of the African American population of the municipal region, the percentage of the population with an income below the Federal Poverty Level, the percentage of the municipality or area of the region's (i.e., subdivided areas of the City of St. Louis and unincorporated areas of St. Louis County) housing units receiving housing assistance, and the percentage of residential parcels zoned as "large lots."

Data source:

- > Experian (4Q) population data derived from recent U.S. Census estimates
- > U.S. Department of Housing and Urban Development datasets on:
 - Housing Choice Vouchers
 - > The number of vouchers by Census tract was converted to municipal region based on the area square mileage of the Census tract relative to the municipal region.
 - Low-Income Housing Tax Credits
 - Project Based Rental Assistance
 - Public Housing Buildings

The analysis does not account for instances in which a single housing unit receives assistance under multiple housing programs.

- > St. Louis County and City of St. Louis Assessors' Parcel Databases from June 2016 and December 2016, respectively
- > Zoning ordinances of municipalities collected throughout calendar year 2016

How Calculated:

Municipalities and areas of the region were ranked for each indicator. A municipality or area was determined to be more exclusive if it had:

- > A lower percentage of rental units below the regional median rental cost;
- > A lower percentage of owner-occupied housing with a housing value below the regional median housing value;
- > A lower percentage of African American population;

- > A lower percentage of population with an income below the Federal Poverty Level;
- > A lower percentage of housing units receiving housing assistance; and
- > A higher percentage of residential parcels zoned as "large lots" (with County Equivalent Zoning of R-1, R-1A or R2).

Municipalities or areas that shared a value for an indicator were provided the same rank and the municipality or area that followed was provided the rank of the next sequential number. Missouri Wonk then created a composite rank by adding each municipal or area's rank for each of the indicators and dividing by the number of indicators (six).

Note 1: In creating this index, researchers recognize that many factors could be included in an index that measures the housing exclusivity of a region. The six indicators listed were chosen because of their representativeness of exclusivity, the availability of data, and the ease with which such data could be converted to the geographic unit of analysis (municipal region).

Note 2: Some municipalities and areas of the region included in the analysis have small populations and low numbers of housing units, which results in small sample sizes and increases the potential for error in the measurements. As a result, the indicators may overstate or understate the presence or prevalence of a measure, which could influence the municipality or area's rankings relative to other municipalities or areas.

Other indices

The values for the indices that follow were transformed to values that represent the geographic area of the municipal region. For instance, when a tract or block group spanned multiple study areas, weighted averages for municipal regions were calculated using Census block population data.

The Poverty Index (Figure 16), School Proficiency Index (Figure 18), Job Proximity Index (Figure 20), Transit Trips Index (Figure 22), and Environmental Health Index (Figure 27) are discussed more in-depth in the July 2016 version of the Affirmatively Furthering Fair Housing (AFFH) Data Documentation document.

The values for municipalities and areas of the region as visualized in the maps in Chapter 4 were determined by dividing the weighted average for the municipal region (transformed as described above) by the weighted average of the entire region's (St. Louis City and County) value for the indicator.

The Poverty Index (Figure 16) illustrates the number of families living at or below the Federal Poverty Level. The poverty rate is determined at the Census tract level.

Data source: American Community Survey (ACS), 2009–2013

How Calculated:

$$POV_i = \left[\left(\frac{pv_i - \mu_{pv}}{\sigma_{pv}} \right) * -1 \right]$$

The mean (μ_{pv}) and standard error (σ_{pv}) are estimated over the national distribution. For this index, a low score indicates high poverty and a high score indicates low poverty. For ease of interpretation, the map for this variable presented in Chapter 4 labels the lowest scoring areas as “Highest Poverty” and the highest scoring areas as “Lowest Poverty.”

The School Proficiency Index (Figure 18) illustrates the performance of 4th grade students on state exams. The level of proficiency indicates school system quality.

Data Source: Great Schools (proficiency data, 2011–2015); Common Core Data (school addresses and enrollment, 2011–2015); SABINS (attendance boundaries, 2011–2012)

How Calculated:

$$School_i = \sum_{n=i}^3 \left(\frac{S_i}{\sum^n S_i} \right) * \left[\frac{1}{2} * r_i + \frac{1}{2} * m_i \right]$$

Where 4th grade students proficient in reading (r) and math (m) on state test scores for up to three schools ($i=1,2,3$) within 1.5 miles of the block-group centroid and S denotes 4th grade school enrollment.

The Job Proximity Index (Figure 20) illustrates the accessibility of job locations within a geographic region in relation to where one resides.

Data Source: Longitudinal Employer-Household Dynamics (LEHD), 2013–2015

How Calculated:

$$A_i = \frac{\sum_{j=1}^n \frac{E_j}{d_{i,j}^2}}{\sum_{j=1}^n \frac{L_j}{d_{i,j}^2}}$$

Where i indexes a given residential block-group, and j indexes all n block groups within a CBSA (Core Based Statistical Area). Distance, d , is measured as “as the crow flies” between block-groups i and j , with distances less than 1 mile set equal to 1. E represents the number of jobs in block-group j , and L is the number of workers in block-group j .

The Household Personal Vehicle Access Index (Figure 21) illustrates areas where households are more or less likely to own a motor vehicle for personal use.

Data Source: American Community Survey (ACS), 2011–2015 5-year estimates; Experian 2016 (4Q) population data derived from recent U.S. Census estimates

How Calculated:

This is calculated by dividing the number of households without access to a vehicle by the total number of households in an area.

The Transit Trips Index (Figure 22) represents how the Department of Housing and Urban Development models transportation behavior for eight household types, showing a mix of family sizes, incomes, and number of household commuters, in order to help determine the impact of particular locations and their amenities on households’ housing and transportation expenses. The modeling was completed for each household type for a renting household and a home-owning household. The index, based on transit usage of one of the eight household types, gauges how likely residents in a community are to utilize public transit.

Data Source: Local Affordability Index (LAI) data, 2008–2015

How Calculated:

This index is based on estimates from one of HUD’s eight household types, specifically: a 3-person single-parent family with income at 50% of the median income for renters for the region (i.e. the Core-Based Statistical Area (CBSA). HUD’s model, the Location Affordability Index Model (LAIM) Version 2, was developed using:

- > 2008–2012 American Community Survey data;
- > U.S. Census TIGER/Line Files; and
- > U.S. Census Longitudinal Employment-Household Dynamics (LEHD) Origin-Destination Employment Statistics (LODES).

Additional information is available at: www.locationaffordability.info.

The Retail Employment Access Index (Figure 23) illustrates access to retail employment and serves as a proxy for residents' access to common household retail needs.

Data Source: American Community Survey (ACS) 2016; Local Affordability Index (LAI) data, 2008–2014; Experian (4Q) population data derived from recent U.S. Census

How Calculated:

As described by the National Environmental Database, “The retail access index considers both the quantity of retail jobs and the distance to those jobs relative to each Census block group. This variable uses a gravity model, a model that includes inverse distance weighting, that considers retail employment both in and adjacent to a given block group.”

The Health Care Access Index (Figure 25) illustrates the number of physicians' offices accessible to households within a 15-minute drive during off-peak travel times.

Data Source: American Community Survey (ACS) 2016; Dun and Bradstreet Business Summary (4Q), 2016; Experian (4Q) population data derived from recent U.S. Census estimates

How Calculated:

This is the count of offices of physicians as defined by North American Industry Classification System (NAICS) classification 621111 within a 15 minute non-peak time drive. Offices of physicians, according to the NAICS of the US Census, includes “establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.”

The Uninsured Population Index (Figure 26) illustrates the percentage of population that is medically uninsured.

Data Source: American Community Survey (ACS) 2011–2015; Experian 2016 (4Q) population data derived from recent U.S. Census estimates

How Calculated:

This is calculated by dividing the uninsured population by the total population.

The Environmental Health Index (Figure 27) illustrates potential exposure to harmful toxins using a combination of standardized EPA estimates of air quality, respiratory, and neurological hazards.

Data Source: National Air Toxics (NATA) data, 2005

How Calculated:

$$EnvHealth_i = \left[\left(\frac{c_i - \mu_c}{\sigma_c} \right) + \left(\frac{r_i - \mu_r}{\sigma_r} \right) + \left(\frac{n_i - \mu_n}{\sigma_n} \right) \right] * -1$$

Where means (μ_c, μ_r, μ_n) and standard errors ($\sigma_c, \sigma_r, \sigma_n$) are estimated over the national distribution. With this data, a high value indicates least exposure and a low score indicates most exposure. The legend for the map provides labels that indicate most exposure and least exposure areas.

REFERENCE LIST

- Purnell JQ, Camberos GJ, Fields RP. (Eds). For the Sake of All: A Report on the Health and Well-being of African Americans in St. Louis-and Why it Matters for Everyone. St Louis, MO: Washington University in St. Louis & St. Louis University. 2014.
- Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Cause of the Causes. *Public Health Reports*. 2014; 129:19-31. doi:pdf/10.1177/00333549141291S206.
- Williams DR, Mohammed SA, Leavell J, Collins C. Race, Socioeconomic Status, and Health: Complexities, Ongoing Challenges, and Research Opportunities. *Annals of the New York Academy of Sciences*. 2010;1186:69-101. doi: 10.1111/j.1749-6632.2009.05339.x.
- Gordon C. *Mapping Decline: St. Louis and the Fate of the American City*. Philadelphia, PA: University of Pennsylvania Press; 2008.
- Rothstein R. The Making of Ferguson: Public Policies at the Root of its Troubles. Economic Policy Institute. Washington D.C.; October 15, 2014.
- Goodman MS, Gilbert KL. Segregation: Divided Cities Lead to Differences in Health. Washington University in St. Louis & St. Louis University. 2013.
- Williams DR, Collins, C. Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health. *Public Health Reports*. 2001; 116, 404-416. doi: 10.1093/phr/116.5.404.
- Kramer M, Hogue CR. Is Segregation Bad for Your Health? *Epidemiologic Reviews*. 2009; 31(1):178-94. doi:10.1093/epirev/mxp001.
- Chetty R, Hendren N, Kilne H, Sauez E. Where is the Land of Opportunity? The Geography of Intergenerational Mobility in the United States. *The Quarterly Journal of Economics*. 2009;129 (4):1553-1623. doi:10.1093/qje/qju022.
- Calvo-Armengol, A. The Effects of Social Networks on Employment and Inequality. *The American Economic Review*. 2004; 94(3), 426-454. doi: 10.1257/0002828041464542.
- DiTomaso N. How Social Networks Drive Black Unemployment. *The New York Times*. May 5, 2013. <https://opinionator.blogs.nytimes.com/2013/05/05/how-social-networks-drive-black-unemployment/>. Accessed on January 7, 2018.
- Joseph ML, Chaskin RJ, Webber HS. The Theoretical Basis for Addressing Poverty through Mixed-income Development. *Urban Affairs Review*. 2007;42:369-409. doi: 10.1177/1078087406294043.
- Orfield G, Ee J, Frankenberge E, Siegel-Hawley G. Brown at 62: School Segregation by Race, Poverty and State. Civil Rights Project, UCLA. 2016.
- Reeves RV. *Dream Hoarders: How the American Upper Middle Class is Leaving Everyone Else in the Dust, Why That is a Problem, and What to Do About It*. Washington D.C.: Brookings Institution Press; 2017.
- Rothstein R. For Public Schools, Segregation then, Segregation since: Education and the Unfinished March. Economic Policy Institute. 2013.
- Mickelson RA. School Integration and K-12 Outcomes: An Updated Quick Synthesis of the Social Science Evidence. The National Coalition on School Diversity, 5. 2016.
- Emmons B. Homeownership and the Racial Wealth Divide. Federal Reserve Bank of St. Louis. 2017. https://www.stlouisfed.org/~media/Publications/Housing-Market-Perspectives/2017/Issue-5/HMP_issue5_web2.pdf. Accessed on January 7, 2018.
- Asante-Muhammed D, Collins C, Hoxie J, Nieves E. The Ever-growing Gap: Without Change, African-American and Latino families Won't Match White Wealth for Centuries. CFED and Institute for Policy Studies. 2016. https://www.ips-dc.org/wp-content/uploads/2016/08/The-Ever-growing-Gap-CFED_IPS-Final-2.pdf. Accessed on January 7, 2018.
- Shapiro T, Meschede T, Osoro S. The Roots of the Widening Racial Wealth Gap: Explain the Black-White Economic Divide. Institute on Assets and Social Policy. 2013. <https://iasp.brandeis.edu/pdfs/Author/shapiro-thomas-m/racialwealthgapbrief.pdf>. Accessed on January 7, 2018.
- Campbell G, Jung K. Historical Census Statistics on Population Totals by Race, 1790 to 1990, and by Hispanic origin, 1970-1990, for large cities and other urban places in the United States. (Population Division, Working Paper No. 76). U.S. Census Bureau. 2005.
- Dred Scott v Sandford*, 60 U.S. 19, 19 How.393. (United States Supreme Court 1856).
- Supreme Court of the State of Missouri. Missouri Digital Heritage Website. <https://www.sos.mo.gov/mdh/curriculum/africanamerican/guide/rg600>. Accessed on February 1, 2018.
- A Preservation Plan for St. Louis Part I: Historic Contexts 8-The African-American Experience. City of St. Louis, MO Website. <https://www.stlouis-mo.gov/government/departments/planning/cultural-resources/preservation-plan/Part-I-African-American-Experience.cfm>. Accessed on February 1, 2018.
- Lemann N. *The Promised Land: The Great Black Migration and How it Changed America*. New York, NY: Knopf Doubleday Publishing Group; 2011.
- Silver C. The Racial Origins of Zoning in American Cities. In: Thomas M, Ritzdorf J, Ritzdorf M eds. *Urban Planning and the African American Community: In the Shadows*. Thousand Oaks, CA: Sage Publications; 1997.
- Hadacheck v. Sebastia*, 239 U.S. 394, 36 S. Ct. 143, 60 L. Ed. 348. (United States Supreme Court 1915).
- 24 Negroes killed in East St. Louis. *St. Louis Post-Dispatch*. July 3, 1917. http://www.stltoday.com/news/archives/archive-article-negroes-killed-in-east-st-louis/article_23fb63a4-bedo-514c-8734-83dacb874993.html. Accessed on February 1, 2018.
- Perkiss A. *Shelley v. Kraemer*: Legal Reform for America's Neighborhoods. National Constitution Center Website. <https://constitutioncenter.org/blog/shelley-v-kraemer-legal-reform-for-americas-neighborhoods>. Published May 9, 2014. Accessed on January 7, 2018.
- Simun A. Tour of Civil Rights Sites Include St. Louis House. *St. Louis Post-Dispatch*. December 20, 1998:D3.
- Rothstein R. *The Color of Law: A Forgotten History of How Our Government Segregated America*. New York, NY: Liveright Publishing Corporation; 2017.
- Jackson KT. *Crabgrass Frontier: The Suburbanization of the United States*. New York, NY: Oxford University Press; 1985.
- Helper R. *Racial Policies and Practices of Real Estate Brokers*. Minneapolis, MN: University of Minnesota Press. 1969: 204.
- Oliveri RC. Setting the Stage for Ferguson: Housing Discriminate and Segregation in St. Louis. *Missouri Law Review*. 2015;80:1053-1075. <https://law.missouri.edu/lawreview/files/2016/04/10.-Oliveri.pdf>. Accessed on January 7, 2018.
- Richardson J, Mitchell B, West N. Home Mortgage Lending in St. Louis, Milwaukee, Minneapolis, and Surrounding Areas. National Community Reinvestment Coalition. July 2016. <https://ncrc.org/wp-content/uploads/2018/01/Home-Mortgage-Lending2.pdf>. Accessed on January 7, 2018.
- Fischel, WA. An Economic History of Zoning and a Cure for its Exclusionary Effects. *Urban Studies*. 2004; 41(2), 317-340. doi: 10.1080/0042098032000165271.
- Fishman R. Bourgeois Utopias: Visions of Suburbia. In: Fainstein S, Campbell S. (eds). *Readings in Urban Theory*. Oxford, Blackwell Publishing; 1996: 23-60.
- U.S. Census Bureau; American Community Survey, 4Q, 2017.
- Revell KD. The Road to *Euclid v. Ambler*: City Planning, State-building, and the Changing Scope of the Police Power. *Studies in American Political Development*. 1996; 13(1), 50-145.
- Village of Euclid v Ambler Realty Co.*, 297 F 307, 314, 315, 317(ND Ohio 1924).
- Theodore H. Social and Economic Poverty. United States Commission on Civil Rights in Human Development Corporation. 1971; box 7:81, SLDC (sl75), Western Historical Manuscript Collection (WHMC) University of Missouri, St. Louis. Cited by: Gordon C. *Mapping Decline: St. Louis and the Fate of the American City*. Philadelphia, PA: University of Pennsylvania Press; 2008:39.
- King PE. Exclusionary Zoning and Open Housing: A Brief Judicial History. *Geographical Review*. 1978;68(4): 459-469.
- Sheilds G. Opening Up the Suburbs: Notes on a Movement for Social Change. *Yale Review of Law and Social Action*. 1972;2(1):305.
- United States National Commission on Urban Problems. Building the American City: Report of the National Commission on Urban Problems to the Congress and to the President of the United States. https://archive.org/details/buildingamericanoonunit_o. Published 1969. Accessed on January 7, 2018.

44. Preliminary Report upon the Business Area, Des Peres, Missouri (1970), vol. 13, ser. 2 (Brown); Preliminary Report on a Comprehensive City Plan for Ferguson, Missouri (1932), vol. 20, ser. 2 (Black); "Minutes of the Meeting of the Zoning Committee of Brentwood" (1 May 1935), vol. 4, ser. 2 (Black), all in Bartholomew Papers; (quote) Transcript of the Record, *City of Moline Acres v. Heidbreder* (1963), RG 600, SC Case Files, MSA. Cited by: Gordon C. *Mapping Decline: St. Louis and the Fate of the American City*. Philadelphia, PA: University of Pennsylvania Press; 2008:137.
45. Report Upon the Proposed Revised Zoning Ordinance, Kirkwood, Missouri (1941) vol. 31 ser. 2, Bartholomew Papers. Cited by: Gordon C. *Mapping Decline: St. Louis and the fate of the American City*. Philadelphia, PA: University of Pennsylvania Press; 2008:136.
46. Clark C. Federal Housing Administration Standards for Land Division. *Journal of the American Institute of Planners*. 1398;4(5):109-112; Jackson KT. *Crabgrass Frontier: The Suburbanization of the United States*. New York, NY. Oxford University Press; 1985:238. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.
47. Sexauer CF. Catholic Capitalism: Charles Vatterott, Civil Rights, and Suburbanization in St. Louis and the Nation, 1919-1971. Ph.D. Dissertation, Department of History, University of Cincinnati. May 6, 2002:219-220. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.
48. U. S. Commission on Civil Rights. Hearing before the United States Commission on Civil Rights. 1959. Washington D.C.: U.S. Government Printing Office. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.
49. Cambria N. A Tale of a House, a Pastor and One of Ferguson's First Black Families. *St. Louis Post-Dispatch*. October 24, 2014.
50. U. S. Commission on Civil Rights. Hearing before the United States Commission on Civil Rights. Hearing held in St. Louis, MO. January 14-17, 1970:203-204. Washington D.C.: U.S. Government Printing Office. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.
51. Turner M, Levy DK, Wissoker D, Aranda D, Pitingolo R, Santos R, The Urban Institute. *Housing Discrimination Against Racial and Ethnic Minorities 2012*. https://www.huduser.gov/portal/Publications/fairhsg/hsg_discrimination_2012.html. Published on June 11, 2013. Accessed on January 7, 2018.
52. Oswald C. Real Estate Solicitation Bill Opposed...Residents Fear Redlining, Racial Steering Agents. *St. Louis Post-Dispatch*. June 20, 1991:1A.
53. Eligon J. A Year After Ferguson, Housing Segregation Defies Tools to Erase It. *The New York Times*. August 8, 2015. <https://www.nytimes.com/2015/08/09/us/a-year-after-ferguson-housing-segregation-defies-tools-to-erase-it.html>. Accessed on January 7, 2018.
54. O'Neil T. A Look Back: Clearing Mill Creek Valley Changed the Face of the City. *St. Louis Post-Dispatch*. August 9, 2009. http://www.stltoday.com/news/local/a-look-back-clearing-of-mill-creek-valley-changed-the/article_04738cde-b0f8-5688-a20e-6fd86266d1ac.html. Accessed on January 7, 2018.
55. Milk Creek Valley. University of Missouri St. Louis Website. <https://www.umsl.edu/virtualstl/phase2/1950/mapandguide/millcreeknode.html>. Accessed on January 7, 2018.
56. Heathcott J, Murphy MA. Corridors of Flight, Zones of Renewal: Planning and Policy in the Making of Metropolitan St. Louis, 1940-1980. *Journal of Urban History*. 2005;31(2):151-189.
57. Tate L. White Flight and Urban Renewal: Wellston's Decline. The Wellston Loop Website. <http://www.thewellstonloop.com/decline>. Accessed on January 7, 2018.
58. Editorial, *St. Louis Argus*, January 8, 1960; *St. Louis Argus*, September 12, 1958:4. Cited by: Heathcott J, Murphy MA. Corridors of Flight, Zones of Renewal: Planning and Policy in the Making of Metropolitan St. Louis, 1940-1980. *Journal of Urban History*. 2005;31(2):151-189.
59. Duffy RW. Reflection: St. Louis Needs to Unravel the Lessons of Pruitt-Igoe. St. Louis Public Radio Website. Published August 11, 2014, <http://news.stpublicradio.org/post/reflection-st-louis-needs-unravel-lessons-pruitt-igoe#stream/0>. Accessed January 7, 2018.
60. Cooperman J. The Story of Segregation in St. Louis. *St. Louis Magazine*. October 17, 2014. <https://www.stlmag.com/news/the-color-line-race-in-st-louis/>. Accessed January 7, 2018.
61. Smithson S. The Greening of McRee Town. *Riverfront Times*. October 8, 2003. <https://www.riverfronttimes.com/stlouis/the-greening-of-mcree-town/Content?oid=2464396>. Accessed on January 7, 2018.
62. The African-American Heritage of St. Louis: A Guide. <https://law.wustl.edu/staff/taylor/spl/stastlcy.htm>. Accessed January 7, 2018.
63. Smith J. You Can't Understand Ferguson Without Understanding These Three Things. The New Republic Website. Published August 15, 2014. <https://newrepublic.com/article/119106/ferguson-missouris-complicated-history-poverty-and-racial-tension>. Accessed January 7, 2018.
64. Staff report. Creve Coeur Ok's \$31,000 for Venable property. *St. Louis Post-Dispatch*. March 15, 1960.
65. United States Council on Civil Rights. 1961 Commission on Civil Rights Report Book 4 Housing. 1961:135-136. Washington D.C.: U.S. Government Printing Office.; State ex rel. *City of Creve Coeur v. Weinstein* 329 S.W.2d 399 (Mo. App. 1959. Reported in *Race Relations Law Reported* 5, 1960:207-215.; Sexauer CF. Catholic Capitalism: Charles Vatterott, Civil Rights, and Suburbanization in St. Louis and the Nation, 1919-1971. Ph.D. Dissertation, Department of History, University of Cincinnati. May 6, 2002:215-216. Cited by: Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Economic Policy Institute. Washington D.C.; October 15, 2014.
66. Moffit K. Clayton was Once Home to a Thriving African-American Neighborhood. Now it's Little-known History. St. Louis Public Radio Website. Published July 17, 2017. <http://news.stpublicradio.org/post/clayton-was-once-home-thriving-african-american-neighborhood-now-it-s-little-known-history#stream/0>. Accessed January 7, 2018.
67. Kohler J. As City Recovers, Racial Tension Remains. *St. Louis Post-Dispatch*. February 15, 2008. http://www.stltoday.com/news/local/crime-and-courts/as-city-recovers-racial-tension-remains/article_3f2b63dc-78b5-11df-a5d1-0017a4a78c22.html. Accessed January 7, 2018.
68. Miller B. Howard-Evans Place: A Middle-Class African-American Suburb in the Heart of St. Louis County. (Master's Thesis, Washington University in St. Louis);2017.
69. Cooperman J. The Kirkwood Shootings: Kirkwood, Meacham Park and the Racial Divide. *St. Louis Magazine*. April 25, 2008. <https://www.stlmag.com/The-Kirkwood-Shootings-Kirkwood-Meacham-Park-and-the-Racial-Divide/>. Accessed January 7, 2018.
70. Bower C. Developer Targets Brentwood Homes/Proposal Would Displace Mostly Black Neighborhood. *St. Louis Post-Dispatch*. October 15, 1995.
71. Boyles A. *Race, Place, and Suburban Policing: Too Close for Comfort*. Oakland, CA: University of California Press;2015.
72. Elfank L. Assessed Property Value Map. Alderman Joe Roddy Website. <http://aldermanroddy.com/486/assessed-property-value-map/>. Published November 23, 2016. Accessed January 7, 2018.
73. Barker J. Tax Breaks Costs St. Louis, School District Almost 30 million in 2017. *St. Louis Post-Dispatch*. March 20, 2018. http://www.stltoday.com/business/local/tax-breaks-cost-st-louis-school-district-almost-million-in/article_2682ca1a-a7bb-583a-85be-61525bf365d1.html. Accessed March 28, 2018.
74. Bryant T. Clayton Boasts Pricey Commercial Office Space. *St. Louis Post-Dispatch*. September 9, 2011. http://www.stltoday.com/business/local/clayton-boasts-pricey-commercial-office-space/article_1719c6c7-7ce0-507f-afb4-bf46db182044.html. Accessed January 7, 2018.
75. Bryant T. St. Louis Panel Approves TIFs for Apartments and Mercedes Dealership. *St. Louis Post-Dispatch*. October 31, 2012. http://www.stltoday.com/news/local/metro/st-louis-panel-approves-tifs-for-apartments-and-mercedes-dealership/article_1a0c57f8-93d2-56c8-bb6c-1f65f2f948b.html. Accessed on January 7, 2018.
76. Barker J. Schnucks Closing Leaves Few Alternatives for North St. Louis Residents. *St. Louis Post-Dispatch*. April 14, 2014. http://www.stltoday.com/business/local/schnucks-closing-leaves-few-alternatives-for-north-st-louis-residents/article_41813f9f-e63b-5c18-b574-a91982301948.html. Accessed on January 7, 2018.

77. The Vacant Properties Research Network. Charting the Multiple Meanings of Blight: A National Literature Review on Addressing the Community Impacts of Blighted Properties. May 20, 2015. https://www.kab.org/sites/default/files/Charting_the_Multiple_Meanings_of_Blight_FINAL_REPORT.pdf. Accessed January 7, 2018.
78. Lee C. Meet the Everly: \$1,475/Month Studios, and a 12.8 Million Tax Break from City Hall. *Riverfront Times*. March 1, 2017. <https://www.riverfronttimes.com/newsblog/2017/03/01/meet-the-everly-1475-month-studios-and-a-128-million-tax-break-from-city-hall>. Accessed on January 7, 2018.
79. Bryant T. Plans for 36-Story Apartment Tower in Central West End Inch Ahead. *St. Louis Post-Dispatch*. December 13, 2016. http://www.stltoday.com/business/local/plans-for-story-apartment-tower-in-central-west-end/article_e9991097-bfb1-55cb-b3f7-7ee36c4d23bd.html. Accessed on January 7, 2018.
80. Bryant T. Save-A-Lot Planned for Pagedale Save-A-Lot will be Beyond Housing's First Commercial Venture. *St. Louis Post-Dispatch*. December 9, 2009. http://www.stltoday.com/business/save-a-lot-planned-for-pagedale-save-a-lot-will/article_dc205d13-4639-5dbe-90d5-7801e42fcfbo.html. Accessed on January 7, 2018.
81. East-West Gateway Council of Governments. Assessment of the Effectiveness and Fiscal Impacts of the Use of Development Incentives in the St. Louis Region. January 2012. <http://www.ewgateway.org/wp-content/uploads/2017/08/TIFFinalRpt.pdf>.
82. Economic Development Profile: North St. Louis County, Missouri. North County Inc. Regional Development Assoc. <http://northstlouiscounty.com/docs/2017EconomicDevelopmentProfile.pdf>. Accessed on February 1, 2018.
83. U.S. Census Bureau; American Community Survey, 2014.
84. Orfield M, Luce, T. American's Racially Diverse Suburbs: Opportunities and Challenges. 2012. https://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1056&context=imo_studies.
85. Lichter T, Parisi D, Taquino M. Decomposing Segregation Within and Between Metropolitan Cities and Suburbs. *American Sociological Review*. 2015;80(4):843-873. doi: 10.1177/0003122415588558.
86. powell ja. Achieving Racial Justice: What's Sprawl Got to Do With it? Poverty and Race Research Action Council newsletter. http://www.prrac.org/full_text.php?text_id=292&item_id=1841&newsletter_id=. Accessed on February 1, 2018.
87. American Sociological Association. Code of Ethics and Policies and Procedures of the ASA Committee on Professional Ethics. July 30, 2015. http://www.asanet.org/sites/default/files/savvy/documents/press/pdfs/ASR_August_2015_Lichter_News_Release.pdf. Accessed on January 7, 2018.
88. St. Charles County Department of Public Health. St. Charles County Food Code. <https://www.sccmo.org/DocumentCenter/Home/View/1679>. Accessed on January 7, 2018.
89. Tate L. The Wellston Loop: The Golden Community. The Wellston Loop Website. <http://www.thewellstonloop.com/wellston-loop>. Accessed on January 7, 2018.
90. Schlinkmann M. Opening of Final Page Extension Leg Marks End of Decades-Long Push. *St. Louis Post-Dispatch*. October 25, 2014. http://www.stltoday.com/news/local/stcharles/opening-of-final-page-extension-leg-marks-end-of-decades/article_fbba857e-80e5-5016-98b8-40dab6a2669f.html. Accessed on January 7, 2018.
91. VonBokel A. Real Estate and Racism in St. Louis. *St. Louis American*. February 23, 2017. http://www.stlamerican.com/news/columnists/guest_columnists/real-estate-and-racism-in-st-louis/article_a32603cc-f97f-11e6-a56f-5ba0c8109f60.html. Accessed on January 7, 2018.
92. Gallagher J. Blame Poverty, Age for Weak North County Home Market. *St. Louis Post-Dispatch*. August 18, 2013. http://www.stltoday.com/news/local/metro/blame-poverty-age-for-weak-north-county-home-market/article_95c998e5-bb87-5bco-9054-83e801b357ac.html. Accessed on January 7, 2018.
93. Goldstein M. Another Shadow in Ferguson as Outside Firms Buy and Rent Out Distressed Homes. *The New York Times*. September 3, 2014. Cited by: Rothstein R. The Making of Ferguson: Public Policies at the Root of its Troubles. Economic Policy Institute. Washington D.C.; October 15, 2014.
94. Massey D, Denton N. *American Apartheid: Segregation and the Making of the Underclass*. Cambridge, MA: Harvard University Press; 1993.
95. McDermott K. 'Promise Zone' Designation Puts St. Louis in Line for Federal Aid. *St. Louis Post-Dispatch*. April 28, 2015. http://www.stltoday.com/news/local/metro/promise-zone-designation-puts-st-louis-in-line-for-federal/article_e7f5a51b-324e-5dd3-8ca2-60d29b548196.html. Accessed on January 7, 2018.
96. Moore D. New Ferguson Job Training Center Represents True Hope as Dignitaries Gather for Opening. *St. Louis Post-Dispatch*. July 26, 2017. http://www.stltoday.com/news/local/metro/new-ferguson-job-training-center-represents-true-hope-as-dignitaries/article_ad38a053-1d27-5bcf-b4f7-616750217f10.html. Accessed on January 7, 2018.
97. Swanstrom T. Equity Planning in a Fragmented Suburban Setting: The Case of St. Louis. *Advancing Equity Planning Now: Seeking a More Just City*. <http://www.umsl.edu/wholecommunities/files/pdfs/KrumholzArticle.pdf>. Accessed on January 7, 2018.
98. Logan JR, Stults BJ. The Persistence of Segregation in the Metropolis: New Findings from the 2010 Census. US2010 Project, 2011.
99. U.S. Census Bureau; American Community Survey, 2015.
100. Environmental Integrity Project. America's Top Power Plant Toxic Polluters. December 2011. <http://www.environmentalintegrity.org/documents/Report-TopUSPowerPlantToxicAirPolluters.pdf>. Accessed on January 7, 2018.
101. Gray B. EPA Declines to Adjust Sulfur Dioxide Regulations in St. Charles, Franklin Counties. *St. Louis Post-Dispatch*. July 2, 2016. http://www.stltoday.com/business/local/epa-declines-to-adjust-sulfur-dioxide-regulations-in-st-charles/article_7c360365-c7e2-5fc8-b91a-ee71f3f41e65.html. Accessed on January 7, 2018.
102. Hallas B. Is Ameren Pollution Making Asthma Worse? KSDK. February 2, 2018. <http://www.ksdk.com/article/news/investigations/is-ameren-pollution-making-asthma-worse/63-513846423>. Accessed on February 21, 2018.
103. Houston D, Wu J, Ong P, Winer A. Structural Disparities of Urban Traffic in Southern California: Implication for Vehicle-related Air Pollution Exposure in Minority and High-poverty Neighborhoods. *Journal of Urban Affairs*. 2004;26(5):565-592.
104. Missouri Department of Health and Senior Services Asthma Prevention and Control Program. Asthma in St. Louis City: Promoting Healthy and Active Children. <http://health.mo.gov/living/healthcondiseases/chronic/asthma/pdf/StLouisCity.pdf>. Accessed on February 21, 2018.
105. Centers for Disease Control and Prevention and U.S. Department of Housing and Urban Development. Disease vectors and pests. In: *Healthy Housing Reference Manual*. Atlanta, GA: U.S. Department OF Health and Human Services; 2006.
106. Goldstein IF. Weather Patterns and Asthma Epidemics in New York City and New Orleans, U.S.A. *International Journal of Biometeorology*. 1980;24(4):329-339.
107. Turyk ME, Hernandez E, Wright RJ, Freels S, Slezak J, Contreras A, et al. Stressful Life events and Asthma in Adolescents. *Pediatric Allergy and Immunology*. 2007; 19: 255-263. doi:10.1111/j.1399-3038.2007.00603.x.
108. Cambria N. Too Many Babies are Dying in St. Louis and One Group is Taking a Stand. *St. Louis Post-Dispatch*. December 16, 2016. http://www.stltoday.com/news/local/metro/too-many-babies-are-dying-in-st-louis-and-one/article_c8ad194f-9b6a-5c2f-b5dd-4c13633b5595.html. Accessed January 7, 2018.
109. Cambria N, Walker M. As the Economy Improves, Evictions in St. Louis Remain Stubbornly High. *St. Louis Post-Dispatch*. October 16, 2016. http://www.stltoday.com/news/local/metro/as-the-economy-improves-evictions-in-st-louis-remain-stubbornly/article_55deb337-b65c-5c3a-a671-de513b6e205d.html. Accessed on January 7, 2018.
110. Desmond M. *Evicted: Poverty and Profit in the American City*. New York, NY: Crown Publishers. 2016.
111. U.S. Census Bureau; American Community Survey, 2016.
112. Farley R, Schuman H, Bianchi S, Colasanto D, Hatchett S. Chocolate City, Vanilla Suburbs': Will the Trend Toward Racially Separate Communities Continue? *Social Science Research*. 1978; 7(4):319-344. doi: 10.1016/0049-089X(78)90017-0.
113. Katz PA. Racists or Tolerant Multiculturalists? How do They Begin? *American Psychologist*. 2003; 58(11):897-909. doi: 10.1037/0003-066X.58.11.897.

114. Petrella C. The Resegregation of America: The Consequences of Creeping Racial Segregation Constitute Nothing Less than a National Crisis. NBC Think. December 30, 2017. <https://www.nbcnews.com/think/opinion/resegregation-america-ncna801446>. Accessed on January 7, 2018.
115. Faulk M. St. Louis Voters Approved \$5 Million for Affordable Housing but Budget Routinely Falls Short. *St. Louis Post-Dispatch*. March 21, 2017. http://www.stltoday.com/news/local/metro/st-louis-voters-approved-million-for-affordable-housing-but-budget/article_9d409257-5d01-5830-809e-98c50dcecf84.html. Accessed on January 7, 2018.
116. O'Dea J. Lending Discrimination, Redlining Still Plague St. Louis, New Data Show. *St. Louis Post-Dispatch*. February 19, 2018. http://www.stltoday.com/business/local/lending-discrimination-redlining-still-plague-st-louis-new-data-show/article_3e1a6847-799b-58d7-a680-651a0c1a2ea8.html. Accessed on March 28, 2018.
117. Erickson K. Tax Credits for Low-income Housing Dealt a Blow by Missouri Commission. *St. Louis Post-Dispatch*. December 19, 2017. http://www.stltoday.com/news/local/govt-and-politics/tax-credits-for-low-income-housing-dealt-a-blow-by/article_6e1ac144-fd69-53b2-bca3-aa4a9d1f51a5.html. Accessed on January 7, 2018.
118. Metzger MW. Section 8 in the St. Louis Region: Local Opportunities to Expand Housing Choice. Center for Social Development-George Warren Brown School of Social Work. November 2014. <https://csd.wustl.edu/Publications/Documents/PB14-29.pdf>. Accessed on January 7, 2018.
119. Cambria N. Arlene Bellamy: Jennings Resident is Locked Out on Day She was Moving, is Sued by Landlord. *St. Louis Post-Dispatch*. October 16, 2016. http://www.stltoday.com/news/arlene-bellamy-jennings-resident-is-locked-out-on-day-she/article_c6d61c59-7710-5349-a72e-a14536b62f11.html. Accessed on January 7, 2018.
120. Legal Services of Eastern Missouri. You and Your Landlord: A St. Louis Area Guide to Tenant Responsibilities and Rights. Legal Services of Eastern Missouri Website. http://www.lsem.org/files/5614/4709/4623/LSEM_Landlord-Tenant_Handbook_2015_Revision.pdf. Accessed on January 7, 2018.
121. Simeone-Cass J. From Complain to Eviction, Here's How the Maplewood Nuisance Ordinance Works. St. Louis Public Radio Website. Published June 15, 2017. <http://news.stlpublicradio.org/post/complaint-eviction-heres-how-maplewood-nuisance-ordinance-works#stream/0>. Accessed January 7, 2018.
122. Kanto N, Metzger MW. Evicting Victims: Reforming St. Louis's Nuisance Ordinance for Survivors of Domestic Violence. Center for Social Development-George Warren Brown School of Social Work. September 2015. <https://csd.wustl.edu/Publications/Documents/PB15-47.pdf>. Accessed on January 7, 2018.

Partners



Improving the health and well-being of African Americans in St. Louis and why it matters for everyone



This project is funded in part by the Missouri Foundation for Health and Wells Fargo.

Appendix D

St. Louis Region CHNA Community Survey 2021

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2021 St. Louis Metro Area Community Health Needs Assessment (CHNA)

Dear Community Members:

This survey is part of the St. Louis Metropolitan Area Community Health Needs Assessment (CHNA) conducted jointly by SSM Health, BJC HealthCare, Mercy, St. Luke's Hospital and Shriners Hospitals for Children St. Louis. The CHNA is conducted by the hospitals every 3 years.

Your responses to this survey are **VERY IMPORTANT**, because they will help guide local solutions and resource allocation for a variety of health and social issues.

Every Voice Counts! We want input directly from you about your health needs and the health of your community: What is going well? What needs improvement? What are some solutions?

The survey will take approximately 10 minutes to complete. All responses will be confidential and anonymous. We will only share combined (aggregated) results from the survey. Once you complete the survey, please share this link with your family, friends and neighbors!

Thank you for your participation and partnership- We are all in this together!

Section I: Health Needs, Access and Information

1. In what state do you reside?

- Missouri
- Illinois
- Other state

* 2. What is the zip code of your primary residence?

* 3. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

* 4. Please select the main health challenge/s you face. (Check all that apply)

- Cancer
- High blood pressure
- Drug addiction
- Diabetes
- Stroke
- Alcohol overuse
- Overweight/obesity
- Heart Disease
- Lung disease
- Joint or back pain
- Other (please specify)

- I do not have any health challenges

* 5. Where do you most often go for routine healthcare

- Physician's Office
- Local Health Department
- Emergency Room
- Urgent Care Clinic
- Community Health Center
- I do not receive routine health care

Other (please specify)

* 6. What barriers prevent you and/or your family from accessing healthcare? (Check all that apply)

- Cultural/religious beliefs
- No health insurance/unable to pay
- My health insurance is not accepted
- Difficulty finding doctors
- Costs/Co-pays
- Don't feel welcome
- Lack of nearby health centers/services/providers
- Transportation/mobility issues
- Scheduling problems
- Fear (e.g. of doctors/health systems/not ready to face or discuss health issues)

- Other (please specify)

- I/my family have no barriers preventing us from accessing health care.

7. Please select the health screenings and/or services for which you need better access. (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Drug and/or alcohol abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Prenatal care | <input type="checkbox"/> HIV AIDS/STIs |
| <input type="checkbox"/> Cholesterol (fats in the blood) | <input type="checkbox"/> Quitting smoking | <input type="checkbox"/> Routine well checkups |
| <input type="checkbox"/> Dental screenings | <input type="checkbox"/> Suicide prevention | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Emergency Preparedness | <input type="checkbox"/> Weight loss help | |
| <input type="checkbox"/> Exercise/physical activity | <input type="checkbox"/> Vaccination/immunization | |
| <input type="checkbox"/> Falls prevention for elderly | <input type="checkbox"/> Mental health/depression | |
| <input type="checkbox"/> Other (please specify) | | |

- I/my family have adequate access to health screenings

* 8. Where do you get most of your health information? (Choose top 3)

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Doctor/Health provider | <input type="checkbox"/> Hospital | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Social Media (Facebook, Twitter, Instagram, etc.) | <input type="checkbox"/> Internet | <input type="checkbox"/> TV |
| <input type="checkbox"/> Family or friends | <input type="checkbox"/> Library | <input type="checkbox"/> Worksite |
| <input type="checkbox"/> Local health department | <input type="checkbox"/> Newspaper/magazines | |
| <input type="checkbox"/> Other (please specify) | | |

9. How often do you need to have someone help you understand instructions, pamphlets or other written materials from your doctor or pharmacy?

- Always
 Often
 Sometimes
 Rarely
 Never

* 10. Do you have children for whose health you are responsible?

- Yes
 No **If NO- Skip to Section II/#16**

* 11. What health screenings, education and/or services do you feel your child/ren need better access to keep them safe and healthy? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Childhood obesity | <input type="checkbox"/> Smoking | <input type="checkbox"/> Mental health |
| <input type="checkbox"/> Physical activity | <input type="checkbox"/> Internet safety | <input type="checkbox"/> Bullying |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Blood lead levels | <input type="checkbox"/> Vaccines |
| <input type="checkbox"/> Alcohol or drug use | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Injury prevention | |
| <input type="checkbox"/> Teen pregnancy | <input type="checkbox"/> Suicide | |
| <input type="checkbox"/> Other (please specify) | | |
| <input type="text"/> | | |
| <input type="checkbox"/> None of the above | | |

12. Please indicate any disabilities that apply to your children. (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mobility/Physical |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Intellectual/Developmental/Cognitive | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Mental Health | |
| <input type="checkbox"/> Other (please specify) | |
| <input type="text"/> | |
| <input type="checkbox"/> My child/ren do not have any disabilities | |

13. Where do you take your child/ren under age 18 for routine health care most often?

- | | |
|---|--|
| <input type="radio"/> Pediatrician's office | <input type="radio"/> Community health center/clinic |
| <input type="radio"/> Local health department | <input type="radio"/> School-based clinic |
| <input type="radio"/> Emergency room | |
| <input type="radio"/> Urgent care clinic | |
| <input type="radio"/> Other (please specify) | |
| <input type="text"/> | |
| <input type="radio"/> My child/ren do not receive routine health care | |

14. Do your children have health insurance?

- Yes
 No
 Not Sure

15. Do your children have dental insurance?

- Yes
- No
- Not Sure

Section II: Community-Where you Live, Learn, Work and Play!

The questions in this section will focus on the social needs and assets of your community that also contribute to health.

* 16. Please choose the best response to reflect your opinion

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
Children in my community have access to high quality education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Children in my community have enough safe places to play	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are places to gather in my community (such as places of worship, community centers, community events, libraries and/or parks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are enough safe and affordable houses and apartments in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel like I belong in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I trust the law enforcement officials in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are opportunities for my voice to be heard about community decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My community has enough good-paying jobs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Healthy, affordable food is easily accessible in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There are enough safe places to be physically active in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 17. What types of safety concerns do you have in your community? (Check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Gun violence | <input type="checkbox"/> Poor or dangerous roads | <input type="checkbox"/> Prostitution |
| <input type="checkbox"/> Burglaries/theft | <input type="checkbox"/> Poor or dangerous sidewalks | <input type="checkbox"/> Sexual assault |
| <input type="checkbox"/> Child abuse | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Vandalism/graffiti |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Gang activity | <input type="checkbox"/> Vacant properties |
| <input type="checkbox"/> Disorderly conduct | <input type="checkbox"/> Hate crimes | |
| <input type="checkbox"/> Poor lighting | <input type="checkbox"/> Mugging/physical assault | |
| <input type="checkbox"/> Other (please specify) | | |

- I do not have any safety concerns in my community

* 18. What concerns do you have about the environmental health of your community? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Water quality | <input type="checkbox"/> Soil contamination |
| <input type="checkbox"/> Air quality/odors | <input type="checkbox"/> Vegetation overgrowth |
| <input type="checkbox"/> Not enough trees | <input type="checkbox"/> Flooding |
| <input type="checkbox"/> Too many trees | <input type="checkbox"/> Wildlife/insects |
| <input type="checkbox"/> Sewage problems | |
| <input type="checkbox"/> Other (please specify) | |

- I do not have any concerns about the environmental health of my community

* 19. How has the COVID-19 (coronavirus) pandemic impacted the following for you/your household?

	Worse	No difference	Better
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paying Bills (medical or other)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Access to healthcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Affording other basic needs (not mentioned above)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

* 20. What do you think are the top STRENGTHS of your community right now?

- | | |
|--|--|
| <input type="checkbox"/> Access to affordable, quality health care | <input type="checkbox"/> Good paying jobs and strong economy |
| <input type="checkbox"/> Access to affordable healthy foods | <input type="checkbox"/> Good places to raise a family |
| <input type="checkbox"/> Access to affordable housing | <input type="checkbox"/> Good schools/quality education |
| <input type="checkbox"/> Access to affordable transportation | <input type="checkbox"/> Opportunities to practice spiritual beliefs |
| <input type="checkbox"/> Access to community parks and other open spaces for physical activity | <input type="checkbox"/> Racial and ethnic diversity |
| <input type="checkbox"/> Clean environment | <input type="checkbox"/> Sense of belonging |
| <input type="checkbox"/> Community safety/low crime | <input type="checkbox"/> Strong community leaders and role models |
| <input type="checkbox"/> Other (please specify) | |

* 21. What do you think are the top CHALLENGES of your community right now?

- | | |
|--|--|
| <input type="checkbox"/> Access to affordable, quality health care | <input type="checkbox"/> Good paying jobs and strong economy |
| <input type="checkbox"/> Access to affordable healthy foods | <input type="checkbox"/> Good places to raise a family |
| <input type="checkbox"/> Access to affordable housing | <input type="checkbox"/> Good schools/quality education |
| <input type="checkbox"/> Access to affordable transportation | <input type="checkbox"/> Opportunities to practice spiritual beliefs |
| <input type="checkbox"/> Access to community parks and other open spaces for physical activity | <input type="checkbox"/> Racial and ethnic diversity |
| <input type="checkbox"/> Clean environment | <input type="checkbox"/> Sense of belonging |
| <input type="checkbox"/> Community safety/crime | <input type="checkbox"/> Strong community leaders and role models |
| <input type="checkbox"/> Other (please specify) | |

Section III: Please tell us a little bit more about yourself

The following questions will help us better understand our community members. You may choose not to answer any questions and all responses will be confidential. We will only share combined/aggregated results.

22. Do you currently have health insurance?

- Yes
- No
- Not Sure

23. Do you currently have dental insurance?

- Yes
- No
- Not Sure

24. With which gender identity do you most identify?

- | | |
|--|---|
| <input type="radio"/> Female | <input type="radio"/> Transgender Male |
| <input type="radio"/> Male | <input type="radio"/> Gender Variant/Non-conforming |
| <input type="radio"/> Transgender Female | <input type="radio"/> Prefer not to answer |
| <input type="radio"/> Not Listed | |

25. What is your sexual orientation?

- Heterosexual or straight
- Gay
- Lesbian
- Bisexual
- A sexual orientation not listed

26. With which race/ethnicity do you identify? You may check more than one.

- African American or Black
- American Indian or Alaska Native
- Asian
- Hispanic or Latino
- Native Hawaiian or other Pacific Islander
- White
- A category not listed

27. What languages do you speak at home?

28. What is your age group?

- | | |
|--------------------------------|-----------------------------|
| <input type="radio"/> Under 18 | <input type="radio"/> 45-54 |
| <input type="radio"/> 18-24 | <input type="radio"/> 55-64 |
| <input type="radio"/> 25-34 | <input type="radio"/> 65-74 |
| <input type="radio"/> 35-44 | <input type="radio"/> 75+ |

29. What is the highest grade or year of school you completed?

- | | |
|--|---|
| <input type="radio"/> Less than 9th grade | <input type="radio"/> Some college credit, no degree |
| <input type="radio"/> 9-12 grade, no diploma | <input type="radio"/> Associate's degree |
| <input type="radio"/> High School graduate or GED | <input type="radio"/> Bachelor's degree |
| <input type="radio"/> Trade/Technical training program | <input type="radio"/> Graduate or professional degree |

30. What is your employment status

- | | |
|--|---|
| <input type="radio"/> Employed, full time (includes self-employed) | <input type="radio"/> Caregiver/Homemaker |
| <input type="radio"/> Employed, part time (includes self-employed) | <input type="radio"/> Student |
| <input type="radio"/> Out of work for more than 1 year | <input type="radio"/> Retired |
| <input type="radio"/> Out of work for less than 1 year | <input type="radio"/> Unable to work |

31. Are you a Veteran?

- Yes
- No

32. Which of these describes your household income last year?

- | | |
|---|--|
| <input type="radio"/> Less than \$10,000 | <input type="radio"/> \$75,000 - \$99,999 |
| <input type="radio"/> \$10,000- \$24,999 | <input type="radio"/> \$100,000- \$149,999 |
| <input type="radio"/> \$25,000- \$49,999 | <input type="radio"/> \$150,000+ |
| <input type="radio"/> \$50,000 - \$74,999 | |

33. Do you consider yourself to be a person with a disability?

- Yes
- No

34. Please select the type of disabilities that apply to you

- | | |
|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mobility/Physical |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Intellectual/Developmental/Cognitive | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Mental Health | |
| <input type="checkbox"/> A disability not listed | |

35. How many adults (age 18+) live in your household (including yourself)?

- 1
- 2
- 3
- 4
- 5
- More than 5

36. How many children under age 18 live in your household?

- 0
- 1
- 2
- 3
- 4
- 5
- More than 5

37. Please indicate your housing status

- Own house
- Rent house/apartment
- Transitional or temporary housing
- Shelter for Unhoused
- Unhoused (do not have regular, adequate, nightly residence)
- Other housing status not listed:

38. If you were able to implement one, single solution to improve your health, what would it be? (No more than 100 characters)

39. If you were able to implement one, single solution to improve the health of your community, what would it be? (No more than 100 characters)

THANK YOU FOR YOUR TIME!

You may place your completed survey in nearby drop box or give to a staff member

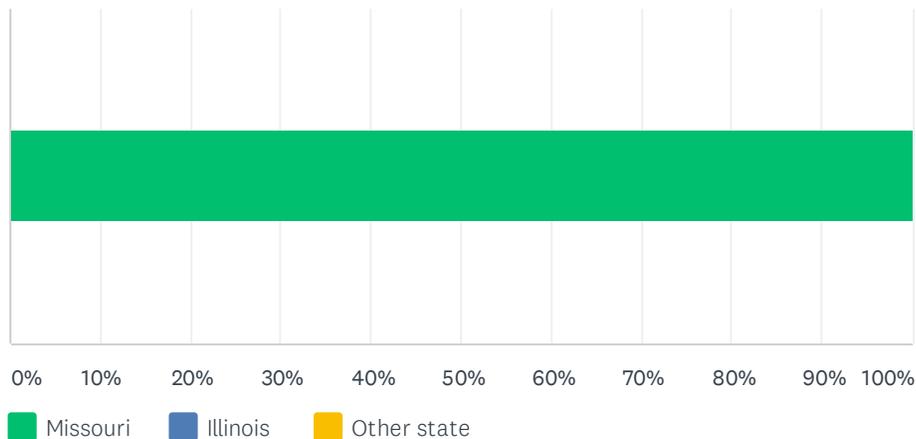
Results of this survey and related Community Health Needs Assessment data will be shared with the community as they become available, between 6 -22 months, depending on the hospital system

Community Survey Results

West St. Louis County

Q1 In what state do you reside?

Answered: 197 Skipped: 0



ANSWER CHOICES	RESPONSES	
Missouri (1)	100.00%	197
Illinois (2)	0.00%	0
Other state (3)	0.00%	0
TOTAL		197

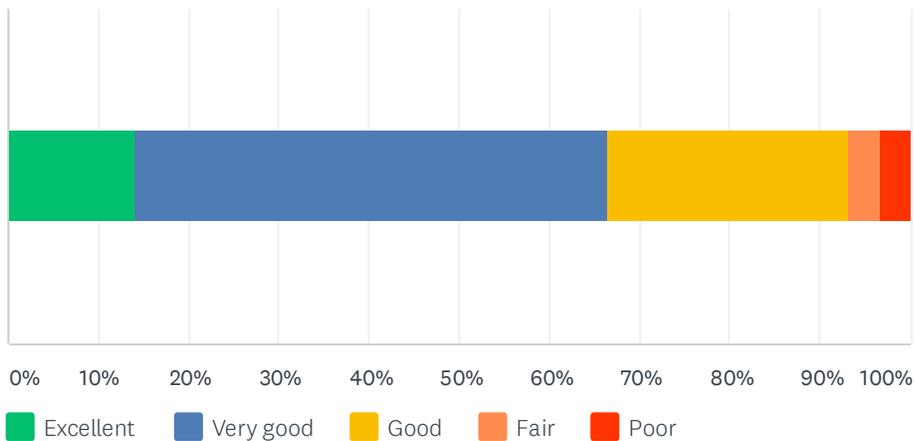
BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	1.00	1.00	1.00	0.00

Q2 What is the zip code of your primary residence?

Answered: 197 Skipped: 0

Q3 In general, would you say your health is:

Answered: 191 Skipped: 6

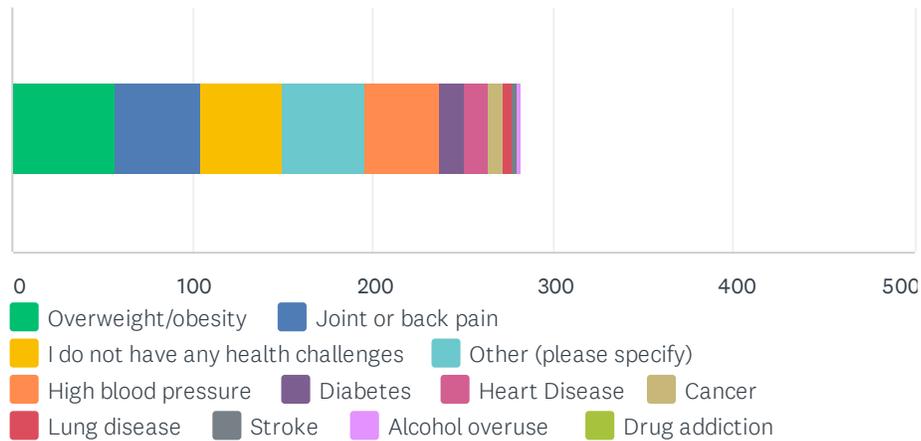


ANSWER CHOICES	RESPONSES	
Excellent (1)	14.14%	27
Very good (2)	52.36%	100
Good (3)	26.70%	51
Fair (4)	3.66%	7
Poor (5)	3.14%	6
TOTAL		191

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	2.00	2.29	0.87

Q4 Please select the main health challenge/s you face. (Check all that apply)

Answered: 191 Skipped: 6

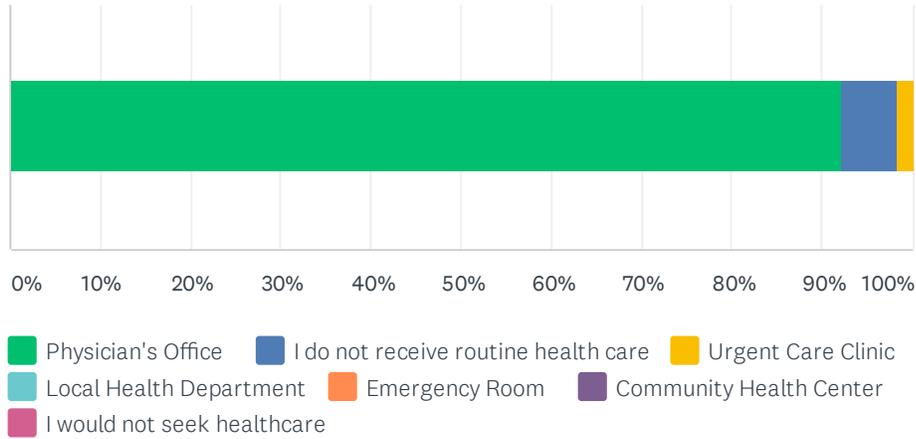


ANSWER CHOICES	RESPONSES	
Overweight/obesity (4)	29.84%	57
Joint or back pain (9)	24.61%	47
I do not have any health challenges (1)	24.08%	46
Other (please specify) (12)	24.08%	46
High blood pressure (6)	21.47%	41
Diabetes (3)	7.33%	14
Heart Disease (8)	6.81%	13
Cancer (2)	4.19%	8
Lung disease (5)	2.62%	5
Stroke (7)	1.57%	3
Alcohol overuse (11)	1.05%	2
Drug addiction (10)	0.00%	0
Total Respondents: 191		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	6.00	7.31	3.48

Q5 Where do you most often go for routine healthcare

Answered: 191 Skipped: 6

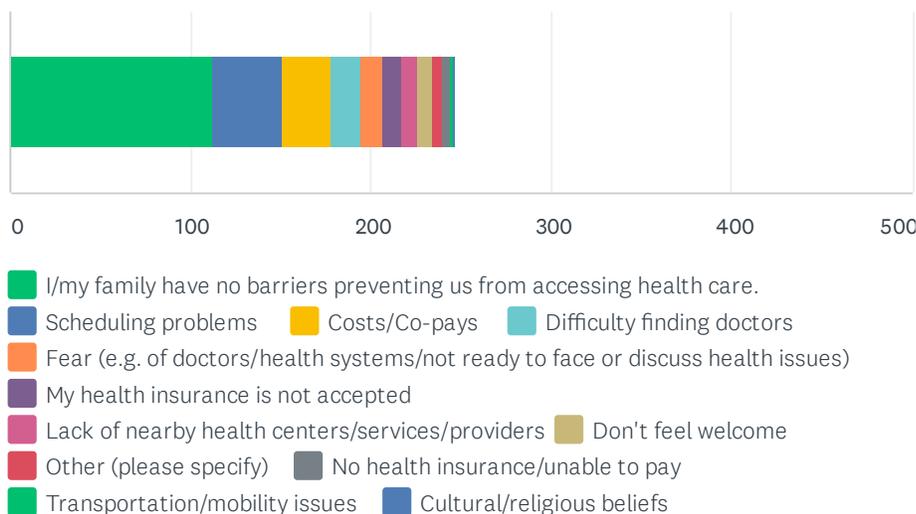


ANSWER CHOICES	RESPONSES	
Physician's Office (1)	92.15%	176
I do not receive routine health care (6)	6.28%	12
Urgent Care Clinic (4)	1.57%	3
Local Health Department (2)	0.00%	0
Emergency Room (3)	0.00%	0
Community Health Center (5)	0.00%	0
I would not seek healthcare (7)	0.00%	0
TOTAL		191

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.36	1.26

Q6 What barriers prevent you and/or your family from accessing healthcare? (Check all that apply)

Answered: 186 Skipped: 11

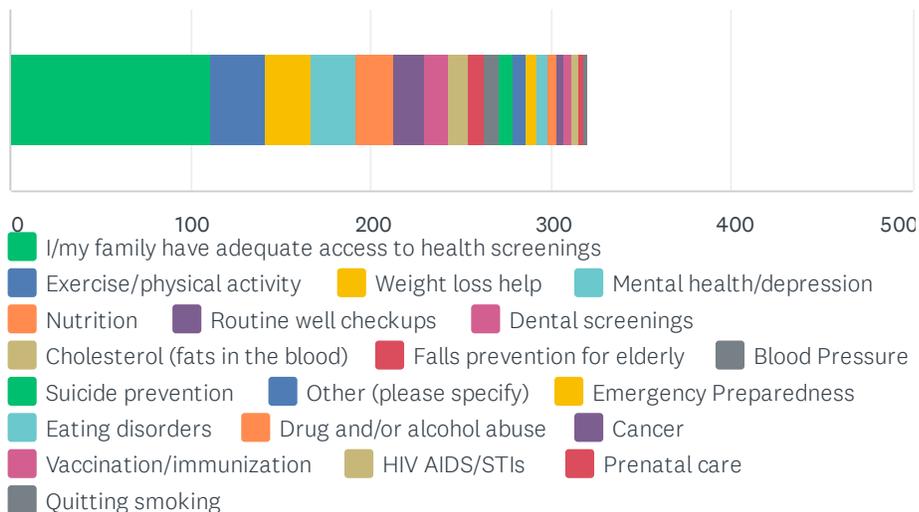


ANSWER CHOICES	RESPONSES	
I/my family have no barriers preventing us from accessing health care. (1)	60.22%	112
Scheduling problems (9)	20.97%	39
Costs/Co-pays (7)	14.52%	27
Difficulty finding doctors (3)	9.14%	17
Fear (e.g. of doctors/health systems/not ready to face or discuss health issues) (5)	6.45%	12
My health insurance is not accepted (10)	5.38%	10
Lack of nearby health centers/services/providers (4)	4.84%	9
Don't feel welcome (11)	4.30%	8
Other (please specify) (12)	3.23%	6
No health insurance/unable to pay (6)	2.15%	4
Transportation/mobility issues (8)	1.08%	2
Cultural/religious beliefs (2)	0.54%	1
Total Respondents: 186		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	7.00	7.37	2.73

Q7 Please select the health screenings and/or services for which you need better access. (Check all that apply)

Answered: 177 Skipped: 20



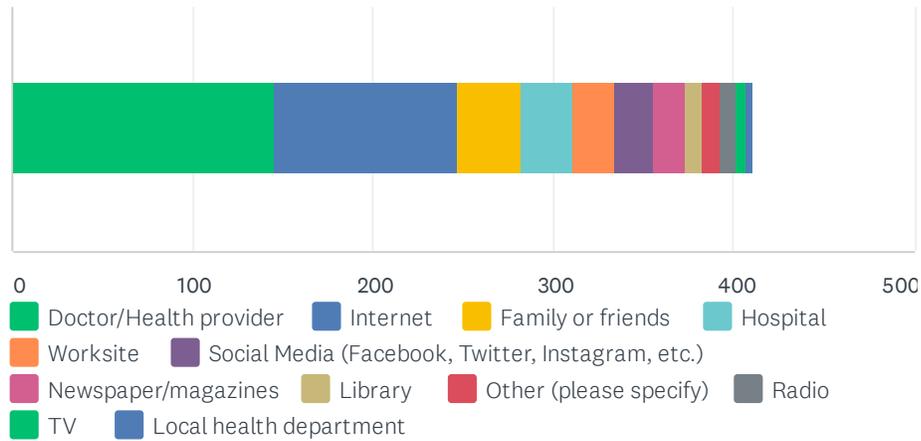
2021 Community Health Needs Assessment (CHNA)

ANSWER CHOICES	RESPONSES	
I/my family have adequate access to health screenings (1)	62.71%	111
Exercise/physical activity (7)	17.51%	31
Weight loss help (13)	14.12%	25
Mental health/depression (15)	14.12%	25
Nutrition (9)	11.86%	21
Routine well checkups (18)	9.60%	17
Dental screenings (5)	7.34%	13
Cholesterol (fats in the blood) (4)	6.21%	11
Falls prevention for elderly (8)	5.08%	9
Blood Pressure (2)	4.52%	8
Suicide prevention (12)	4.52%	8
Other (please specify) (20)	3.95%	7
Emergency Preparedness (6)	3.39%	6
Eating disorders (19)	3.39%	6
Drug and/or alcohol abuse (16)	2.82%	5
Cancer (3)	2.26%	4
Vaccination/immunization (14)	2.26%	4
HIV AIDS/STIs (17)	2.26%	4
Prenatal care (10)	1.69%	3
Quitting smoking (11)	1.13%	2
Total Respondents: 177		

BASIC STATISTICS				
Minimum 2.00	Maximum 21.00	Median 10.00	Mean 10.86	Standard Deviation 5.11

Q8 Where do you get most of your health information? (Choose top 3)

Answered: 179 Skipped: 18

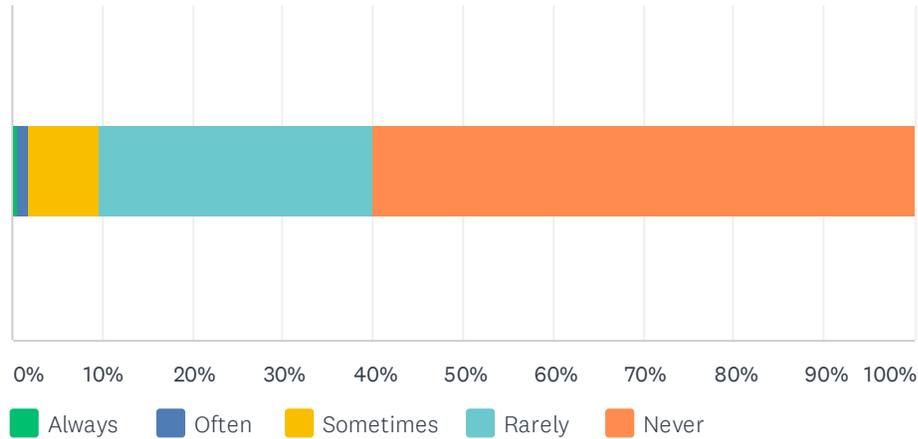


ANSWER CHOICES	RESPONSES	
Doctor/Health provider (1)	81.56%	146
Internet (6)	56.42%	101
Family or friends (3)	19.55%	35
Hospital (5)	16.20%	29
Worksite (11)	12.85%	23
Social Media (Facebook, Twitter, Instagram, etc.) (2)	11.73%	21
Newspaper/magazines (8)	10.06%	18
Library (7)	5.59%	10
Other (please specify) (12)	5.59%	10
Radio (9)	5.03%	9
TV (10)	2.79%	5
Local health department (4)	2.23%	4
Total Respondents: 179		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	12.00	4.00	4.33	3.26

Q9 How often do you need to have someone help you understand instructions, pamphlets or other written materials from your doctor or pharmacy?

Answered: 175 Skipped: 22

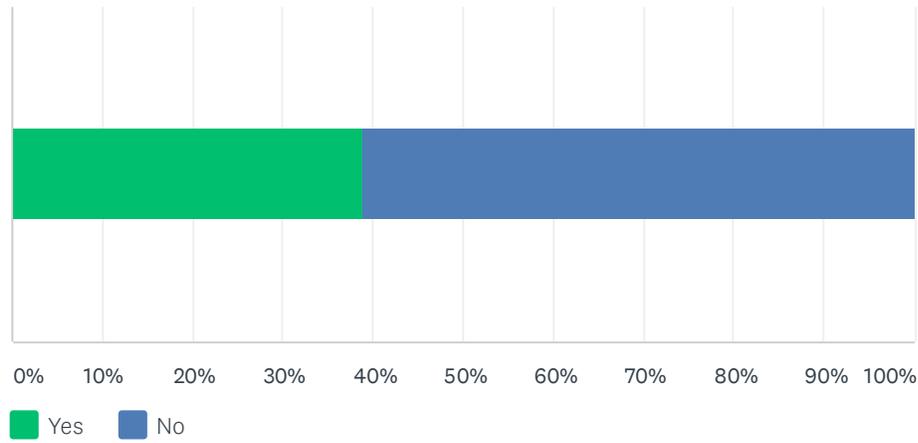


ANSWER CHOICES	RESPONSES	
Always (1)	0.57%	1
Often (2)	1.14%	2
Sometimes (3)	8.00%	14
Rarely (4)	30.29%	53
Never (5)	60.00%	105
TOTAL		175

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.48	0.74

Q10 Do you have children for whose health you are responsible?

Answered: 175 Skipped: 22

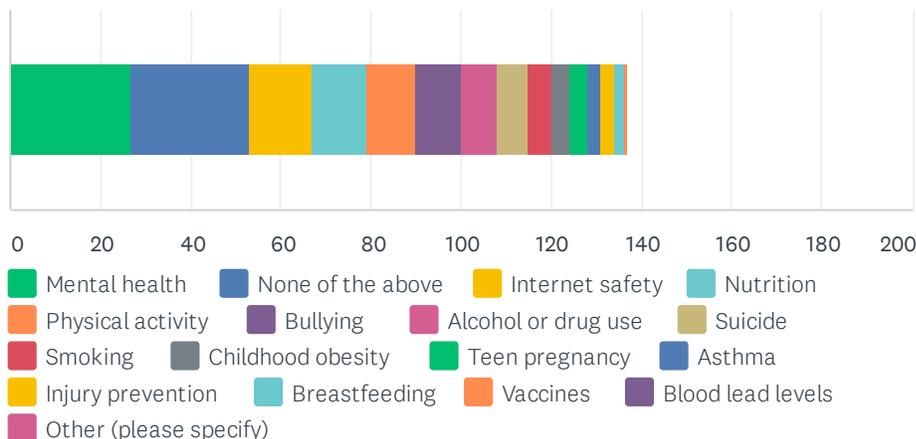


ANSWER CHOICES	RESPONSES	
Yes (1)	38.86%	68
No (2)	61.14%	107
TOTAL		175

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.61	0.49

Q11 What health screenings, education and/or services do you feel your child/ren need better access to keep them safe and healthy? (Check all that apply)

Answered: 67 Skipped: 130



ANSWER CHOICES	RESPONSES	
Mental health (14)	40.30%	27
None of the above (1)	38.81%	26
Internet safety (9)	20.90%	14
Nutrition (4)	17.91%	12
Physical activity (3)	16.42%	11
Bullying (15)	14.93%	10
Alcohol or drug use (5)	11.94%	8
Suicide (13)	10.45%	7
Smoking (8)	7.46%	5
Childhood obesity (2)	5.97%	4
Teen pregnancy (7)	5.97%	4
Asthma (11)	4.48%	3
Injury prevention (12)	4.48%	3
Breastfeeding (6)	2.99%	2
Vaccines (16)	1.49%	1
Blood lead levels (10)	0.00%	0
Other (please specify) (17)	0.00%	0
Total Respondents: 67		

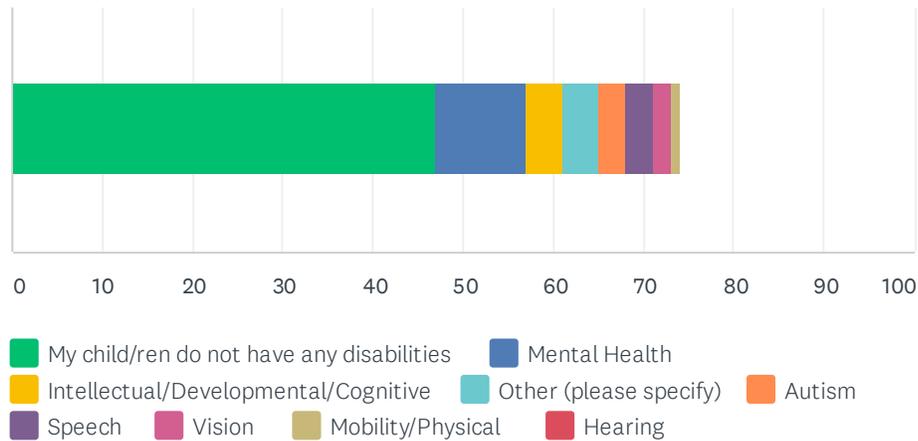
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum 2.00	Maximum 16.00	Median 9.00	Mean 9.36	Standard Deviation 4.53
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Q12 Please indicate any disabilities that apply to your children. (Check all that apply)

Answered: 66 Skipped: 131

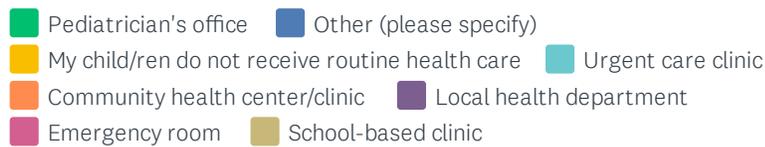
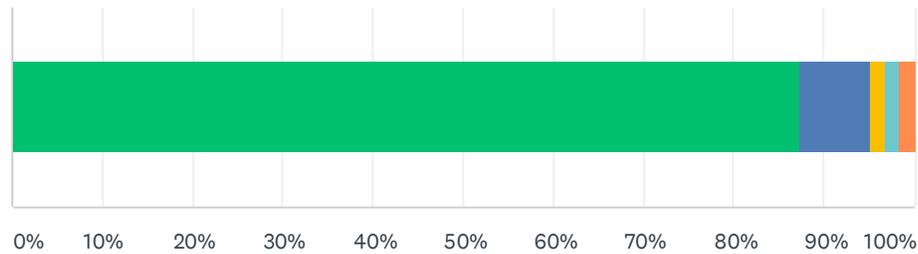


ANSWER CHOICES	RESPONSES	
My child/ren do not have any disabilities (1)	71.21%	47
Mental Health (5)	15.15%	10
Intellectual/Developmental/Cognitive (4)	6.06%	4
Other (please specify) (9)	6.06%	4
Autism (2)	4.55%	3
Speech (7)	4.55%	3
Vision (8)	3.03%	2
Mobility/Physical (6)	1.52%	1
Hearing (3)	0.00%	0
Total Respondents: 66		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	10.00	5.00	5.74	2.33

Q13 Where do you take your child/ren under age 18 for routine health care most often?

Answered: 63 Skipped: 134

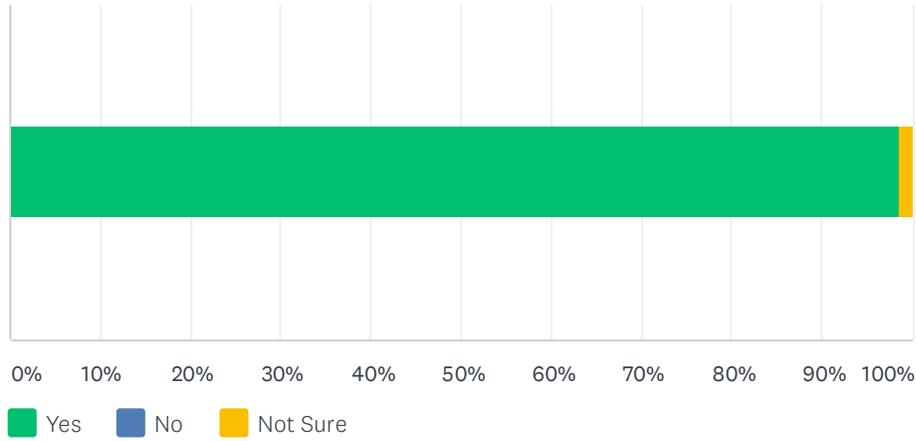


ANSWER CHOICES	RESPONSES	
Pediatrician's office (2)	87.30%	55
Other (please specify) (8)	7.94%	5
My child/ren do not receive routine health care (1)	1.59%	1
Urgent care clinic (5)	1.59%	1
Community health center/clinic (6)	1.59%	1
Local health department (3)	0.00%	0
Emergency room (4)	0.00%	0
School-based clinic (7)	0.00%	0
TOTAL		63

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	9.00	2.00	2.68	1.97

Q14 Do your children have health insurance?

Answered: 67 Skipped: 130

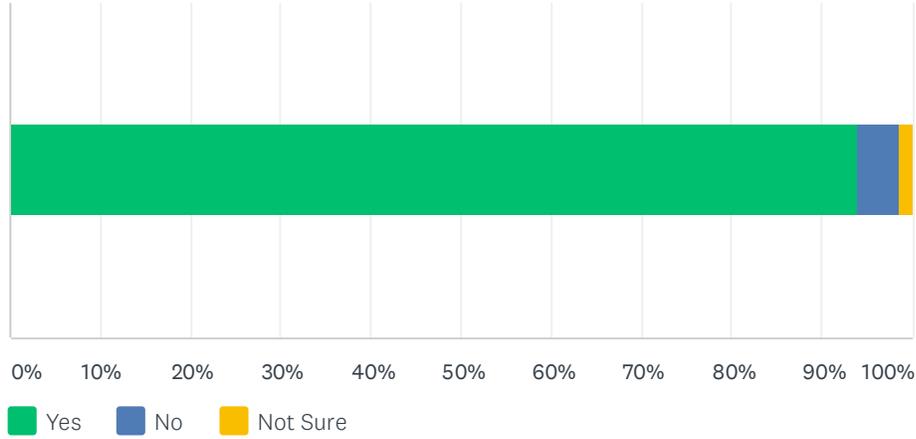


ANSWER CHOICES	RESPONSES	
Yes (1)	98.51%	66
No (2)	0.00%	0
Not Sure (3)	1.49%	1
TOTAL		67

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.03	0.24

Q15 Do your children have dental insurance?

Answered: 67 Skipped: 130

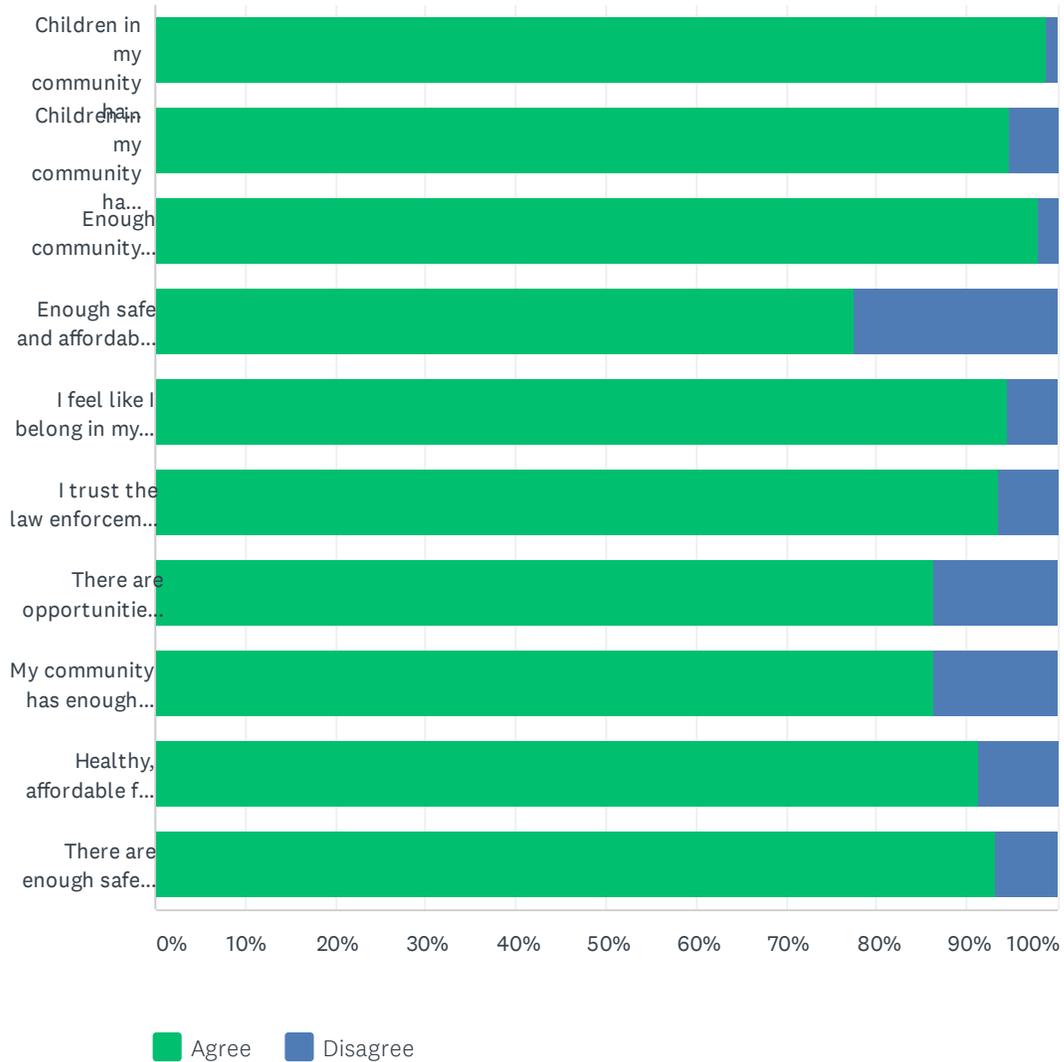


ANSWER CHOICES	RESPONSES	
Yes (1)	94.03%	63
No (2)	4.48%	3
Not Sure (3)	1.49%	1
TOTAL		67

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.07	0.31

Q16 Please choose the best response to reflect your opinion

Answered: 168 Skipped: 29



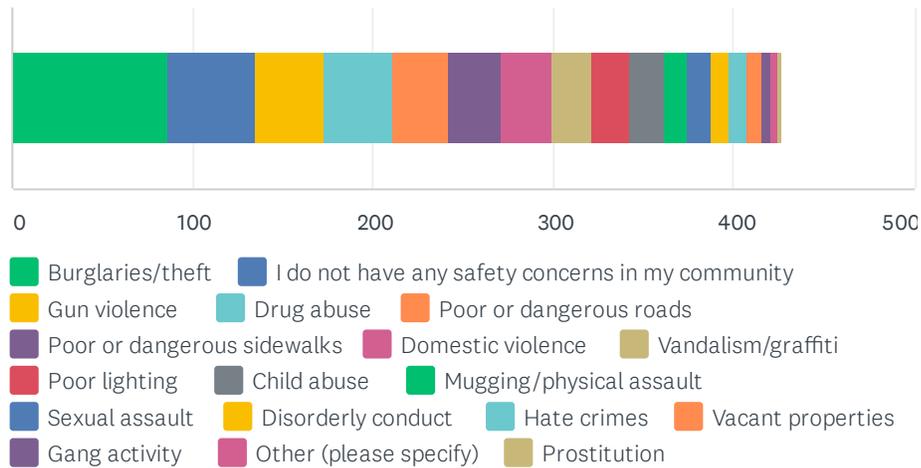
2021 Community Health Needs Assessment (CHNA)

	AGREE	DISAGREE	TOTAL	WEIGHTED AVERAGE
Children in my community have access to high quality education	98.74% 157	1.26% 2	159	1.01
Children in my community have enough safe places to play	94.87% 148	5.13% 8	156	1.05
Enough community gatherings: parks, places of worship, community events	98.06% 152	1.94% 3	155	1.02
Enough safe and affordable houses and apartments in my community	77.44% 103	22.56% 30	133	1.23
I feel like I belong in my community	94.63% 141	5.37% 8	149	1.05
I trust the law enforcement officials in my community	93.51% 144	6.49% 10	154	1.06
There are opportunities for my voice to be heard about community decisions	86.36% 114	13.64% 18	132	1.14
My community has enough good-paying jobs	86.36% 114	13.64% 18	132	1.14
Healthy, affordable food is easily accessible in my community	91.28% 136	8.72% 13	149	1.09
There are enough safe places to be physically active in my community	93.13% 149	6.88% 11	160	1.07

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Children in my community have access to high quality education	1.00	4.00	1.00	1.52	0.65
Children in my community have enough safe places to play	1.00	5.00	2.00	1.75	0.83
Enough community gatherings: parks, places of worship, community events	1.00	4.00	1.00	1.52	0.72
Enough safe and affordable houses and apartments in my community	1.00	5.00	2.00	2.32	1.18
I feel like I belong in my community	1.00	5.00	2.00	1.86	0.88
I trust the law enforcement officials in my community	1.00	5.00	1.00	1.71	0.93
There are opportunities for my voice to be heard about community decisions	1.00	5.00	2.00	2.17	1.01
My community has enough good-paying jobs	1.00	5.00	2.00	2.17	0.98
Healthy, affordable food is easily accessible in my community	1.00	5.00	2.00	1.89	0.93
There are enough safe places to be physically active in my community	1.00	5.00	2.00	1.75	0.88

Q17 What types of safety concerns do you have in your community? (Check all that apply)

Answered: 167 Skipped: 30



ANSWER CHOICES	RESPONSES	
Burglaries/theft (3)	51.50%	86
I do not have any safety concerns in my community (1)	29.34%	49
Gun violence (2)	22.75%	38
Drug abuse (10)	22.75%	38
Poor or dangerous roads (8)	18.56%	31
Poor or dangerous sidewalks (9)	17.37%	29
Domestic violence (5)	16.77%	28
Vandalism/graffiti (16)	13.17%	22
Poor lighting (7)	12.57%	21
Child abuse (4)	11.38%	19
Mugging/physical assault (13)	8.38%	14
Sexual assault (15)	7.78%	13
Disorderly conduct (6)	5.99%	10
Hate crimes (12)	5.99%	10
Vacant properties (17)	4.79%	8
Gang activity (11)	2.99%	5
Other (please specify) (18)	2.40%	4
Prostitution (14)	1.20%	2
Total Respondents: 167		

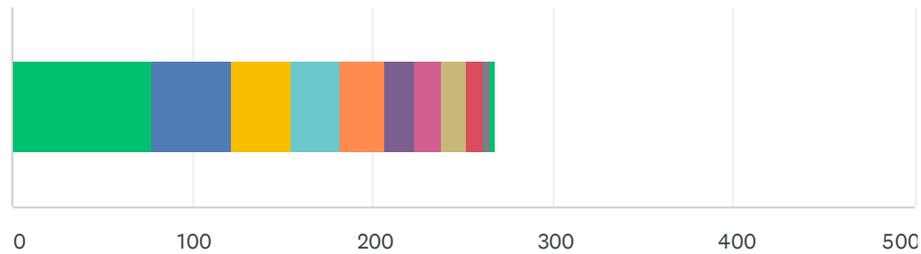
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum 2.00	Maximum 19.00	Median 7.00	Mean 7.38	Standard Deviation 4.59
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Q18 What concerns do you have about the environmental health of your community? (Check all that apply)

Answered: 166 Skipped: 31



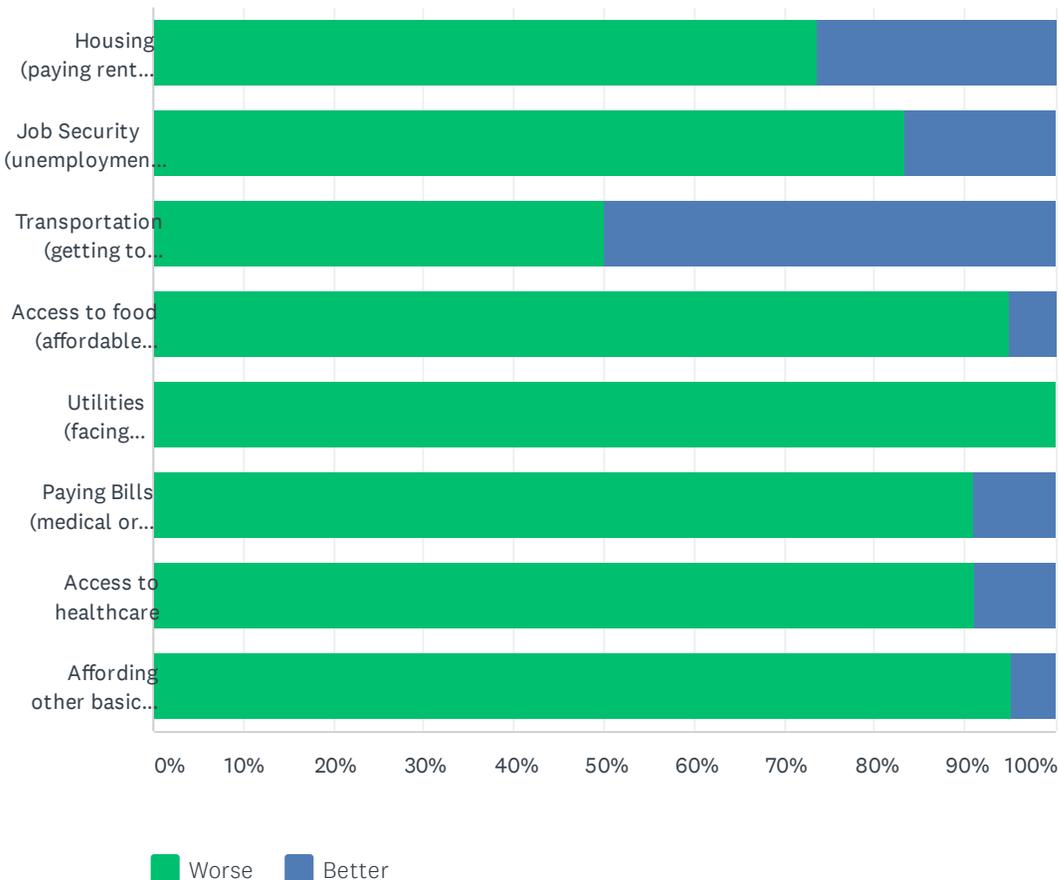
- I do not have any concerns about the environmental health of my community
- Wildlife/insects ■ Water quality ■ Flooding ■ Air quality/odors
- Sewage problems ■ Not enough trees ■ Soil contamination
- Vegetation overgrowth ■ Other (please specify) ■ Too many trees

ANSWER CHOICES	RESPONSES	
I do not have any concerns about the environmental health of my community (1)	46.39%	77
Wildlife/insects (10)	26.51%	44
Water quality (2)	20.48%	34
Flooding (9)	16.27%	27
Air quality/odors (3)	15.06%	25
Sewage problems (6)	9.64%	16
Not enough trees (4)	9.04%	15
Soil contamination (7)	8.43%	14
Vegetation overgrowth (8)	5.42%	9
Other (please specify) (11)	2.41%	4
Too many trees (5)	1.81%	3
Total Respondents: 166		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	12.00	7.00	6.36	3.19

Q19 How has the COVID-19 (coronavirus) pandemic impacted the following for you/your household?

Answered: 165 Skipped: 32



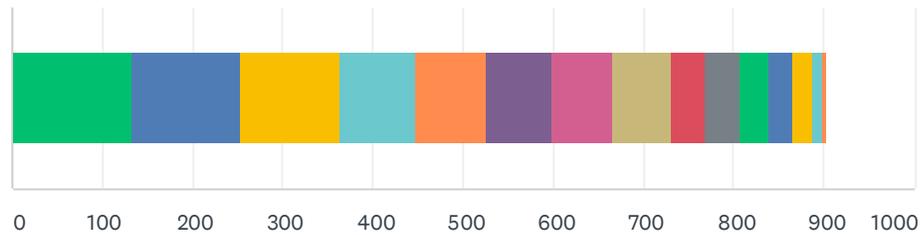
	WORSE	BETTER	TOTAL
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	73.68% 14	26.32% 5	19
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	83.33% 30	16.67% 6	36
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	50.00% 7	50.00% 7	14
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	95.00% 19	5.00% 1	20
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	100.00% 8	0.00% 0	8
Paying Bills (medical or other)	90.91% 20	9.09% 2	22
Access to healthcare	91.18% 31	8.82% 3	34
Affording other basic needs (not mentioned above)	95.24% 20	4.76% 1	21

2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	1.00	3.00	2.00	1.95	0.33
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	1.00	3.00	2.00	1.85	0.44
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	1.00	3.00	2.00	2.00	0.29
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	1.00	3.00	2.00	1.89	0.33
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	1.00	2.00	2.00	1.95	0.22
Paying Bills (medical or other)	1.00	3.00	2.00	1.89	0.35
Access to healthcare	1.00	3.00	2.00	1.83	0.42
Affording other basic needs (not mentioned above)	1.00	3.00	2.00	1.88	0.34

Q20 What do you think are the top STRENGTHS of your community right now?

Answered: 164 Skipped: 33



- Good schools/quality education
- Good places to raise a family
- Access to community parks and other open spaces for physical activity
- Community safety/low crime
- Opportunities to practice spiritual beliefs
- Access to affordable, quality health care
- Clean environment
- Access to affordable healthy foods
- Good paying jobs and strong economy
- Sense of belonging
- Racial and ethnic diversity
- Access to affordable housing
- Strong community leaders and role models
- Access to affordable transportation
- Other (please specify)

ANSWER CHOICES	RESPONSES	
Good schools/quality education (10)	80.49%	132
Good places to raise a family (9)	74.39%	122
Access to community parks and other open spaces for physical activity (5)	67.07%	110
Community safety/low crime (7)	50.61%	83
Opportunities to practice spiritual beliefs (11)	48.78%	80
Access to affordable, quality health care (1)	43.29%	71
Clean environment (6)	42.07%	69
Access to affordable healthy foods (2)	39.02%	64
Good paying jobs and strong economy (8)	23.78%	39
Sense of belonging (13)	23.17%	38
Racial and ethnic diversity (12)	19.51%	32
Access to affordable housing (3)	15.85%	26
Strong community leaders and role models (14)	13.41%	22
Access to affordable transportation (4)	6.71%	11
Other (please specify) (15)	3.05%	5
Total Respondents: 164		

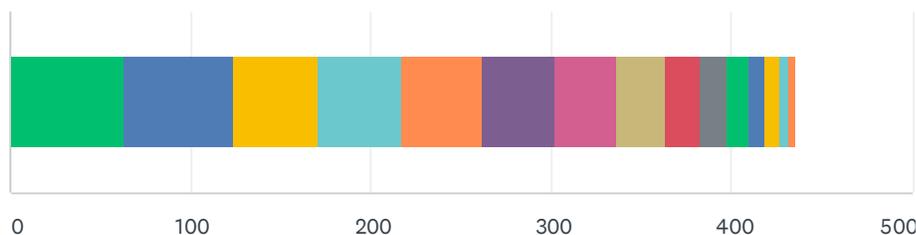
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	8.00	7.45	3.58

Q21 What do you think are the top CHALLENGES of your community right now?

Answered: 162 Skipped: 35



- Access to affordable housing
- Racial and ethnic diversity
- Access to affordable transportation
- Strong community leaders and role models
- Good paying jobs and strong economy
- Community safety/crime
- Access to affordable, quality health care
- Sense of belonging
- Access to affordable healthy foods
- Other (please specify)
- Clean environment
- Access to community parks and other open spaces for physical activity
- Good schools/quality education
- Good places to raise a family
- Opportunities to practice spiritual beliefs

ANSWER CHOICES	RESPONSES	
Access to affordable housing (3)	38.89%	63
Racial and ethnic diversity (12)	37.04%	60
Access to affordable transportation (4)	29.63%	48
Strong community leaders and role models (14)	28.40%	46
Good paying jobs and strong economy (8)	27.78%	45
Community safety/crime (7)	24.69%	40
Access to affordable, quality health care (1)	20.99%	34
Sense of belonging (13)	16.67%	27
Access to affordable healthy foods (2)	12.35%	20
Other (please specify) (15)	9.26%	15
Clean environment (6)	7.41%	12
Access to community parks and other open spaces for physical activity (5)	5.56%	9
Good schools/quality education (10)	4.94%	8
Good places to raise a family (9)	3.09%	5
Opportunities to practice spiritual beliefs (11)	2.47%	4
Total Respondents: 162		

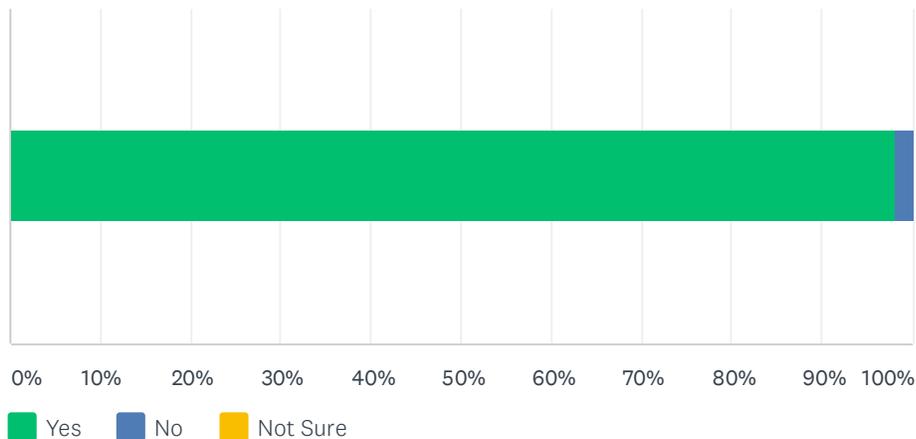
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	7.00	7.62	4.53

Q22 Do you currently have health insurance?

Answered: 162 Skipped: 35

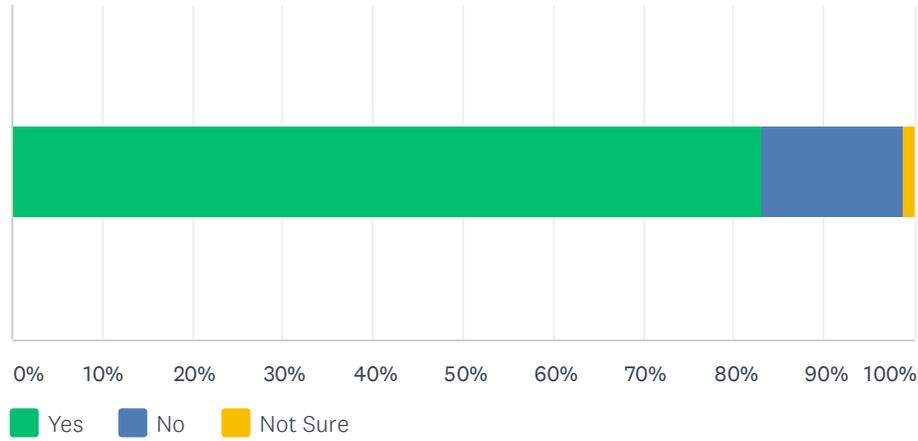


ANSWER CHOICES	RESPONSES
Yes (1)	98.15% 159
No (2)	1.85% 3
Not Sure (3)	0.00% 0
TOTAL	162

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.02	0.13

Q23 Do you currently have dental insurance?

Answered: 160 Skipped: 37

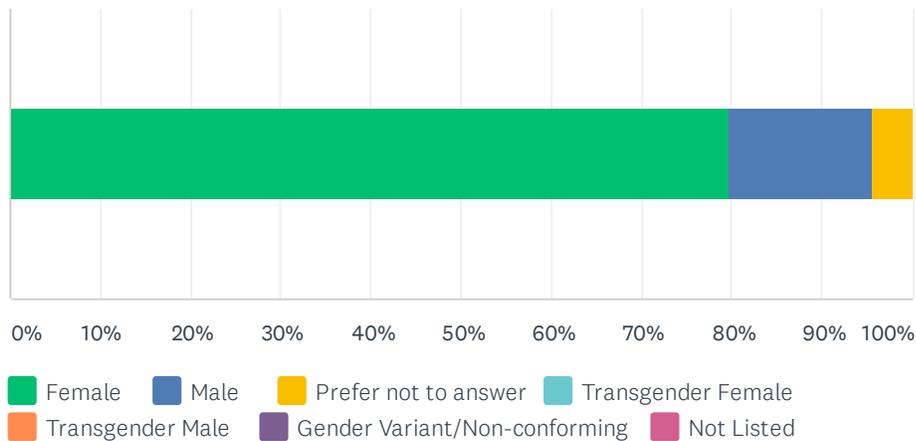


ANSWER CHOICES	RESPONSES	
Yes (1)	83.13%	133
No (2)	15.63%	25
Not Sure (3)	1.25%	2
TOTAL		160

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.18	0.42

Q24 With which gender identity do you most identify?

Answered: 162 Skipped: 35

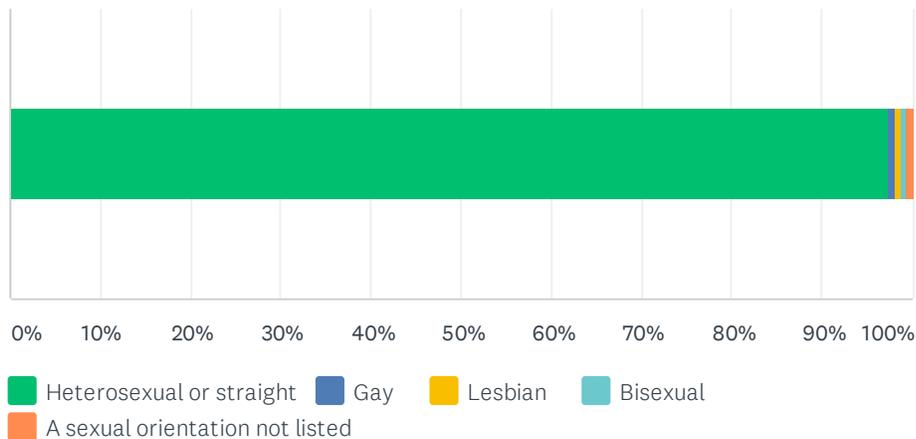


ANSWER CHOICES	RESPONSES	
Female (1)	79.63%	129
Male (2)	16.05%	26
Prefer not to answer (6)	4.32%	7
Transgender Female (3)	0.00%	0
Transgender Male (4)	0.00%	0
Gender Variant/Non-conforming (5)	0.00%	0
Not Listed (7)	0.00%	0
TOTAL		162

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.38	1.05

Q25 What is your sexual orientation?

Answered: 159 Skipped: 38

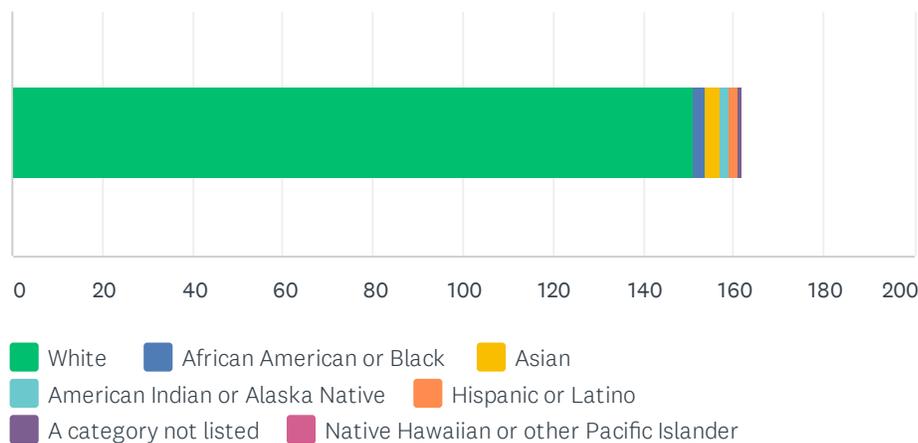


ANSWER CHOICES	RESPONSES	
Heterosexual or straight (1)	97.48%	155
Gay (2)	0.63%	1
Lesbian (3)	0.63%	1
Bisexual (4)	0.63%	1
A sexual orientation not listed (5)	0.63%	1
TOTAL		159

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	1.00	1.06	0.43

Q26 With which race/ethnicity do you identify? You may check more than one.

Answered: 159 Skipped: 38

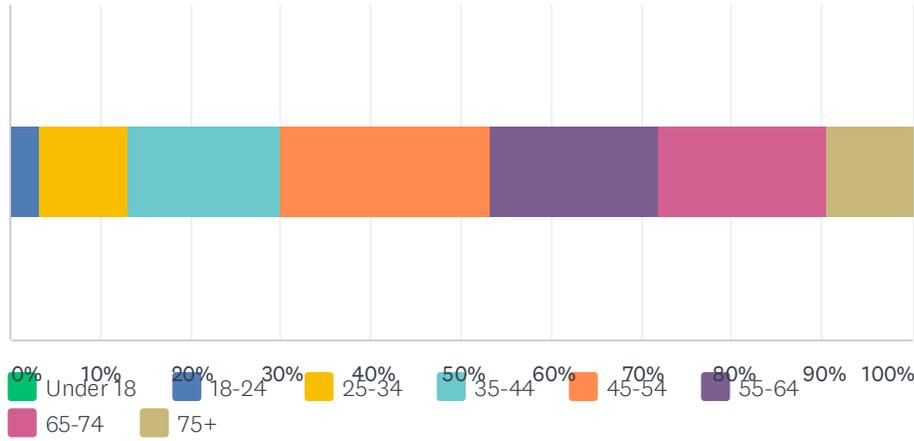


ANSWER CHOICES	RESPONSES	
White (6)	94.97%	151
African American or Black (1)	1.89%	3
Asian (3)	1.89%	3
American Indian or Alaska Native (2)	1.26%	2
Hispanic or Latino (4)	1.26%	2
A category not listed (7)	0.63%	1
Native Hawaiian or other Pacific Islander (5)	0.00%	0
Total Respondents: 159		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	6.00	5.78	0.91

Q28 What is your age group?

Answered: 160 Skipped: 37

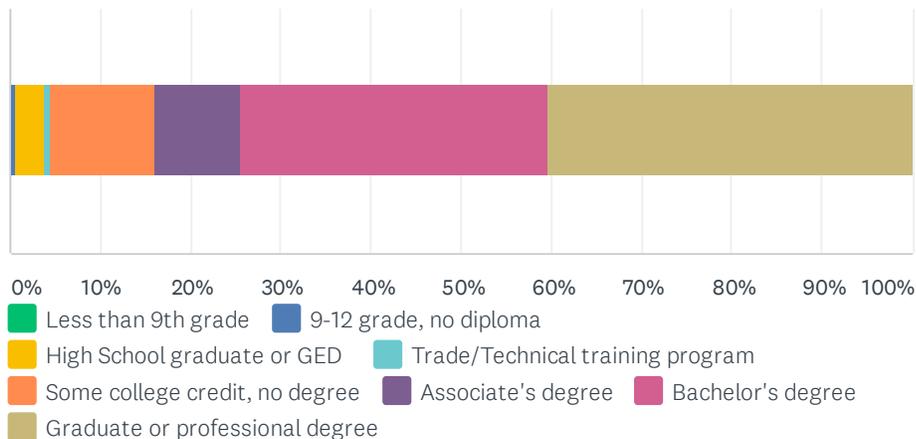


ANSWER CHOICES	RESPONSES
Under 18 (1)	0.00% 0
18-24 (2)	3.13% 5
25-34 (3)	10.00% 16
35-44 (4)	16.88% 27
45-54 (5)	23.13% 37
55-64 (6)	18.75% 30
65-74 (7)	18.75% 30
75+ (8)	9.38% 15
TOTAL	160

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	8.00	5.00	5.38	1.58

Q29 What is the highest grade or year of school you completed?

Answered: 161 Skipped: 36

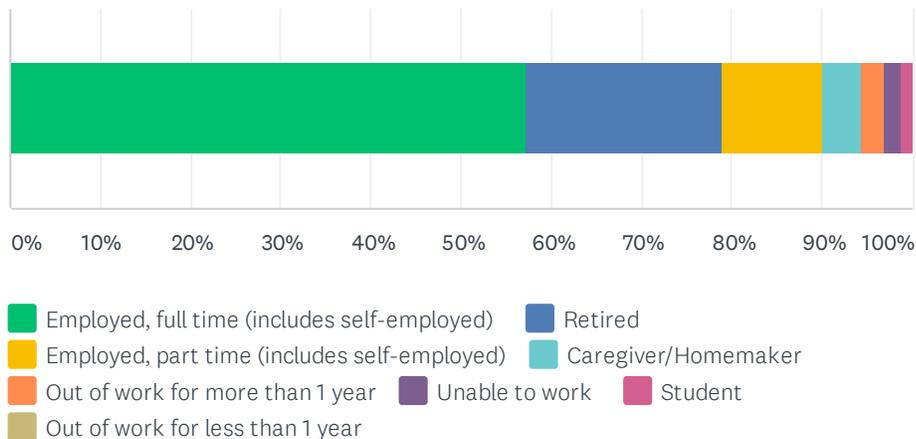


ANSWER CHOICES	RESPONSES	
Less than 9th grade (1)	0.00%	0
9-12 grade, no diploma (2)	0.62%	1
High School graduate or GED (3)	3.11%	5
Trade/Technical training program (4)	0.62%	1
Some college credit, no degree (5)	11.80%	19
Associate's degree (6)	9.32%	15
Bachelor's degree (7)	34.16%	55
Graduate or professional degree (8)	40.37%	65
TOTAL		161

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	8.00	7.00	6.90	1.29

Q30 What is your employment status

Answered: 161 Skipped: 36

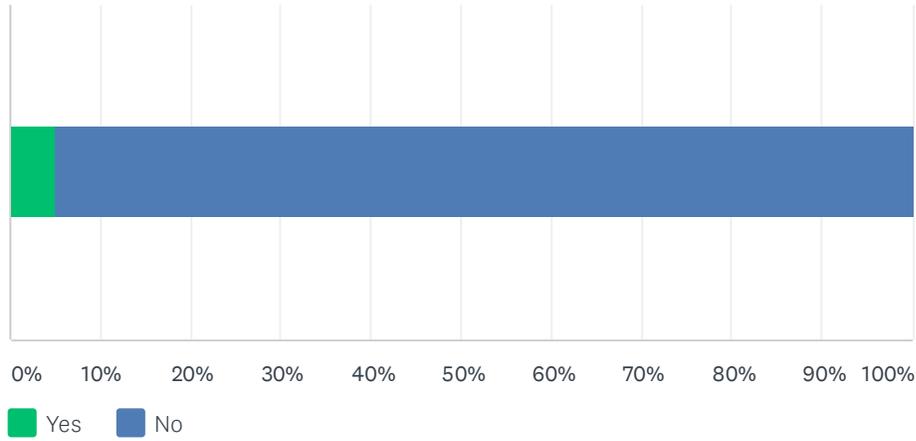


ANSWER CHOICES	RESPONSES	
Employed, full time (includes self-employed) (1)	57.14%	92
Retired (7)	21.74%	35
Employed, part time (includes self-employed) (2)	11.18%	18
Caregiver/Homemaker (5)	4.35%	7
Out of work for more than 1 year (3)	2.48%	4
Unable to work (8)	1.86%	3
Student (6)	1.24%	2
Out of work for less than 1 year (4)	0.00%	0
TOTAL		161

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	1.00	2.83	2.57

Q31 Are you a Veteran?

Answered: 159 Skipped: 38

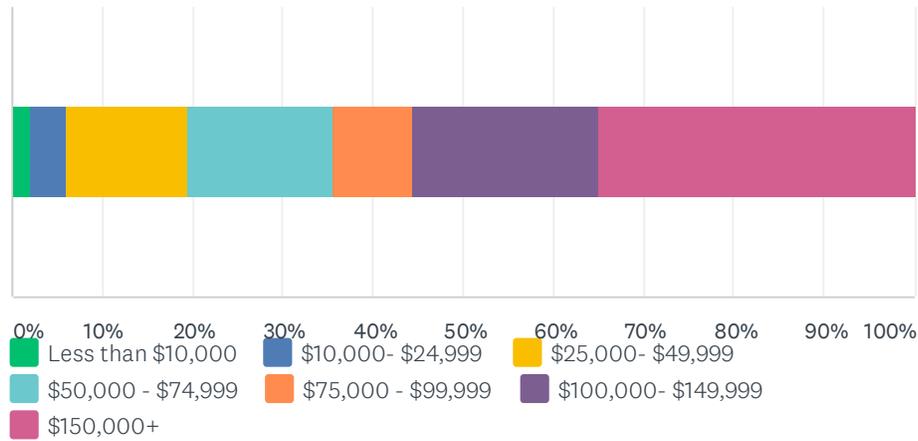


ANSWER CHOICES	RESPONSES
Yes (1)	5.03% 8
No (2)	94.97% 151
TOTAL	159

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.95	0.22

Q32 Which of these describes your household income last year?

Answered: 149 Skipped: 48

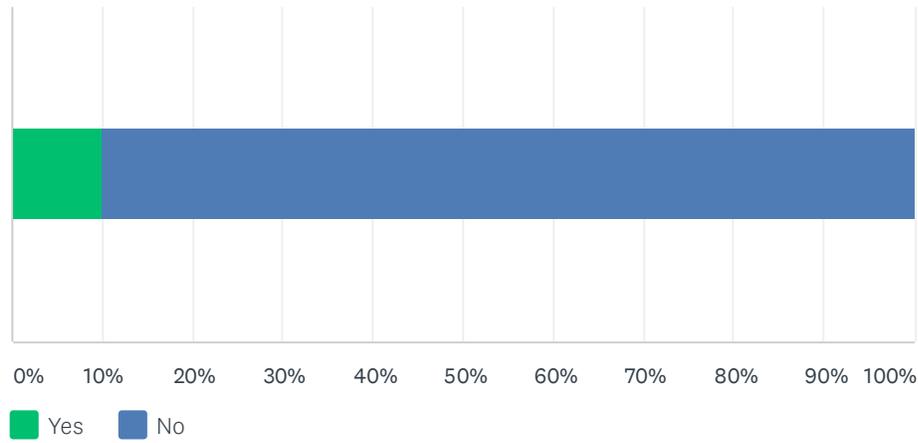


ANSWER CHOICES	RESPONSES
Less than \$10,000 (1)	2.01% 3
\$10,000- \$24,999 (2)	4.03% 6
\$25,000- \$49,999 (3)	13.42% 20
\$50,000 - \$74,999 (4)	16.11% 24
\$75,000 - \$99,999 (5)	8.72% 13
\$100,000- \$149,999 (6)	20.81% 31
\$150,000+ (7)	34.90% 52
TOTAL	149

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	6.00	5.28	1.71

Q33 Do you consider yourself to be a person with a disability?

Answered: 159 Skipped: 38

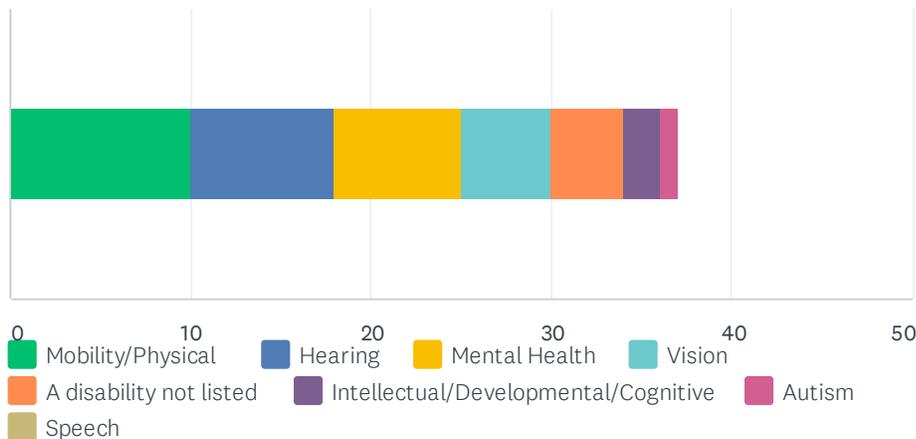


ANSWER CHOICES	RESPONSES	
Yes (1)	10.06%	16
No (2)	89.94%	143
TOTAL		159

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.90	0.30

Q34 Please select the type of disabilities that apply to you

Answered: 25 Skipped: 172

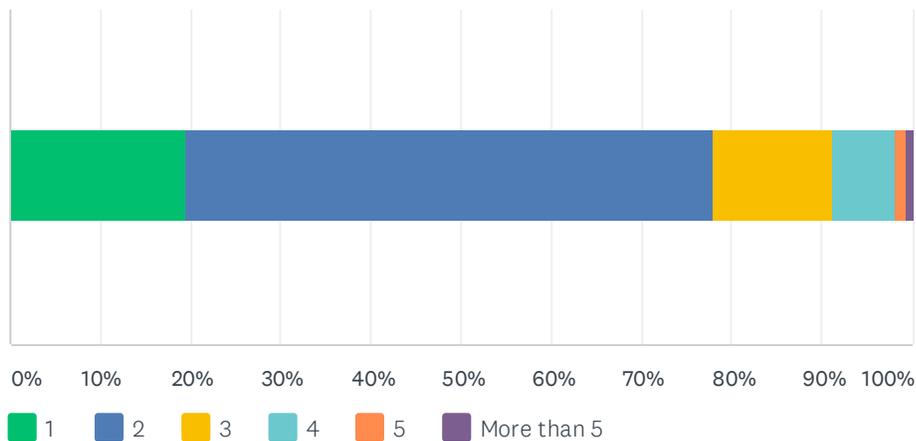


ANSWER CHOICES	RESPONSES	
Mobility/Physical (5)	40.00%	10
Hearing (2)	32.00%	8
Mental Health (4)	28.00%	7
Vision (7)	20.00%	5
A disability not listed (8)	16.00%	4
Intellectual/Developmental/Cognitive (3)	8.00%	2
Autism (1)	4.00%	1
Speech (6)	0.00%	0
Total Respondents: 25		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	5.00	4.54	2.02

Q35 How many adults (age 18+) live in your household (including yourself)?

Answered: 159 Skipped: 38

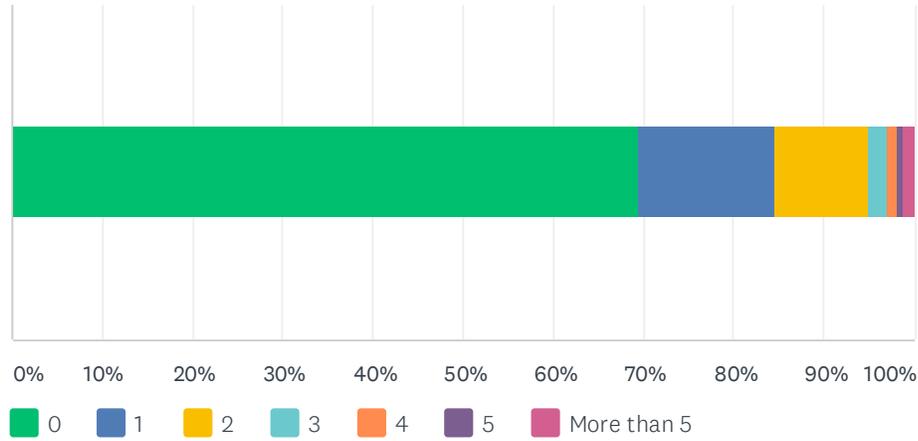


ANSWER CHOICES	RESPONSES	
1 (1)	19.50%	31
2 (2)	58.49%	93
3 (3)	13.21%	21
4 (4)	6.92%	11
5 (5)	1.26%	2
More than 5 (6)	0.63%	1
TOTAL		159

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	2.00	2.14	0.89

Q36 How many children under age 18 live in your household?

Answered: 161 Skipped: 36

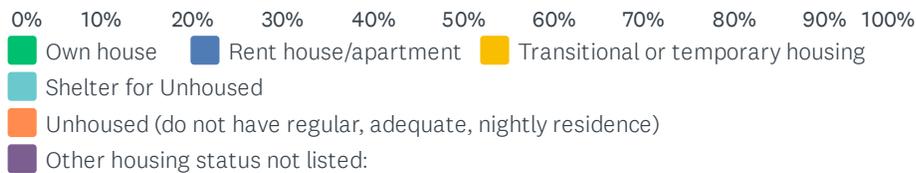


ANSWER CHOICES	RESPONSES	
0 (1)	69.57%	112
1 (2)	14.91%	24
2 (3)	10.56%	17
3 (4)	1.86%	3
4 (5)	1.24%	2
5 (6)	0.62%	1
More than 5 (7)	1.24%	2
TOTAL		161

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	1.00	1.57	1.10

Q37 Please indicate your housing status

Answered: 160 Skipped: 37



ANSWER CHOICES	RESPONSES	
Own house (1)	87.50%	140
Rent house/apartment (2)	10.63%	17
Transitional or temporary housing (3)	0.00%	0
Shelter for Unhoused (4)	0.00%	0
Unhoused (do not have regular, adequate, nightly residence) (5)	0.00%	0
Other housing status not listed: (6)	1.88%	3
TOTAL		160

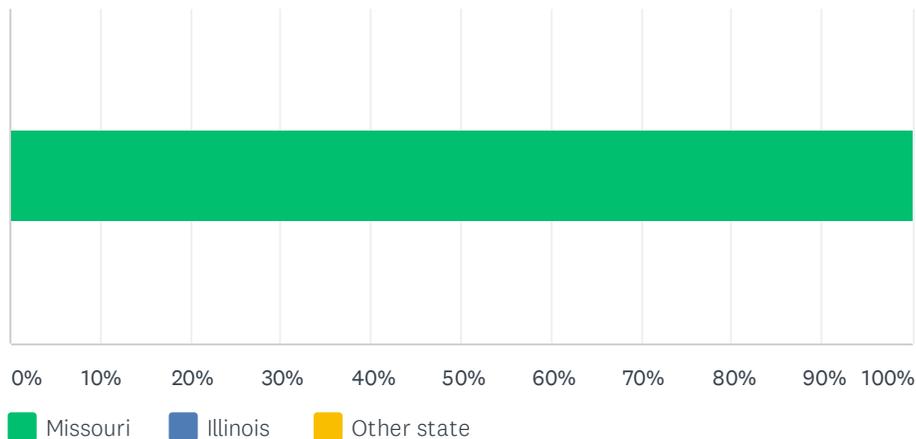
BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.20	0.73

Community Survey Results

North St. Louis County

Q1 In what state do you reside?

Answered: 494 Skipped: 1



ANSWER CHOICES	RESPONSES	
Missouri (1)	100.00%	494
Illinois (2)	0.00%	0
Other state (3)	0.00%	0
TOTAL		494

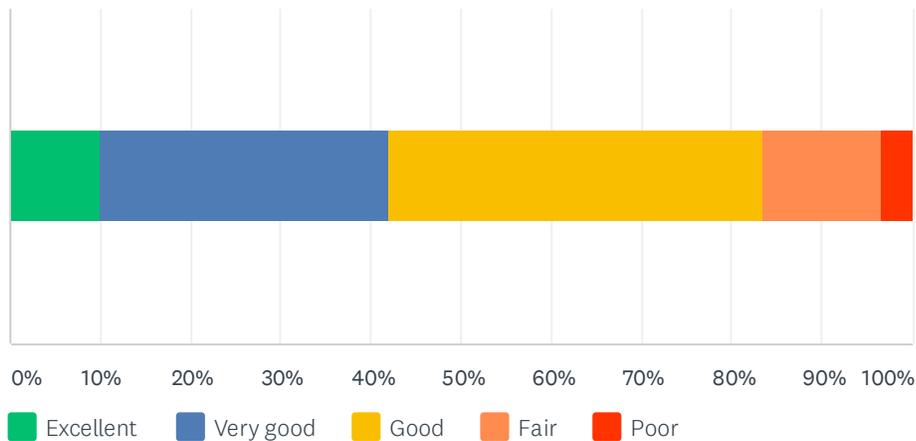
BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	1.00	1.00	1.00	0.00

Q2 What is the zip code of your primary residence?

Answered: 495 Skipped: 0

Q3 In general, would you say your health is:

Answered: 474 Skipped: 21

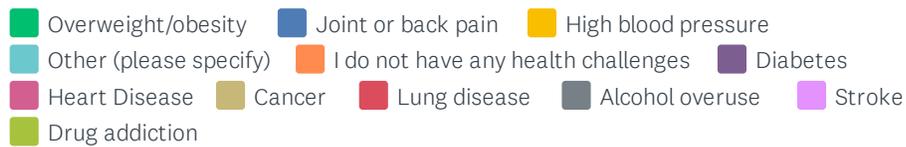
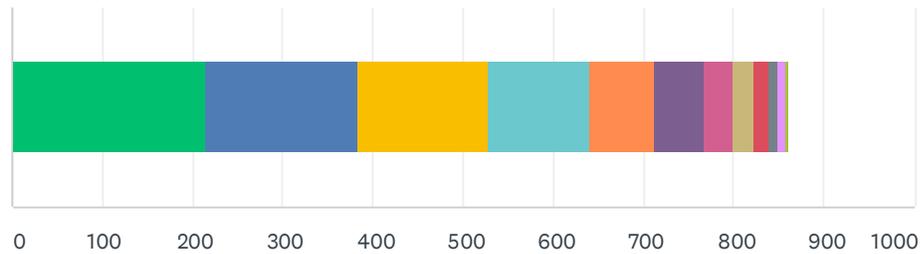


ANSWER CHOICES	RESPONSES	
Excellent (1)	10.13%	48
Very good (2)	31.86%	151
Good (3)	41.56%	197
Fair (4)	13.08%	62
Poor (5)	3.38%	16
TOTAL		474

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	3.00	2.68	0.94

Q4 Please select the main health challenge/s you face. (Check all that apply)

Answered: 474 Skipped: 21

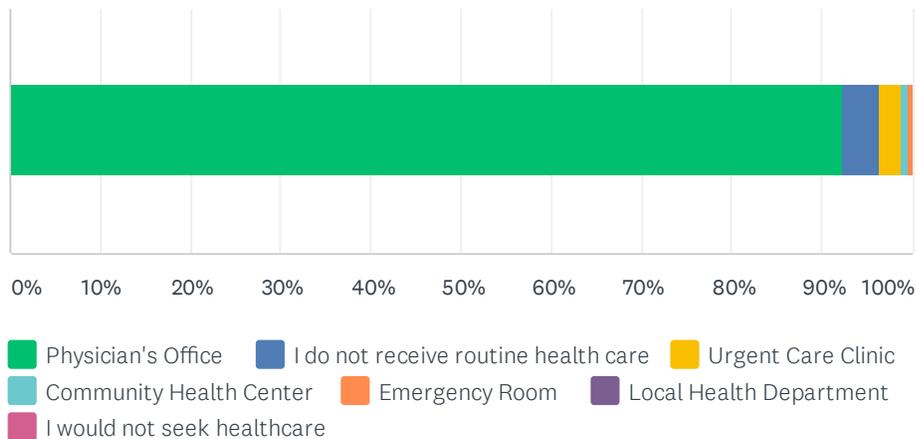


ANSWER CHOICES	RESPONSES	
Overweight/obesity (4)	45.36%	215
Joint or back pain (9)	35.65%	169
High blood pressure (6)	30.59%	145
Other (please specify) (12)	23.42%	111
I do not have any health challenges (1)	15.19%	72
Diabetes (3)	11.81%	56
Heart Disease (8)	6.75%	32
Cancer (2)	5.06%	24
Lung disease (5)	3.16%	15
Alcohol overuse (11)	2.32%	11
Stroke (7)	1.48%	7
Drug addiction (10)	1.05%	5
Total Respondents: 474		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	6.00	6.91	3.29

Q5 Where do you most often go for routine healthcare

Answered: 474 Skipped: 21

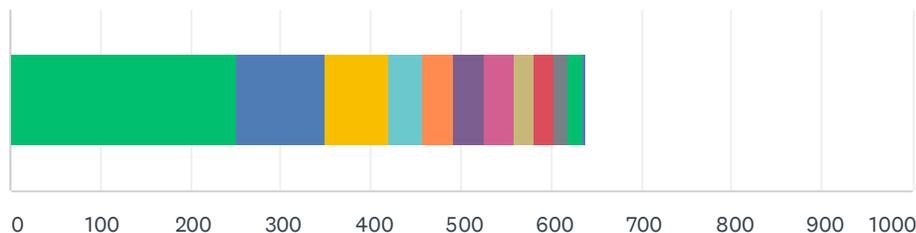


ANSWER CHOICES	RESPONSES	
Physician's Office (1)	92.41%	438
I do not receive routine health care (6)	4.01%	19
Urgent Care Clinic (4)	2.32%	11
Community Health Center (5)	0.84%	4
Emergency Room (3)	0.42%	2
Local Health Department (2)	0.00%	0
I would not seek healthcare (7)	0.00%	0
TOTAL		474

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.31	1.12

Q6 What barriers prevent you and/or your family from accessing healthcare? (Check all that apply)

Answered: 467 Skipped: 28



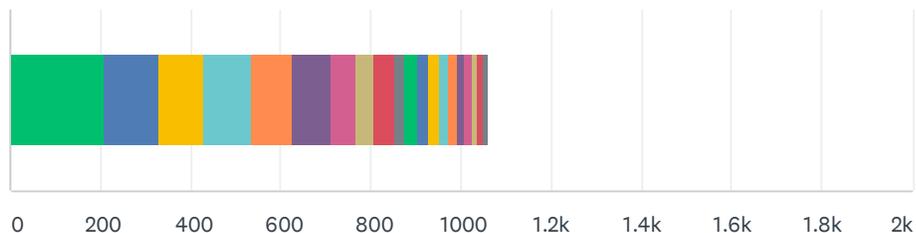
- I/my family have no barriers preventing us from accessing health care.
- Costs/Co-pays ■ Scheduling problems
- Fear (e.g. of doctors/health systems/not ready to face or discuss health issues)
- Difficulty finding doctors ■ No health insurance/unable to pay
- My health insurance is not accepted ■ Don't feel welcome
- Other (please specify) ■ Lack of nearby health centers/services/providers
- Transportation/mobility issues ■ Cultural/religious beliefs

ANSWER CHOICES	RESPONSES	
I/my family have no barriers preventing us from accessing health care. (1)	53.75%	251
Costs/Co-pays (7)	21.20%	99
Scheduling problems (9)	14.99%	70
Fear (e.g. of doctors/health systems/not ready to face or discuss health issues) (5)	7.92%	37
Difficulty finding doctors (3)	7.49%	35
No health insurance/unable to pay (6)	7.49%	35
My health insurance is not accepted (10)	6.64%	31
Don't feel welcome (11)	4.71%	22
Other (please specify) (12)	4.71%	22
Lack of nearby health centers/services/providers (4)	3.43%	16
Transportation/mobility issues (8)	3.43%	16
Cultural/religious beliefs (2)	1.07%	5
Total Respondents: 467		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	7.00	7.38	2.63

Q7 Please select the health screenings and/or services for which you need better access. (Check all that apply)

Answered: 453 Skipped: 42



- I/my family have adequate access to health screenings
- Weight loss help
- Exercise/physical activity
- Mental health/depression
- Nutrition
- Dental screenings
- Routine well checkups
- Cholesterol (fats in the blood)
- Blood Pressure
- Cancer
- Emergency Preparedness
- Eating disorders
- Suicide prevention
- Drug and/or alcohol abuse
- Vaccination/immunization
- Falls prevention for elderly
- Other (please specify)
- Prenatal care
- Quitting smoking
- HIV AIDS/STIs

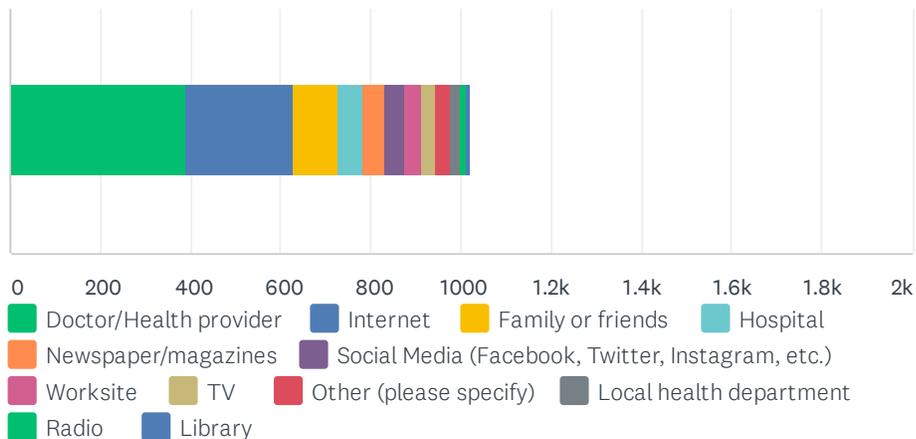
2021 Community Health Needs Assessment (CHNA)

ANSWER CHOICES	RESPONSES	
I/my family have adequate access to health screenings (1)	46.36%	210
Weight loss help (13)	26.05%	118
Exercise/physical activity (7)	22.74%	103
Mental health/depression (15)	22.52%	102
Nutrition (9)	20.31%	92
Dental screenings (5)	18.98%	86
Routine well checkups (18)	12.36%	56
Cholesterol (fats in the blood) (4)	9.27%	42
Blood Pressure (2)	9.05%	41
Cancer (3)	5.96%	27
Emergency Preparedness (6)	5.74%	26
Eating disorders (19)	5.52%	25
Suicide prevention (12)	4.86%	22
Drug and/or alcohol abuse (16)	4.64%	21
Vaccination/immunization (14)	4.19%	19
Falls prevention for elderly (8)	3.97%	18
Other (please specify) (20)	3.75%	17
Prenatal care (10)	2.87%	13
Quitting smoking (11)	2.65%	12
HIV AIDS/STIs (17)	2.43%	11
Total Respondents: 453		

BASIC STATISTICS				
Minimum 2.00	Maximum 21.00	Median 9.00	Mean 10.37	Standard Deviation 5.08

Q8 Where do you get most of your health information? (Choose top 3)

Answered: 453 Skipped: 42

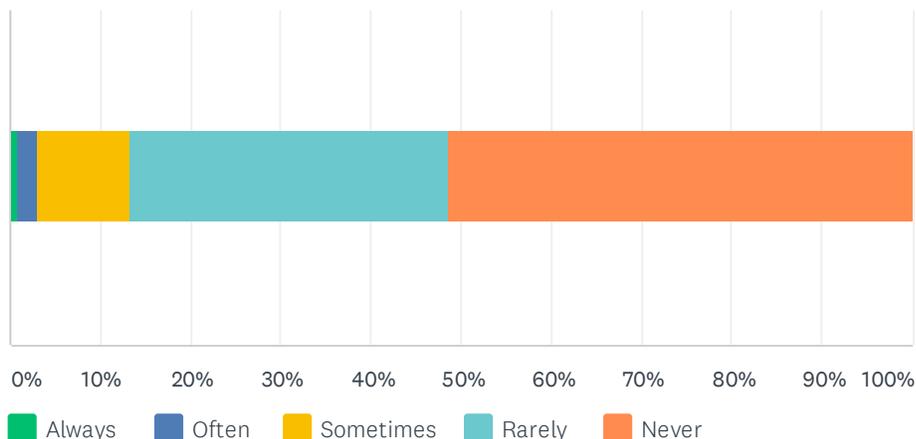


ANSWER CHOICES	RESPONSES	
Doctor/Health provider (1)	85.87%	389
Internet (6)	52.76%	239
Family or friends (3)	22.08%	100
Hospital (5)	11.92%	54
Newspaper/magazines (8)	11.26%	51
Social Media (Facebook, Twitter, Instagram, etc.) (2)	9.71%	44
Worksite (11)	7.95%	36
TV (10)	6.84%	31
Other (please specify) (12)	6.84%	31
Local health department (4)	5.96%	27
Radio (9)	2.65%	12
Library (7)	1.77%	8
Total Respondents: 453		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	12.00	3.00	4.15	3.25

Q9 How often do you need to have someone help you understand instructions, pamphlets or other written materials from your doctor or pharmacy?

Answered: 450 Skipped: 45

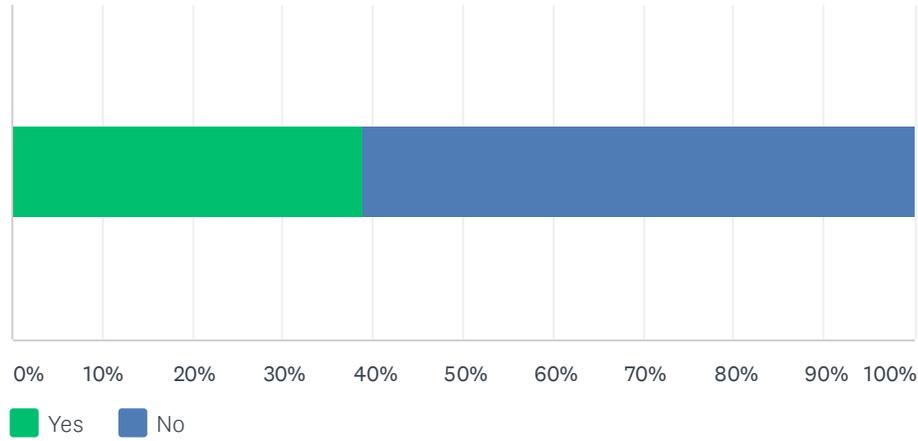


ANSWER CHOICES	RESPONSES	
Always (1)	0.89%	4
Often (2)	2.22%	10
Sometimes (3)	10.22%	46
Rarely (4)	35.33%	159
Never (5)	51.33%	231
TOTAL		450

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.34	0.82

Q10 Do you have children for whose health you are responsible?

Answered: 450 Skipped: 45

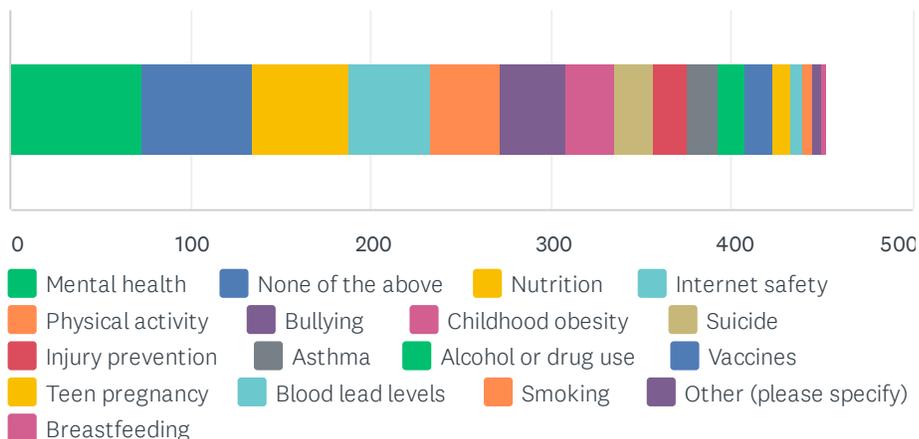


ANSWER CHOICES	RESPONSES	
Yes (1)	38.89%	175
No (2)	61.11%	275
TOTAL		450

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.61	0.49

Q11 What health screenings, education and/or services do you feel your child/ren need better access to keep them safe and healthy? (Check all that apply)

Answered: 174 Skipped: 321



ANSWER CHOICES	RESPONSES	
Mental health (14)	41.95%	73
None of the above (1)	35.63%	62
Nutrition (4)	30.46%	53
Internet safety (9)	25.86%	45
Physical activity (3)	22.41%	39
Bullying (15)	20.69%	36
Childhood obesity (2)	15.52%	27
Suicide (13)	12.07%	21
Injury prevention (12)	11.49%	20
Asthma (11)	9.77%	17
Alcohol or drug use (5)	8.62%	15
Vaccines (16)	8.62%	15
Teen pregnancy (7)	5.75%	10
Blood lead levels (10)	4.02%	7
Smoking (8)	2.87%	5
Other (please specify) (17)	2.87%	5
Breastfeeding (6)	1.72%	3
Total Respondents: 174		

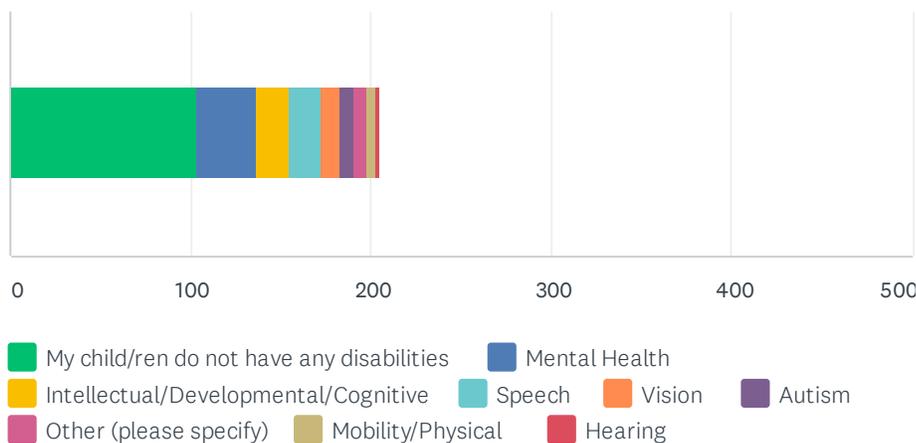
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	18.00	9.00	9.34	4.84

Q12 Please indicate any disabilities that apply to your children. (Check all that apply)

Answered: 168 Skipped: 327

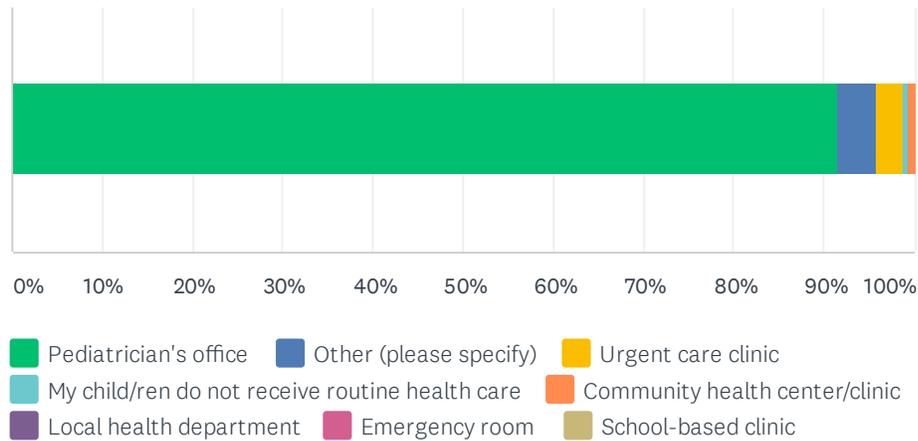


ANSWER CHOICES	RESPONSES	
My child/ren do not have any disabilities (1)	61.31%	103
Mental Health (5)	20.24%	34
Intellectual/Developmental/Cognitive (4)	10.71%	18
Speech (7)	10.71%	18
Vision (8)	5.95%	10
Autism (2)	4.76%	8
Other (please specify) (9)	4.17%	7
Mobility/Physical (6)	2.98%	5
Hearing (3)	1.19%	2
Total Respondents: 168		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	10.00	5.00	5.59	1.99

Q13 Where do you take your child/ren under age 18 for routine health care most often?

Answered: 167 Skipped: 328

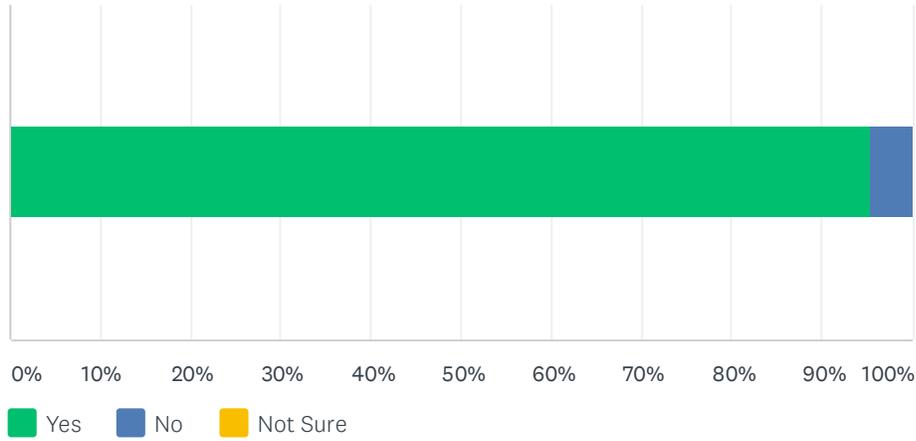


ANSWER CHOICES	RESPONSES	
Pediatrician's office (2)	91.62%	153
Other (please specify) (8)	4.19%	7
Urgent care clinic (5)	2.99%	5
My child/ren do not receive routine health care (1)	0.60%	1
Community health center/clinic (6)	0.60%	1
Local health department (3)	0.00%	0
Emergency room (4)	0.00%	0
School-based clinic (7)	0.00%	0
TOTAL		167

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	9.00	2.00	2.41	1.51

Q14 Do your children have health insurance?

Answered: 171 Skipped: 324

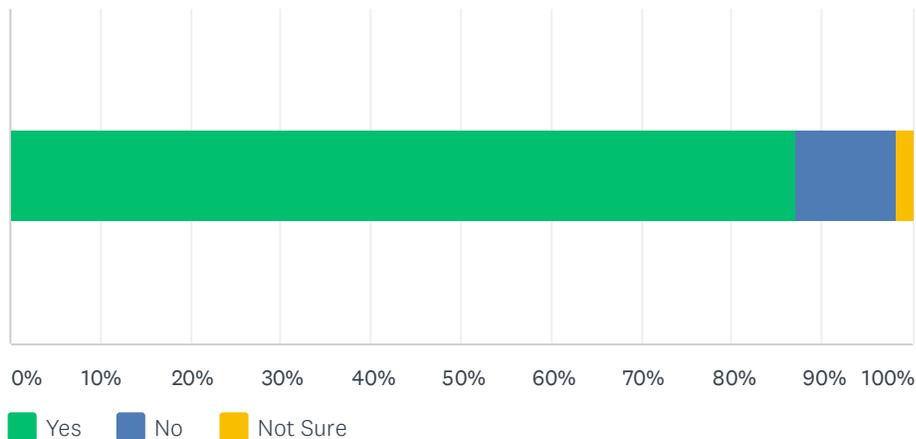


ANSWER CHOICES	RESPONSES	
Yes (1)	95.32%	163
No (2)	4.68%	8
Not Sure (3)	0.00%	0
TOTAL		171

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.05	0.21

Q15 Do your children have dental insurance?

Answered: 171 Skipped: 324

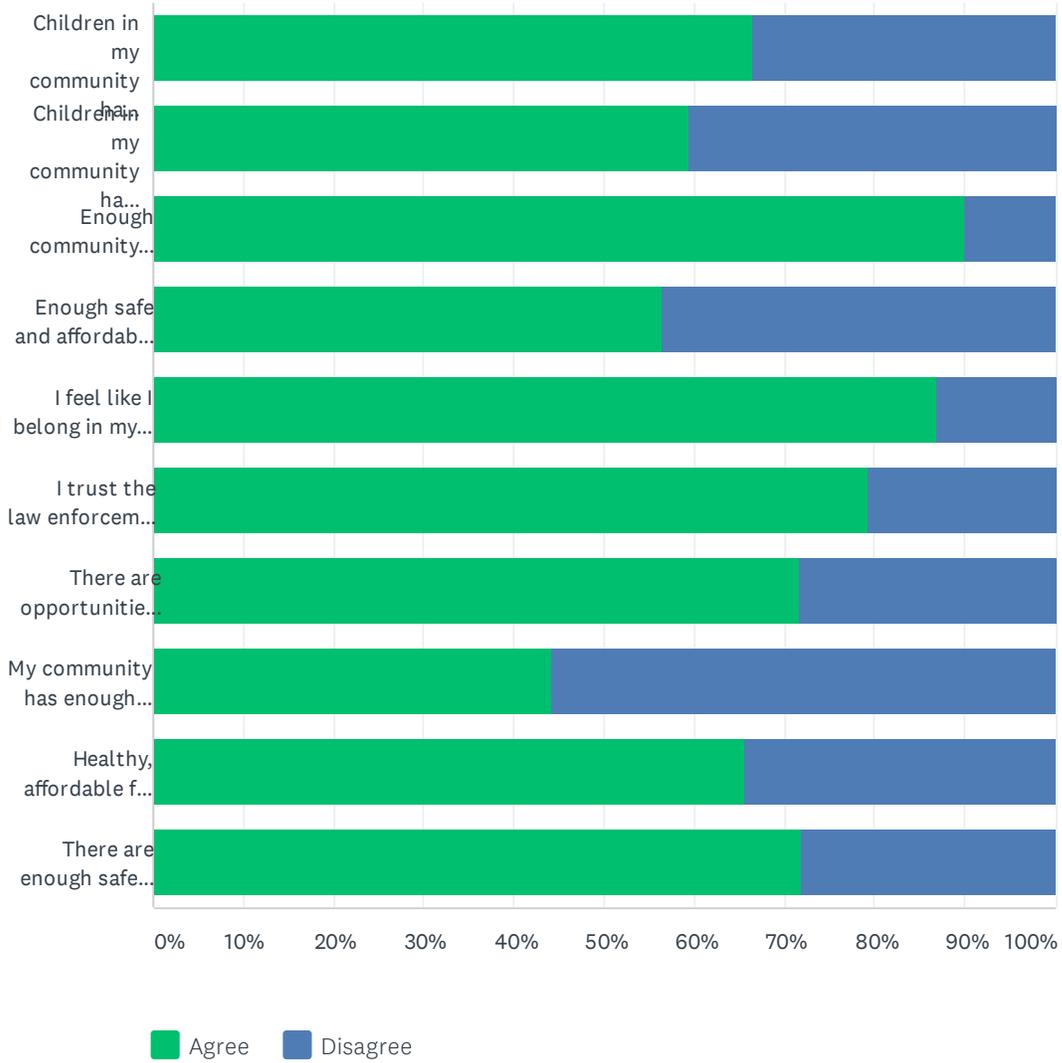


ANSWER CHOICES	RESPONSES	
Yes (1)	87.13%	149
No (2)	11.11%	19
Not Sure (3)	1.75%	3
TOTAL		171

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.15	0.40

Q16 Please choose the best response to reflect your opinion

Answered: 427 Skipped: 68



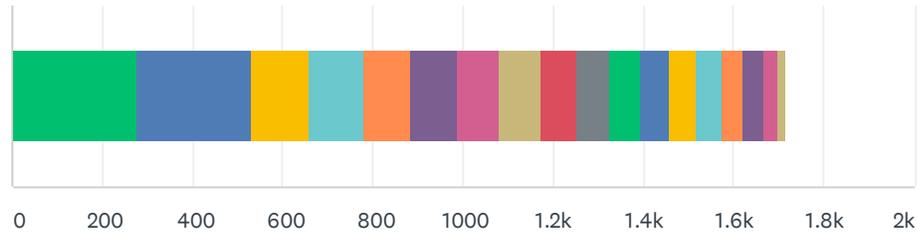
2021 Community Health Needs Assessment (CHNA)

	AGREE	DISAGREE	TOTAL	WEIGHTED AVERAGE
Children in my community have access to high quality education	66.47% 220	33.53% 111	331	1.34
Children in my community have enough safe places to play	59.48% 207	40.52% 141	348	1.41
Enough community gatherings: parks, places of worship, community events	90.03% 334	9.97% 37	371	1.10
Enough safe and affordable houses and apartments in my community	56.48% 170	43.52% 131	301	1.44
I feel like I belong in my community	86.89% 265	13.11% 40	305	1.13
I trust the law enforcement officials in my community	79.22% 263	20.78% 69	332	1.21
There are opportunities for my voice to be heard about community decisions	71.73% 203	28.27% 80	283	1.28
My community has enough good-paying jobs	44.25% 127	55.75% 160	287	1.56
Healthy, affordable food is easily accessible in my community	65.71% 228	34.29% 119	347	1.34
There are enough safe places to be physically active in my community	71.88% 248	28.12% 97	345	1.28

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Children in my community have access to high quality education	1.00	5.00	2.00	2.64	1.23
Children in my community have enough safe places to play	1.00	5.00	3.00	2.81	1.23
Enough community gatherings: parks, places of worship, community events	1.00	5.00	2.00	2.07	0.94
Enough safe and affordable houses and apartments in my community	1.00	5.00	3.00	2.92	1.12
I feel like I belong in my community	1.00	5.00	2.00	2.32	0.95
I trust the law enforcement officials in my community	1.00	5.00	2.00	2.38	1.15
There are opportunities for my voice to be heard about community decisions	1.00	5.00	3.00	2.66	1.00
My community has enough good-paying jobs	1.00	5.00	3.00	3.12	1.12
Healthy, affordable food is easily accessible in my community	1.00	5.00	2.00	2.70	1.18
There are enough safe places to be physically active in my community	1.00	5.00	2.00	2.55	1.14

Q17 What types of safety concerns do you have in your community? (Check all that apply)

Answered: 424 Skipped: 71



- Burglaries/theft
- Gun violence
- Drug abuse
- Poor or dangerous roads
- Poor lighting
- Vacant properties
- Poor or dangerous sidewalks
- Disorderly conduct
- Mugging/physical assault
- Domestic violence
- Hate crimes
- Vandalism/graffiti
- Gang activity
- Child abuse
- I do not have any safety concerns in my community
- Sexual assault
- Other (please specify)
- Prostitution

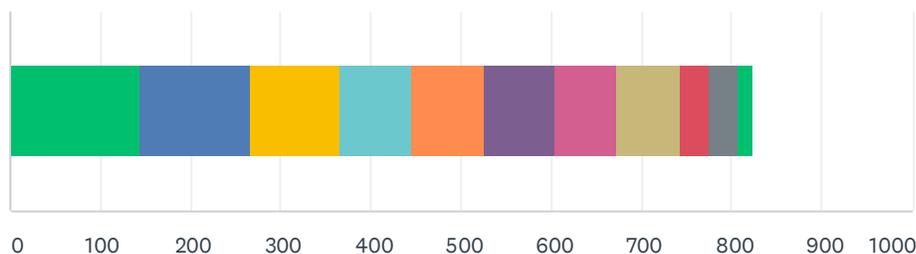
2021 Community Health Needs Assessment (CHNA)

ANSWER CHOICES	RESPONSES	
Burglaries/theft (3)	65.80%	279
Gun violence (2)	58.96%	250
Drug abuse (10)	30.42%	129
Poor or dangerous roads (8)	28.30%	120
Poor lighting (7)	25.00%	106
Vacant properties (17)	24.76%	105
Poor or dangerous sidewalks (9)	21.93%	93
Disorderly conduct (6)	20.99%	89
Mugging/physical assault (13)	19.58%	83
Domestic violence (5)	17.22%	73
Hate crimes (12)	15.57%	66
Vandalism/graffiti (16)	15.09%	64
Gang activity (11)	14.15%	60
Child abuse (4)	13.92%	59
I do not have any safety concerns in my community (1)	11.32%	48
Sexual assault (15)	9.91%	42
Other (please specify) (18)	7.31%	31
Prostitution (14)	4.25%	18
Total Respondents: 424		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	19.00	7.00	7.87	4.98

Q18 What concerns do you have about the environmental health of your community? (Check all that apply)

Answered: 419 Skipped: 76



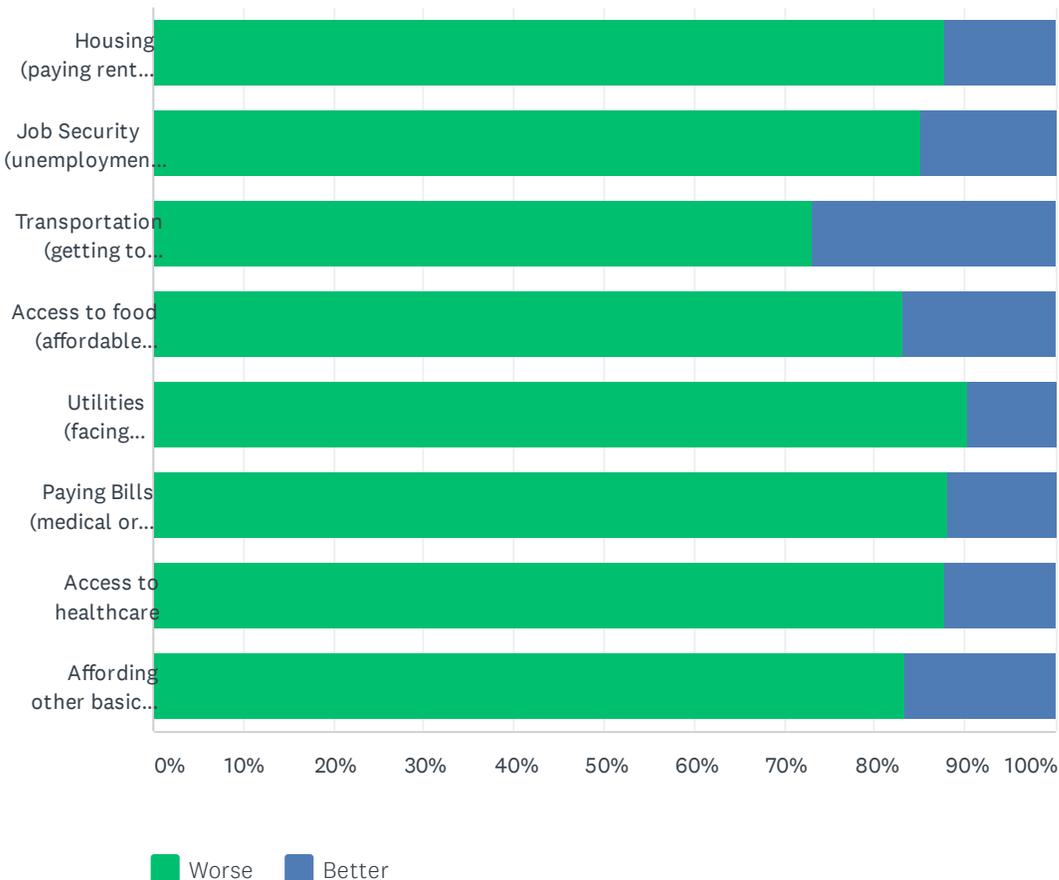
- I do not have any concerns about the environmental health of my community
- Air quality/odors ■ Water quality ■ Sewage problems
- Soil contamination ■ Wildlife/insects ■ Vegetation overgrowth
- Flooding ■ Other (please specify) ■ Not enough trees ■ Too many trees

ANSWER CHOICES	RESPONSES	
I do not have any concerns about the environmental health of my community (1)	34.61%	145
Air quality/odors (3)	29.12%	122
Water quality (2)	23.39%	98
Sewage problems (6)	19.33%	81
Soil contamination (7)	19.33%	81
Wildlife/insects (10)	18.38%	77
Vegetation overgrowth (8)	16.47%	69
Flooding (9)	16.47%	69
Other (please specify) (11)	7.88%	33
Not enough trees (4)	7.64%	32
Too many trees (5)	3.82%	16
Total Respondents: 419		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	12.00	6.00	6.14	3.02

Q19 How has the COVID-19 (coronavirus) pandemic impacted the following for you/your household?

Answered: 413 Skipped: 82



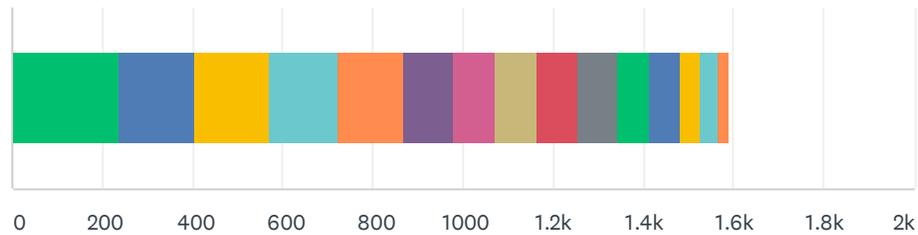
	WORSE	BETTER	TOTAL
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	87.72% 50	12.28% 7	57
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	85.05% 91	14.95% 16	107
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	73.08% 38	26.92% 14	52
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	83.13% 69	16.87% 14	83
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	90.38% 47	9.62% 5	52
Paying Bills (medical or other)	88.10% 74	11.90% 10	84
Access to healthcare	87.76% 86	12.24% 12	98
Affording other basic needs (not mentioned above)	83.33% 60	16.67% 12	72

2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	1.00	3.00	2.00	1.90	0.36
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	1.00	3.00	2.00	1.82	0.48
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	1.00	3.00	2.00	1.94	0.35
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	1.00	3.00	2.00	1.87	0.43
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	1.00	3.00	2.00	1.90	0.34
Paying Bills (medical or other)	1.00	3.00	2.00	1.84	0.43
Access to healthcare	1.00	3.00	2.00	1.82	0.45
Affording other basic needs (not mentioned above)	1.00	3.00	2.00	1.88	0.40

Q20 What do you think are the top STRENGTHS of your community right now?

Answered: 408 Skipped: 87



- Access to community parks and other open spaces for physical activity
- Opportunities to practice spiritual beliefs
- Good places to raise a family
- Racial and ethnic diversity
- Good schools/quality education
- Access to affordable healthy foods
- Access to affordable, quality health care
- Sense of belonging
- Clean environment
- Community safety/low crime
- Access to affordable housing
- Access to affordable transportation
- Good paying jobs and strong economy
- Strong community leaders and role models
- Other (please specify)

ANSWER CHOICES	RESPONSES	
Access to community parks and other open spaces for physical activity (5)	58.33%	238
Opportunities to practice spiritual beliefs (11)	40.93%	167
Good places to raise a family (9)	40.20%	164
Racial and ethnic diversity (12)	37.25%	152
Good schools/quality education (10)	36.27%	148
Access to affordable healthy foods (2)	26.72%	109
Access to affordable, quality health care (1)	22.79%	93
Sense of belonging (13)	22.55%	92
Clean environment (6)	22.06%	90
Community safety/low crime (7)	21.32%	87
Access to affordable housing (3)	18.38%	75
Access to affordable transportation (4)	16.67%	68
Good paying jobs and strong economy (8)	10.29%	42
Strong community leaders and role models (14)	10.29%	42
Other (please specify) (15)	5.64%	23
Total Respondents: 408		

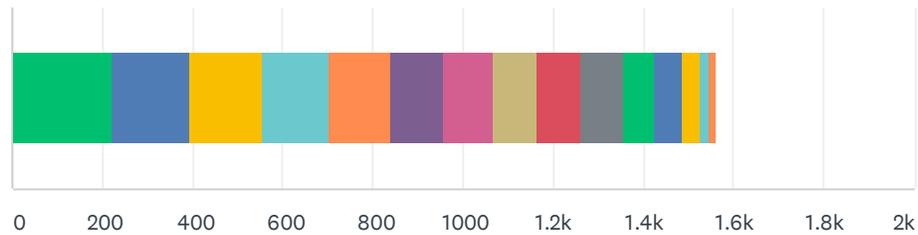
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	8.00	7.69	3.85

Q21 What do you think are the top CHALLENGES of your community right now?

Answered: 401 Skipped: 94



- Community safety/crime
- Good paying jobs and strong economy
- Access to affordable housing
- Strong community leaders and role models
- Good schools/quality education
- Access to affordable, quality health care
- Access to affordable healthy foods
- Access to affordable transportation
- Clean environment
- Racial and ethnic diversity
- Sense of belonging
- Good places to raise a family
- Access to community parks and other open spaces for physical activity
- Opportunities to practice spiritual beliefs
- Other (please specify)

ANSWER CHOICES	RESPONSES	
Community safety/crime (7)	54.61%	219
Good paying jobs and strong economy (8)	43.39%	174
Access to affordable housing (3)	39.90%	160
Strong community leaders and role models (14)	37.66%	151
Good schools/quality education (10)	33.42%	134
Access to affordable, quality health care (1)	29.43%	118
Access to affordable healthy foods (2)	27.93%	112
Access to affordable transportation (4)	24.19%	97
Clean environment (6)	23.94%	96
Racial and ethnic diversity (12)	23.69%	95
Sense of belonging (13)	17.71%	71
Good places to raise a family (9)	14.96%	60
Access to community parks and other open spaces for physical activity (5)	10.22%	41
Opportunities to practice spiritual beliefs (11)	4.74%	19
Other (please specify) (15)	3.74%	15
Total Respondents: 401		

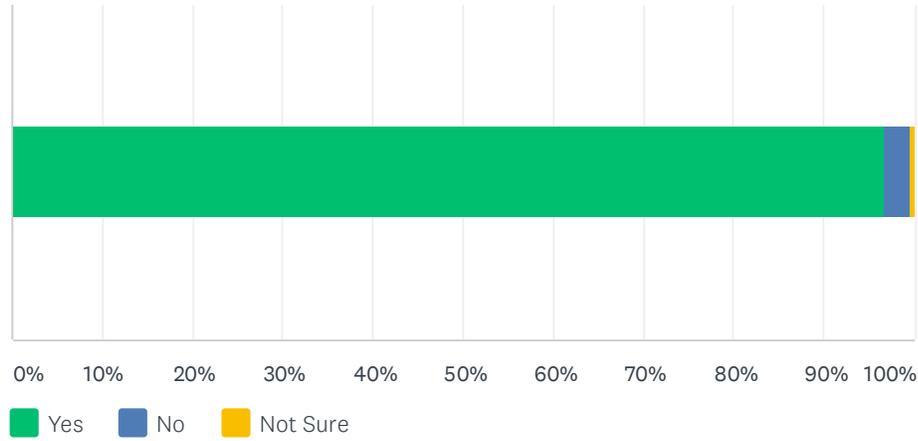
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	7.00	7.30	4.07

Q22 Do you currently have health insurance?

Answered: 399 Skipped: 96

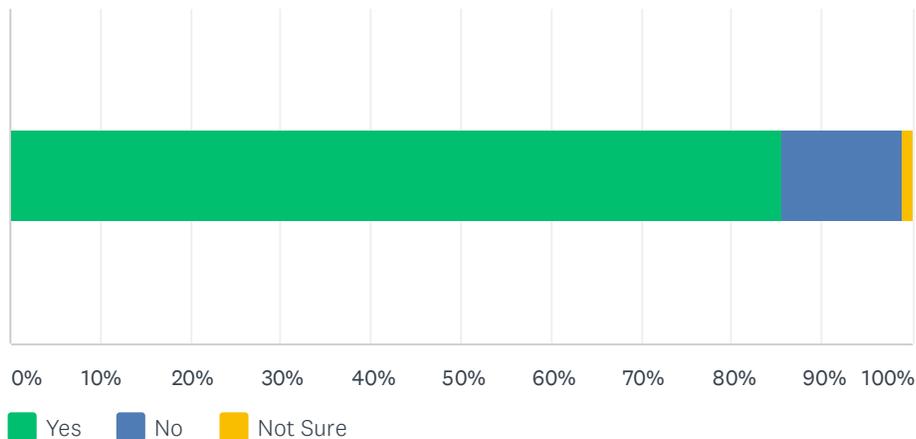


ANSWER CHOICES	RESPONSES	
Yes (1)	96.74%	386
No (2)	2.76%	11
Not Sure (3)	0.50%	2
TOTAL		399

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.04	0.21

Q23 Do you currently have dental insurance?

Answered: 399 Skipped: 96

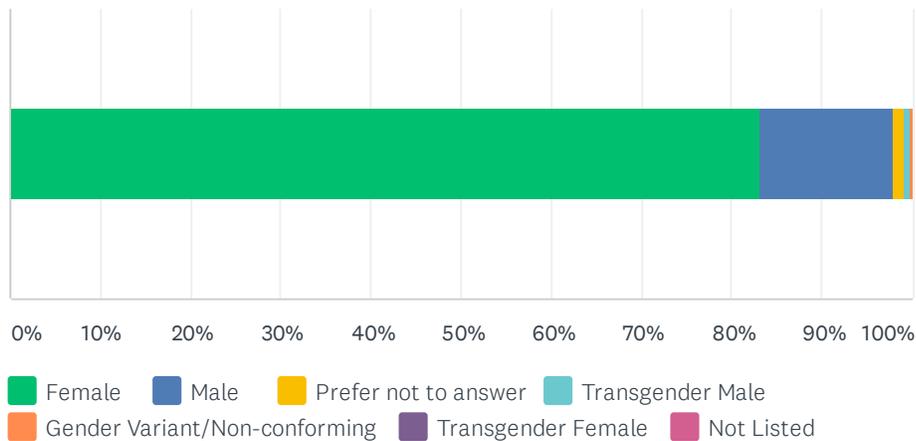


ANSWER CHOICES	RESPONSES	
Yes (1)	85.46%	341
No (2)	13.53%	54
Not Sure (3)	1.00%	4
TOTAL		399

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.16	0.39

Q24 With which gender identity do you most identify?

Answered: 397 Skipped: 98

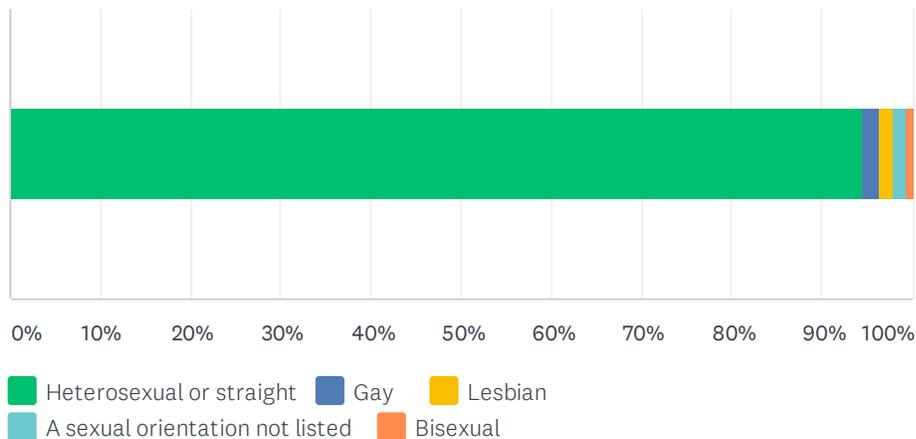


ANSWER CHOICES	RESPONSES	
Female (1)	83.12%	330
Male (2)	14.86%	59
Prefer not to answer (6)	1.26%	5
Transgender Male (4)	0.50%	2
Gender Variant/Non-conforming (5)	0.25%	1
Transgender Female (3)	0.00%	0
Not Listed (7)	0.00%	0
TOTAL		397

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.24	0.70

Q25 What is your sexual orientation?

Answered: 391 Skipped: 104

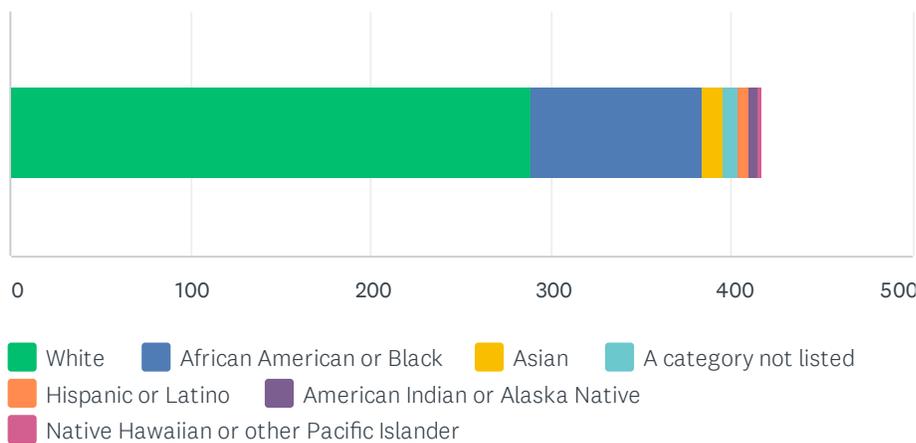


ANSWER CHOICES	RESPONSES	
Heterosexual or straight (1)	94.63%	370
Gay (2)	1.79%	7
Lesbian (3)	1.53%	6
A sexual orientation not listed (5)	1.53%	6
Bisexual (4)	0.51%	2
TOTAL		391

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	1.00	1.13	0.60

Q26 With which race/ethnicity do you identify? You may check more than one.

Answered: 393 Skipped: 102



ANSWER CHOICES	RESPONSES	
White (6)	73.54%	289
African American or Black (1)	24.17%	95
Asian (3)	3.05%	12
A category not listed (7)	2.04%	8
Hispanic or Latino (4)	1.53%	6
American Indian or Alaska Native (2)	1.27%	5
Native Hawaiian or other Pacific Islander (5)	0.51%	2
Total Respondents: 393		

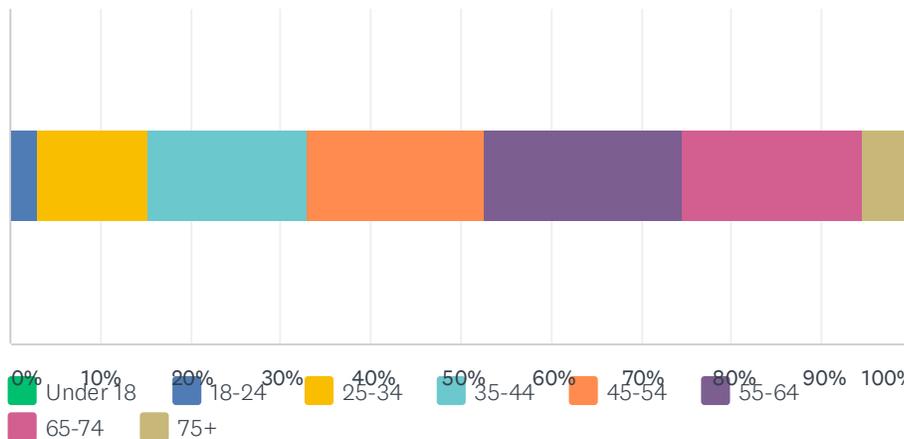
BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	6.00	4.71	2.14

Q27 What languages do you speak at home?

Answered: 371 Skipped: 124

Q28 What is your age group?

Answered: 391 Skipped: 104

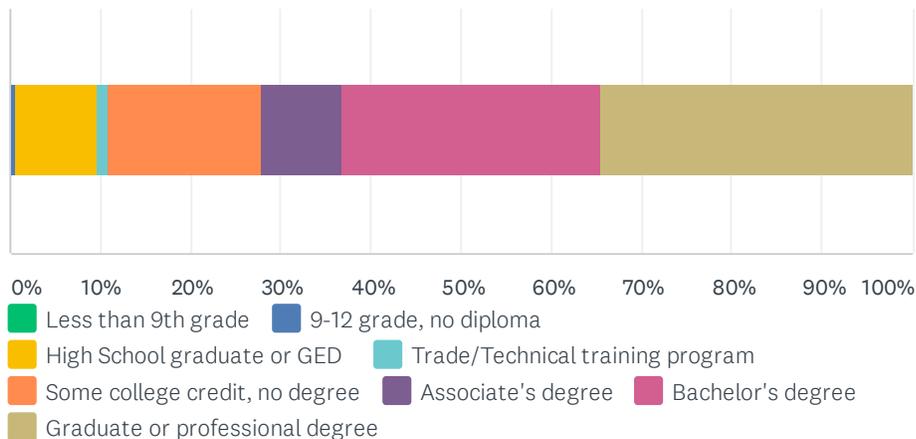


ANSWER CHOICES	RESPONSES
Under 18 (1)	0.26% 1
18-24 (2)	2.81% 11
25-34 (3)	12.28% 48
35-44 (4)	17.65% 69
45-54 (5)	19.69% 77
55-64 (6)	21.74% 85
65-74 (7)	20.20% 79
75+ (8)	5.37% 21
TOTAL	391

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	5.00	5.27	1.55

Q29 What is the highest grade or year of school you completed?

Answered: 394 Skipped: 101

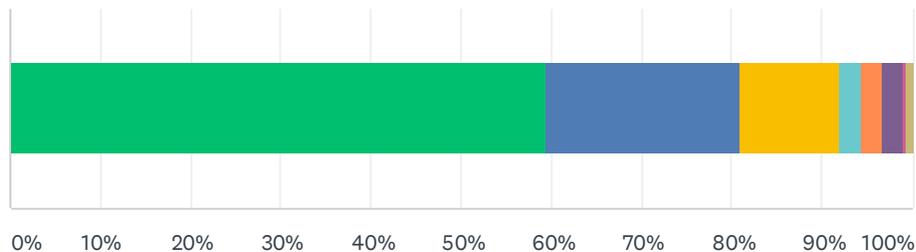


ANSWER CHOICES	RESPONSES
Less than 9th grade (1)	0.25% 1
9-12 grade, no diploma (2)	0.25% 1
High School graduate or GED (3)	9.14% 36
Trade/Technical training program (4)	1.27% 5
Some college credit, no degree (5)	17.01% 67
Associate's degree (6)	8.88% 35
Bachelor's degree (7)	28.68% 113
Graduate or professional degree (8)	34.52% 136
TOTAL	394

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	7.00	6.48	1.61

Q30 What is your employment status

Answered: 394 Skipped: 101

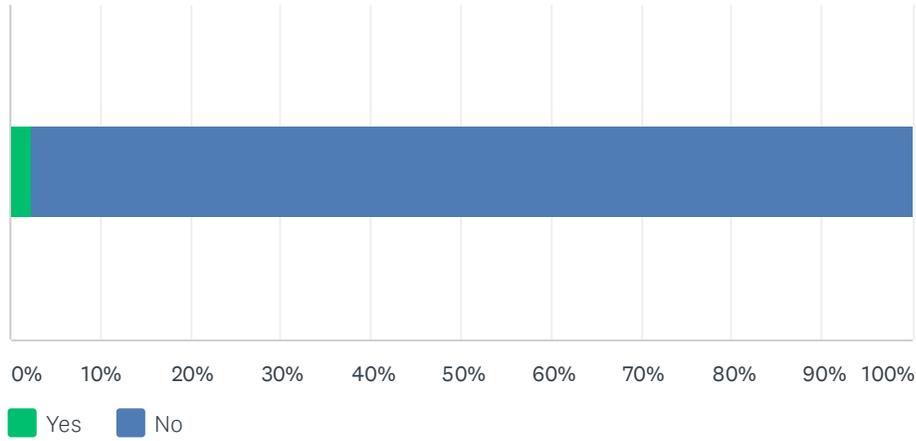


ANSWER CHOICES	RESPONSES	
Employed, full time (includes self-employed) (1)	59.39%	234
Retired (7)	21.57%	85
Employed, part time (includes self-employed) (2)	10.91%	43
Unable to work (8)	2.54%	10
Out of work for more than 1 year (3)	2.28%	9
Caregiver/Homemaker (5)	2.28%	9
Out of work for less than 1 year (4)	0.51%	2
Student (6)	0.51%	2
TOTAL		394

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	1.00	2.76	2.58

Q31 Are you a Veteran?

Answered: 388 Skipped: 107

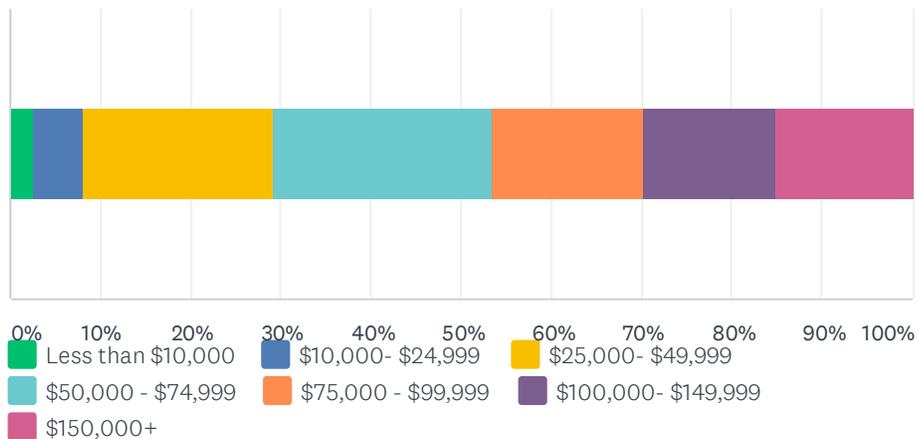


ANSWER CHOICES	RESPONSES
Yes (1)	2.32% 9
No (2)	97.68% 379
TOTAL	388

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.98	0.15

Q32 Which of these describes your household income last year?

Answered: 371 Skipped: 124

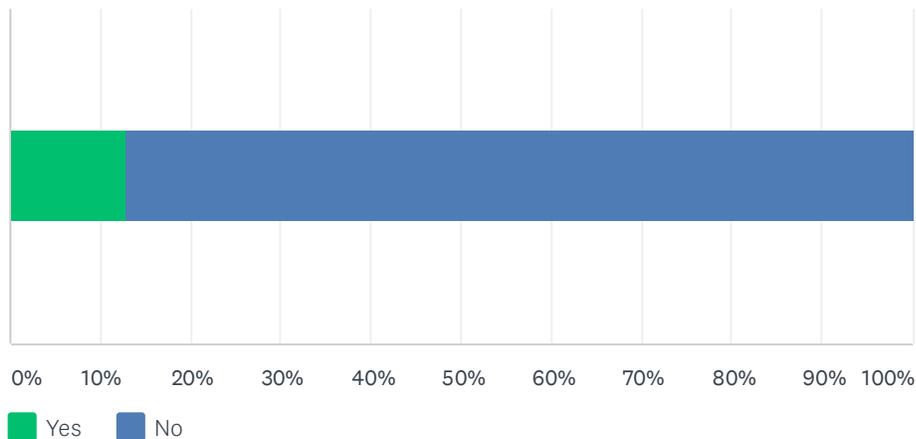


ANSWER CHOICES	RESPONSES	
Less than \$10,000 (1)	2.70%	10
\$10,000- \$24,999 (2)	5.39%	20
\$25,000- \$49,999 (3)	21.02%	78
\$50,000 - \$74,999 (4)	24.26%	90
\$75,000 - \$99,999 (5)	16.98%	63
\$100,000- \$149,999 (6)	14.56%	54
\$150,000+ (7)	15.09%	56
TOTAL		371

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	4.00	4.51	1.59

Q33 Do you consider yourself to be a person with a disability?

Answered: 395 Skipped: 100

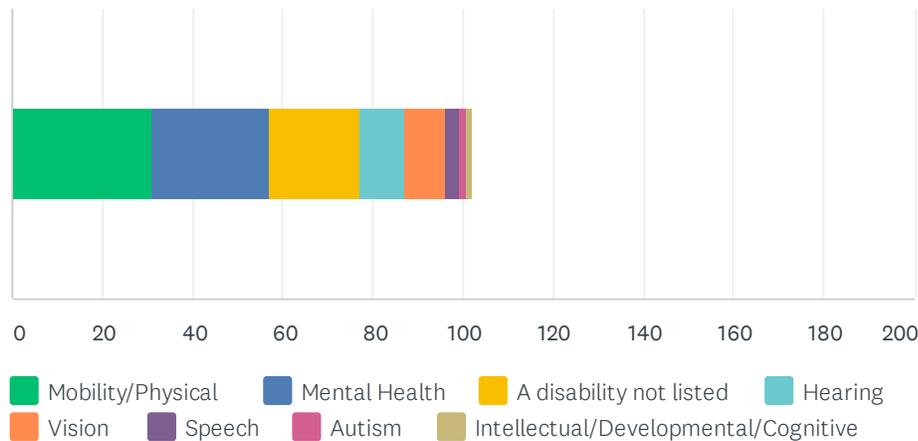


ANSWER CHOICES	RESPONSES
Yes (1)	12.91% 51
No (2)	87.09% 344
TOTAL	395

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.87	0.34

Q34 Please select the type of disabilities that apply to you

Answered: 76 Skipped: 419

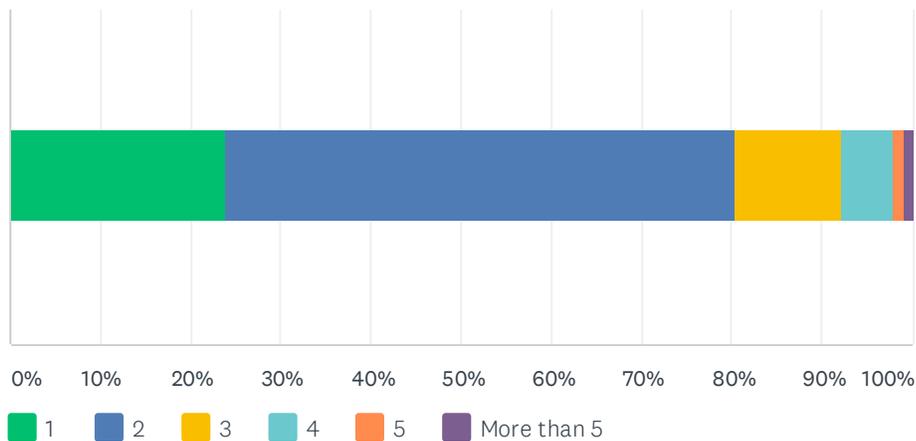


ANSWER CHOICES	RESPONSES	
Mobility/Physical (5)	40.79%	31
Mental Health (4)	34.21%	26
A disability not listed (8)	26.32%	20
Hearing (2)	13.16%	10
Vision (7)	11.84%	9
Speech (6)	3.95%	3
Autism (1)	2.63%	2
Intellectual/Developmental/Cognitive (3)	1.32%	1
Total Respondents: 76		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	5.00	5.15	1.90

Q35 How many adults (age 18+) live in your household (including yourself)?

Answered: 392 Skipped: 103

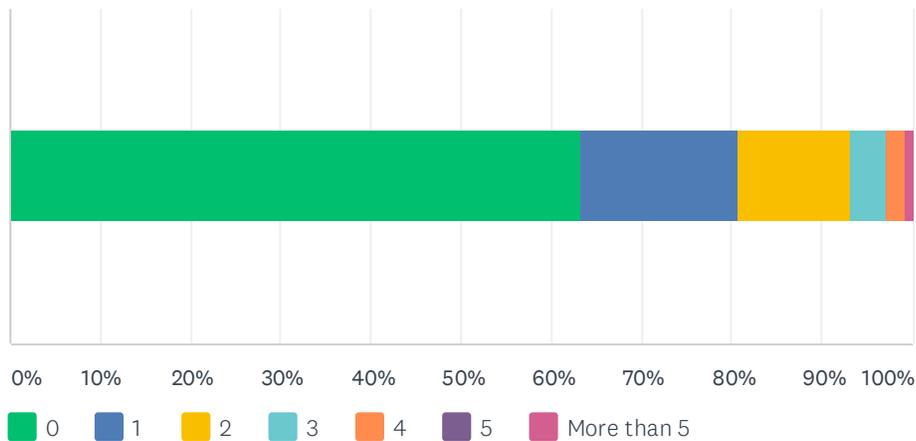


ANSWER CHOICES	RESPONSES	
1 (1)	23.98%	94
2 (2)	56.38%	221
3 (3)	11.73%	46
4 (4)	5.87%	23
5 (5)	1.28%	5
More than 5 (6)	0.77%	3
TOTAL		392

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	2.00	2.06	0.91

Q36 How many children under age 18 live in your household?

Answered: 390 Skipped: 105



ANSWER CHOICES	RESPONSES	
0 (1)	63.33%	247
1 (2)	17.44%	68
2 (3)	12.31%	48
3 (4)	4.10%	16
4 (5)	2.05%	8
5 (6)	0.00%	0
More than 5 (7)	0.77%	3
TOTAL		390

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	1.00	1.67	1.09

Q37 Please indicate your housing status

Answered: 388 Skipped: 107



0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- Own house
- Rent house/apartment
- Transitional or temporary housing
- Shelter for Unhoused
- Unhoused (do not have regular, adequate, nightly residence)
- Other housing status not listed:

ANSWER CHOICES	RESPONSES	
Own house (1)	80.15%	311
Rent house/apartment (2)	16.75%	65
Transitional or temporary housing (3)	0.77%	3
Shelter for Unhoused (4)	0.26%	1
Unhoused (do not have regular, adequate, nightly residence) (5)	0.00%	0
Other housing status not listed: (6)	2.06%	8
TOTAL		388

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.29	0.81

Q38 If you were able to implement one, single solution to improve your health, what would it be? (No more than 100 characters)

Answered: 290 Skipped: 205

Q39 If you were able to implement one, single solution to improve the health of your community, what would it be? (No more than 100 characters)

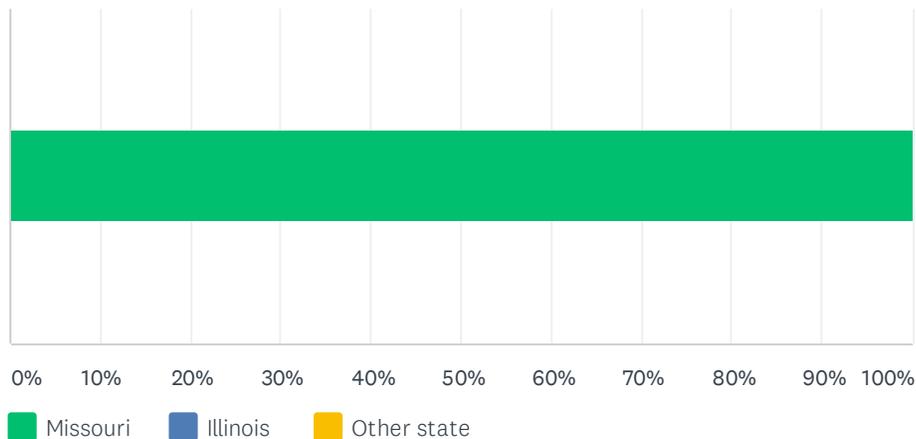
Answered: 269 Skipped: 226

Community Survey Results

St. Louis City

Q1 In what state do you reside?

Answered: 377 Skipped: 0



ANSWER CHOICES	RESPONSES	
Missouri (1)	100.00%	377
Illinois (2)	0.00%	0
Other state (3)	0.00%	0
TOTAL		377

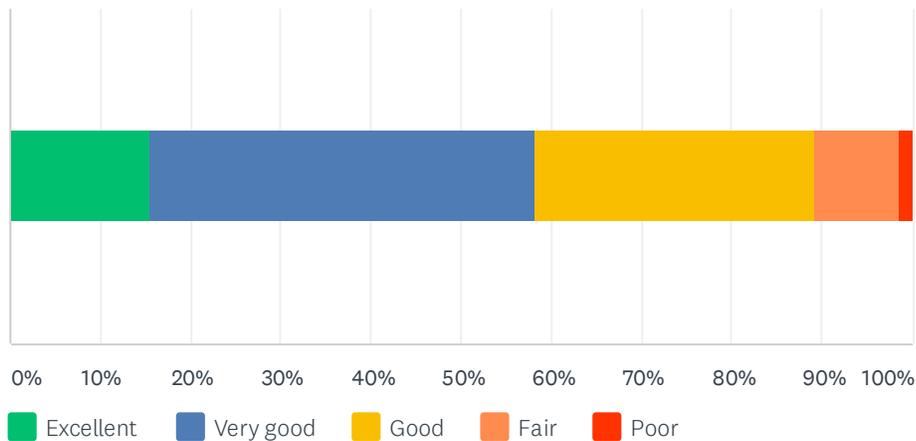
BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	1.00	1.00	1.00	0.00

Q2 What is the zip code of your primary residence?

Answered: 377 Skipped: 0

Q3 In general, would you say your health is:

Answered: 367 Skipped: 10

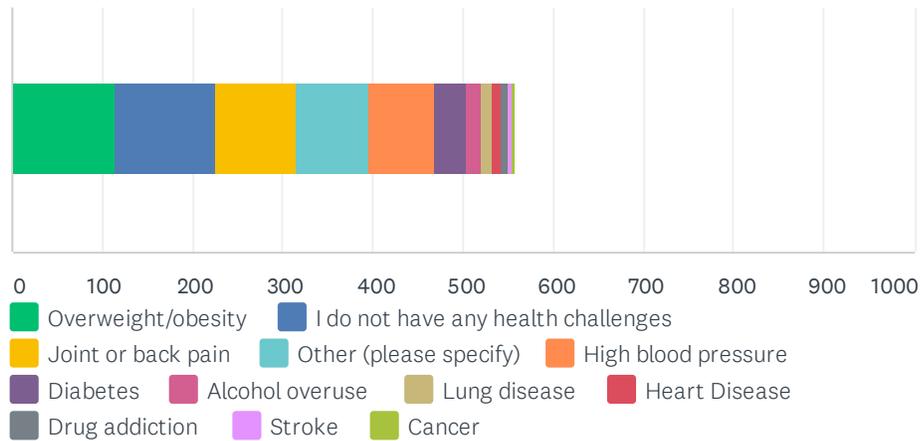


ANSWER CHOICES	RESPONSES	
Excellent (1)	15.53%	57
Very good (2)	42.78%	157
Good (3)	30.79%	113
Fair (4)	9.54%	35
Poor (5)	1.36%	5
TOTAL		367

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	2.00	2.38	0.91

Q4 Please select the main health challenge/s you face. (Check all that apply)

Answered: 367 Skipped: 10

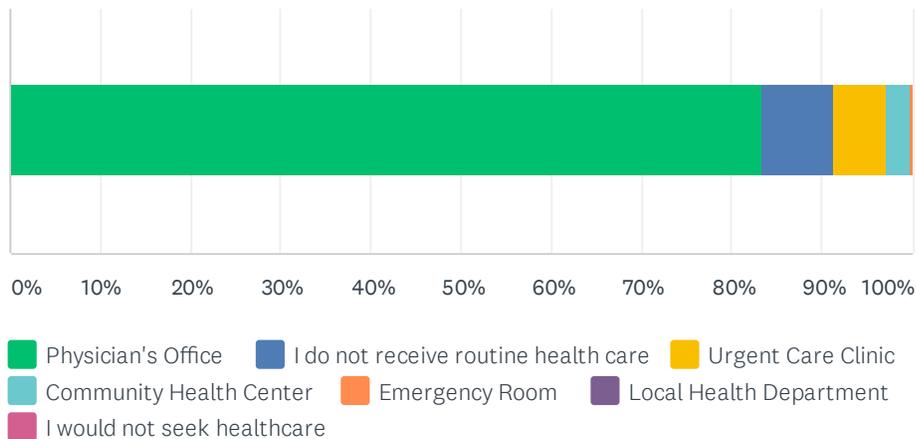


ANSWER CHOICES	RESPONSES	
Overweight/obesity (4)	31.34%	115
I do not have any health challenges (1)	29.97%	110
Joint or back pain (9)	24.52%	90
Other (please specify) (12)	21.80%	80
High blood pressure (6)	19.62%	72
Diabetes (3)	10.35%	38
Alcohol overuse (11)	4.09%	15
Lung disease (5)	3.27%	12
Heart Disease (8)	3.00%	11
Drug addiction (10)	2.18%	8
Stroke (7)	1.09%	4
Cancer (2)	0.82%	3
Total Respondents: 367		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	6.00	7.33	3.46

Q5 Where do you most often go for routine healthcare

Answered: 367 Skipped: 10

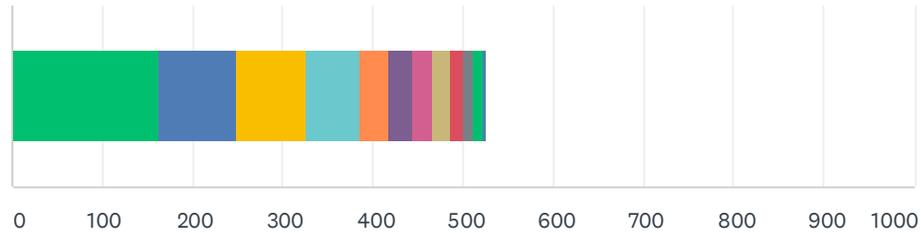


ANSWER CHOICES	RESPONSES	
Physician's Office (1)	83.38%	306
I do not receive routine health care (6)	7.90%	29
Urgent Care Clinic (4)	5.99%	22
Community Health Center (5)	2.45%	9
Emergency Room (3)	0.27%	1
Local Health Department (2)	0.00%	0
I would not seek healthcare (7)	0.00%	0
TOTAL		367

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.68	1.57

Q6 What barriers prevent you and/or your family from accessing healthcare? (Check all that apply)

Answered: 355 Skipped: 22



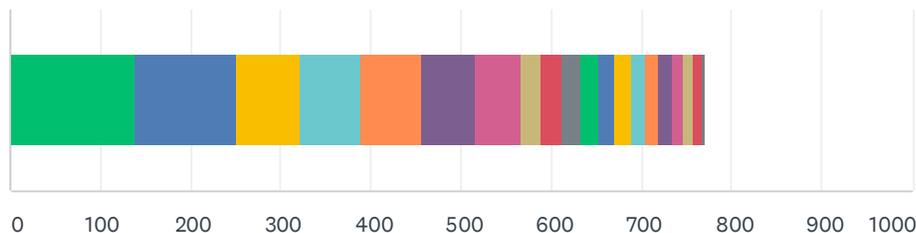
- I/my family have no barriers preventing us from accessing health care.
- Scheduling problems ■ Costs/Co-pays ■ Difficulty finding doctors
- Fear (e.g. of doctors/health systems/not ready to face or discuss health issues)
- Other (please specify) ■ My health insurance is not accepted
- No health insurance/unable to pay ■ Transportation/mobility issues
- Lack of nearby health centers/services/providers ■ Don't feel welcome
- Cultural/religious beliefs

ANSWER CHOICES	RESPONSES	
I/my family have no barriers preventing us from accessing health care. (1)	45.92%	163
Scheduling problems (9)	23.94%	85
Costs/Co-pays (7)	21.97%	78
Difficulty finding doctors (3)	16.90%	60
Fear (e.g. of doctors/health systems/not ready to face or discuss health issues) (5)	9.01%	32
Other (please specify) (12)	7.32%	26
My health insurance is not accepted (10)	6.20%	22
No health insurance/unable to pay (6)	5.35%	19
Transportation/mobility issues (8)	4.23%	15
Lack of nearby health centers/services/providers (4)	3.66%	13
Don't feel welcome (11)	2.82%	10
Cultural/religious beliefs (2)	0.85%	3
Total Respondents: 355		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	7.00	7.19	2.84

Q7 Please select the health screenings and/or services for which you need better access. (Check all that apply)

Answered: 338 Skipped: 39



- I/my family have adequate access to health screenings
- Mental health/depression
- Exercise/physical activity
- Dental screenings
- Routine well checkups
- Weight loss help
- Nutrition
- Blood Pressure
- Emergency Preparedness
- Quitting smoking
- Suicide prevention
- Cholesterol (fats in the blood)
- Falls prevention for elderly
- Cancer
- Vaccination/immunization
- Other (please specify)
- HIV AIDS/STIs
- Drug and/or alcohol abuse
- Eating disorders
- Prenatal care

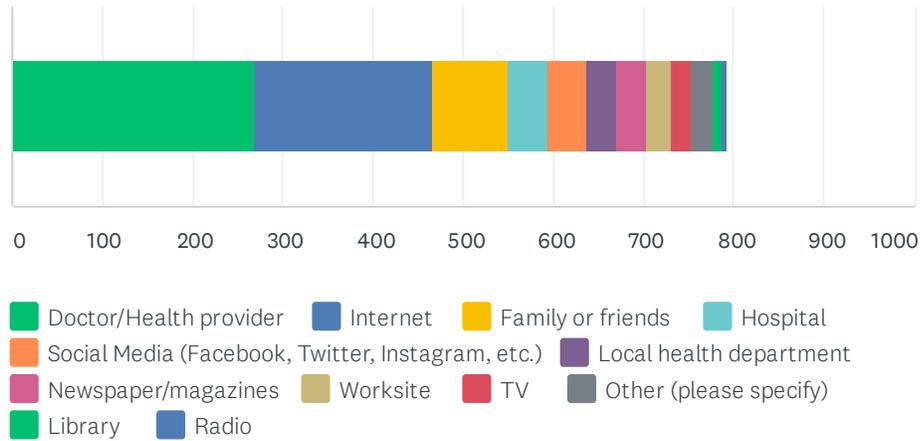
2021 Community Health Needs Assessment (CHNA)

ANSWER CHOICES	RESPONSES	
I/my family have adequate access to health screenings (1)	40.83%	138
Mental health/depression (15)	33.43%	113
Exercise/physical activity (7)	20.71%	70
Dental screenings (5)	20.12%	68
Routine well checkups (18)	19.53%	66
Weight loss help (13)	18.05%	61
Nutrition (9)	14.79%	50
Blood Pressure (2)	6.80%	23
Emergency Preparedness (6)	6.80%	23
Quitting smoking (11)	6.21%	21
Suicide prevention (12)	5.92%	20
Cholesterol (fats in the blood) (4)	5.33%	18
Falls prevention for elderly (8)	5.33%	18
Cancer (3)	4.44%	15
Vaccination/immunization (14)	4.44%	15
Other (please specify) (20)	4.44%	15
HIV AIDS/STIs (17)	3.55%	12
Drug and/or alcohol abuse (16)	3.25%	11
Eating disorders (19)	2.96%	10
Prenatal care (10)	1.48%	5
Total Respondents: 338		

BASIC STATISTICS				
Minimum 2.00	Maximum 21.00	Median 12.00	Mean 11.07	Standard Deviation 5.10

Q8 Where do you get most of your health information? (Choose top 3)

Answered: 345 Skipped: 32

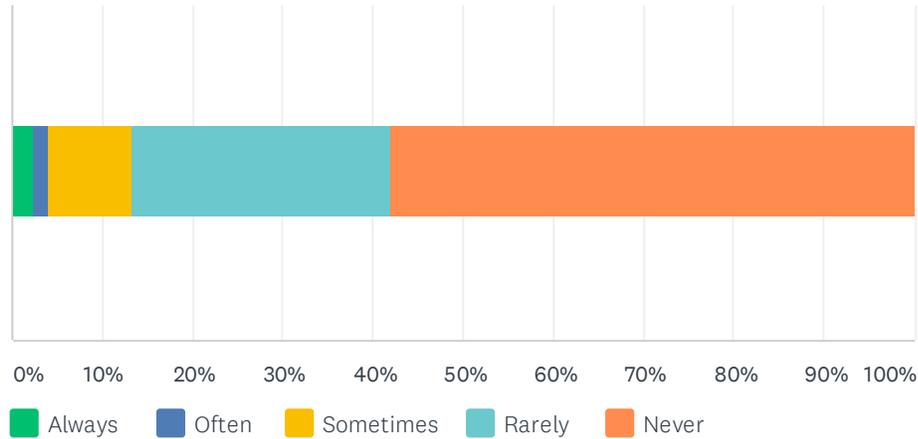


ANSWER CHOICES	RESPONSES	
Doctor/Health provider (1)	78.26%	270
Internet (6)	56.81%	196
Family or friends (3)	24.64%	85
Hospital (5)	12.75%	44
Social Media (Facebook, Twitter, Instagram, etc.) (2)	12.17%	42
Local health department (4)	9.86%	34
Newspaper/magazines (8)	8.99%	31
Worksite (11)	8.12%	28
TV (10)	6.96%	24
Other (please specify) (12)	6.96%	24
Library (7)	2.61%	9
Radio (9)	2.03%	7
Total Respondents: 345		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	12.00	3.50	4.22	3.17

Q9 How often do you need to have someone help you understand instructions, pamphlets or other written materials from your doctor or pharmacy?

Answered: 341 Skipped: 36

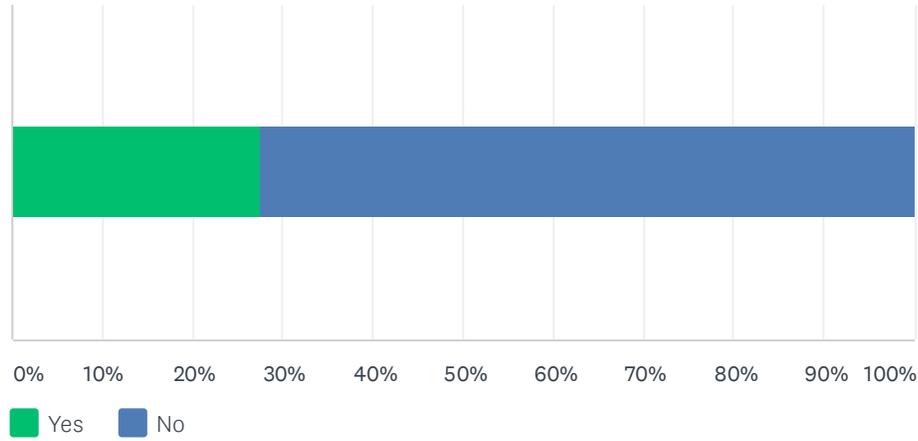


ANSWER CHOICES	RESPONSES	
Always (1)	2.35%	8
Often (2)	1.76%	6
Sometimes (3)	9.09%	31
Rarely (4)	28.74%	98
Never (5)	58.06%	198
TOTAL		341

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.38	0.90

Q10 Do you have children for whose health you are responsible?

Answered: 341 Skipped: 36

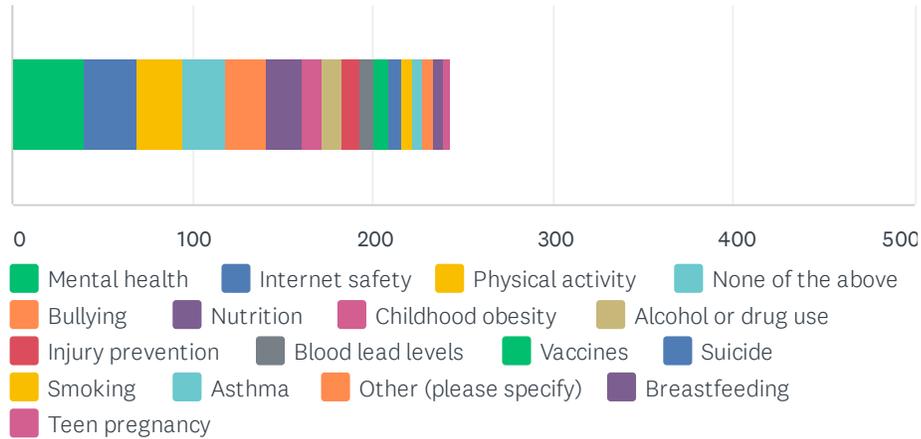


ANSWER CHOICES	RESPONSES	
Yes (1)	27.57%	94
No (2)	72.43%	247
TOTAL		341

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.72	0.45

Q11 What health screenings, education and/or services do you feel your child/ren need better access to keep them safe and healthy? (Check all that apply)

Answered: 92 Skipped: 285



ANSWER CHOICES	RESPONSES	
Mental health (14)	43.48%	40
Internet safety (9)	31.52%	29
Physical activity (3)	27.17%	25
None of the above (1)	26.09%	24
Bullying (15)	25.00%	23
Nutrition (4)	21.74%	20
Childhood obesity (2)	11.96%	11
Alcohol or drug use (5)	11.96%	11
Injury prevention (12)	10.87%	10
Blood lead levels (10)	8.70%	8
Vaccines (16)	8.70%	8
Suicide (13)	7.61%	7
Smoking (8)	6.52%	6
Asthma (11)	6.52%	6
Other (please specify) (17)	6.52%	6
Breastfeeding (6)	5.43%	5
Teen pregnancy (7)	4.35%	4
Total Respondents: 92		

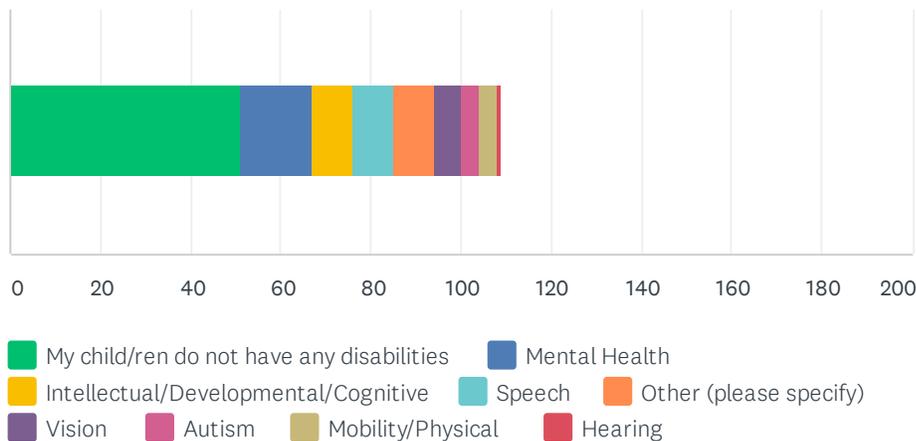
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	18.00	9.00	9.58	4.80

Q12 Please indicate any disabilities that apply to your children. (Check all that apply)

Answered: 88 Skipped: 289

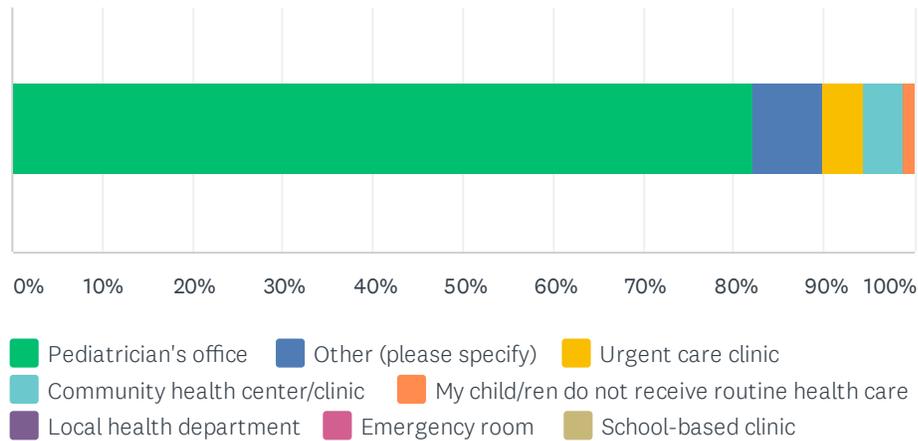


ANSWER CHOICES	RESPONSES	
My child/ren do not have any disabilities (1)	57.95%	51
Mental Health (5)	18.18%	16
Intellectual/Developmental/Cognitive (4)	10.23%	9
Speech (7)	10.23%	9
Other (please specify) (9)	10.23%	9
Vision (8)	6.82%	6
Autism (2)	4.55%	4
Mobility/Physical (6)	4.55%	4
Hearing (3)	1.14%	1
Total Respondents: 88		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	10.00	5.00	6.07	2.28

Q13 Where do you take your child/ren under age 18 for routine health care most often?

Answered: 90 Skipped: 287

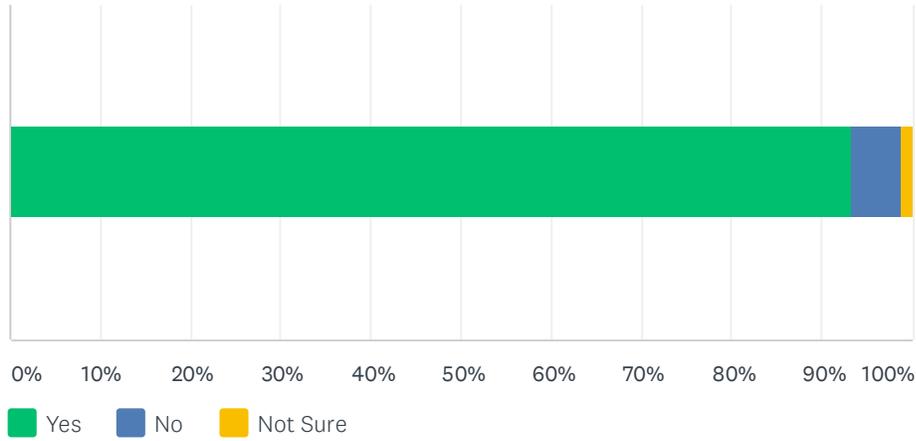


ANSWER CHOICES	RESPONSES	
Pediatrician's office (2)	82.22%	74
Other (please specify) (8)	7.78%	7
Urgent care clinic (5)	4.44%	4
Community health center/clinic (6)	4.44%	4
My child/ren do not receive routine health care (1)	1.11%	1
Local health department (3)	0.00%	0
Emergency room (4)	0.00%	0
School-based clinic (7)	0.00%	0
TOTAL		90

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	9.00	2.00	2.87	2.06

Q14 Do your children have health insurance?

Answered: 90 Skipped: 287

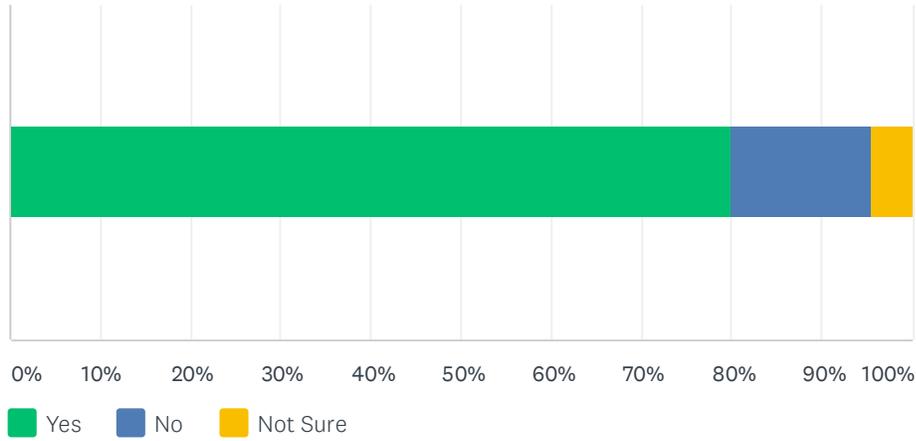


ANSWER CHOICES	RESPONSES	
Yes (1)	93.33%	84
No (2)	5.56%	5
Not Sure (3)	1.11%	1
TOTAL		90

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.08	0.31

Q15 Do your children have dental insurance?

Answered: 90 Skipped: 287

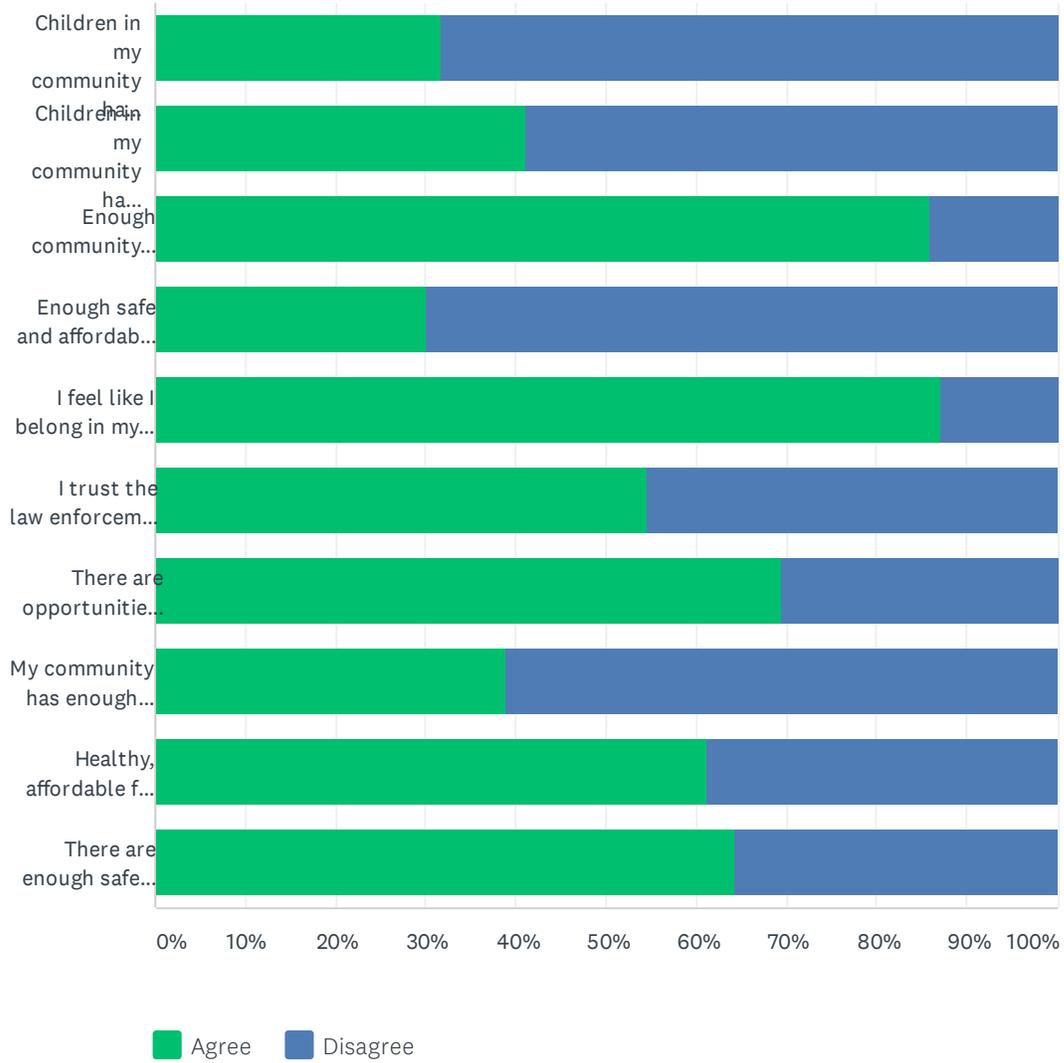


ANSWER CHOICES	RESPONSES	
Yes (1)	80.00%	72
No (2)	15.56%	14
Not Sure (3)	4.44%	4
TOTAL		90

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.24	0.52

Q16 Please choose the best response to reflect your opinion

Answered: 320 Skipped: 57



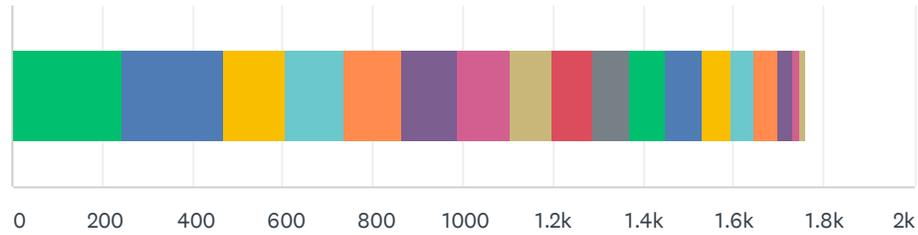
2021 Community Health Needs Assessment (CHNA)

	AGREE	DISAGREE	TOTAL	WEIGHTED AVERAGE
Children in my community have access to high quality education	31.74% 73	68.26% 157	230	1.68
Children in my community have enough safe places to play	41.25% 106	58.75% 151	257	1.59
Enough community gatherings: parks, places of worship, community events	85.93% 232	14.07% 38	270	1.14
Enough safe and affordable houses and apartments in my community	30.20% 74	69.80% 171	245	1.70
I feel like I belong in my community	87.24% 212	12.76% 31	243	1.13
I trust the law enforcement officials in my community	54.70% 128	45.30% 106	234	1.45
There are opportunities for my voice to be heard about community decisions	69.57% 144	30.43% 63	207	1.30
My community has enough good-paying jobs	39.06% 91	60.94% 142	233	1.61
Healthy, affordable food is easily accessible in my community	61.26% 155	38.74% 98	253	1.39
There are enough safe places to be physically active in my community	64.20% 165	35.80% 92	257	1.36

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Children in my community have access to high quality education	1.00	5.00	3.00	3.35	1.12
Children in my community have enough safe places to play	1.00	5.00	3.00	3.26	1.25
Enough community gatherings: parks, places of worship, community events	1.00	5.00	2.00	2.25	0.97
Enough safe and affordable houses and apartments in my community	1.00	5.00	4.00	3.42	1.12
I feel like I belong in my community	1.00	5.00	2.00	2.28	0.93
I trust the law enforcement officials in my community	1.00	5.00	3.00	2.97	1.26
There are opportunities for my voice to be heard about community decisions	1.00	5.00	3.00	2.73	0.93
My community has enough good-paying jobs	1.00	5.00	3.00	3.27	1.12
Healthy, affordable food is easily accessible in my community	1.00	5.00	3.00	2.83	1.14
There are enough safe places to be physically active in my community	1.00	5.00	2.00	2.71	1.23

Q17 What types of safety concerns do you have in your community? (Check all that apply)

Answered: 318 Skipped: 59



- Gun violence
 Burglaries/theft
 Vacant properties
- Poor or dangerous roads
 Drug abuse
 Poor or dangerous sidewalks
- Mugging/physical assault
 Poor lighting
 Domestic violence
- Disorderly conduct
 Gang activity
 Vandalism/graffiti
 Hate crimes
- Sexual assault
 Child abuse
 Prostitution
- I do not have any safety concerns in my community
 Other (please specify)

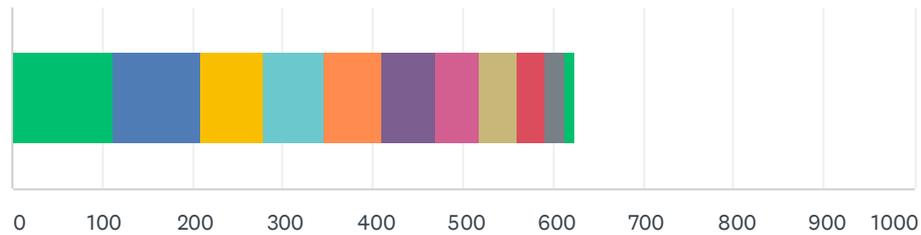
2021 Community Health Needs Assessment (CHNA)

ANSWER CHOICES	RESPONSES	
Gun violence (2)	77.36%	246
Burglaries/theft (3)	70.13%	223
Vacant properties (17)	43.08%	137
Poor or dangerous roads (8)	40.88%	130
Drug abuse (10)	40.25%	128
Poor or dangerous sidewalks (9)	38.36%	122
Mugging/physical assault (13)	36.79%	117
Poor lighting (7)	29.87%	95
Domestic violence (5)	28.62%	91
Disorderly conduct (6)	25.47%	81
Gang activity (11)	25.16%	80
Vandalism/graffiti (16)	25.16%	80
Hate crimes (12)	19.81%	63
Sexual assault (15)	17.30%	55
Child abuse (4)	16.04%	51
Prostitution (14)	10.38%	33
I do not have any safety concerns in my community (1)	4.40%	14
Other (please specify) (18)	3.77%	12
Total Respondents: 318		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	19.00	8.00	8.41	4.97

Q18 What concerns do you have about the environmental health of your community? (Check all that apply)

Answered: 316 Skipped: 61



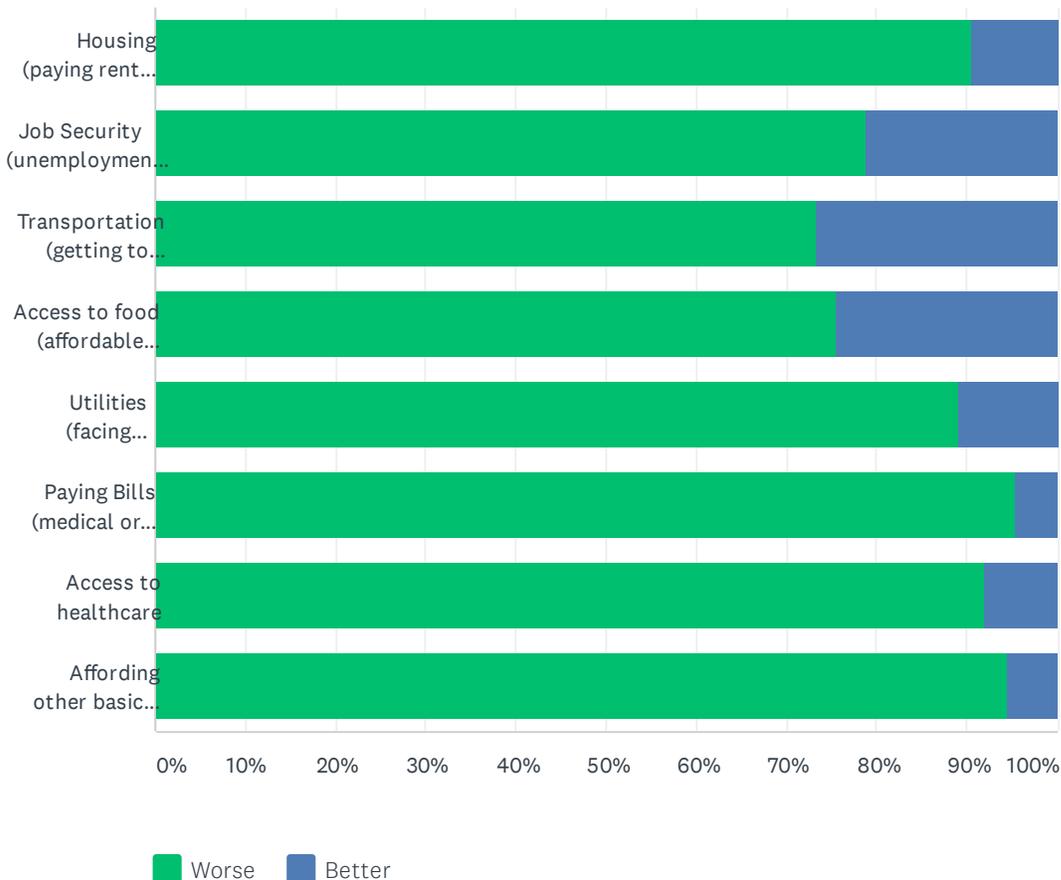
- Air quality/odors
- I do not have any concerns about the environmental health of my community
- Sewage problems ■ Water quality ■ Not enough trees
- Vegetation overgrowth ■ Wildlife/insects ■ Soil contamination
- Flooding ■ Other (please specify) ■ Too many trees

ANSWER CHOICES	RESPONSES	
Air quality/odors (3)	35.76%	113
I do not have any concerns about the environmental health of my community (1)	30.38%	96
Sewage problems (6)	22.15%	70
Water quality (2)	20.89%	66
Not enough trees (4)	20.25%	64
Vegetation overgrowth (8)	19.30%	61
Wildlife/insects (10)	15.19%	48
Soil contamination (7)	13.61%	43
Flooding (9)	9.49%	30
Other (please specify) (11)	6.65%	21
Too many trees (5)	4.11%	13
Total Respondents: 316		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	12.00	6.00	5.68	2.87

Q19 How has the COVID-19 (coronavirus) pandemic impacted the following for you/your household?

Answered: 313 Skipped: 64



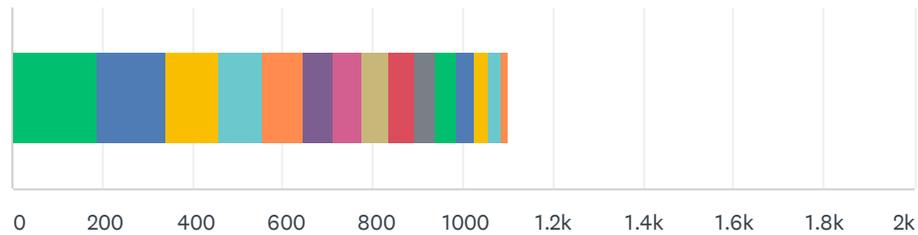
	WORSE	BETTER	TOTAL
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	90.57% 48	9.43% 5	53
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	78.85% 82	21.15% 22	104
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	73.33% 33	26.67% 12	45
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	75.44% 43	24.56% 14	57
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	89.13% 41	10.87% 5	46
Paying Bills (medical or other)	95.45% 63	4.55% 3	66
Access to healthcare	91.95% 80	8.05% 7	87
Affording other basic needs (not mentioned above)	94.64% 53	5.36% 3	56

2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS					
	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	1.00	3.00	2.00	1.86	0.39
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	1.00	3.00	2.00	1.81	0.55
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	1.00	3.00	2.00	1.93	0.37
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	1.00	3.00	2.00	1.91	0.42
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	1.00	3.00	2.00	1.88	0.37
Paying Bills (medical or other)	1.00	3.00	2.00	1.81	0.42
Access to healthcare	1.00	3.00	2.00	1.77	0.47
Affording other basic needs (not mentioned above)	1.00	3.00	2.00	1.84	0.39

Q20 What do you think are the top STRENGTHS of your community right now?

Answered: 310 Skipped: 67



- Access to community parks and other open spaces for physical activity
- Racial and ethnic diversity
- Opportunities to practice spiritual beliefs
- Good places to raise a family
- Sense of belonging
- Access to affordable healthy foods
- Access to affordable transportation
- Strong community leaders and role models
- Access to affordable, quality health care
- Clean environment
- Access to affordable housing
- Good schools/quality education
- Community safety/low crime
- Good paying jobs and strong economy
- Other (please specify)

ANSWER CHOICES	RESPONSES	
Access to community parks and other open spaces for physical activity (5)	61.29%	190
Racial and ethnic diversity (12)	48.39%	150
Opportunities to practice spiritual beliefs (11)	38.39%	119
Good places to raise a family (9)	30.65%	95
Sense of belonging (13)	30.00%	93
Access to affordable healthy foods (2)	20.97%	65
Access to affordable transportation (4)	20.65%	64
Strong community leaders and role models (14)	18.71%	58
Access to affordable, quality health care (1)	18.06%	56
Clean environment (6)	16.45%	51
Access to affordable housing (3)	13.87%	43
Good schools/quality education (10)	12.58%	39
Community safety/low crime (7)	10.65%	33
Good paying jobs and strong economy (8)	9.68%	30
Other (please specify) (15)	4.84%	15
Total Respondents: 310		

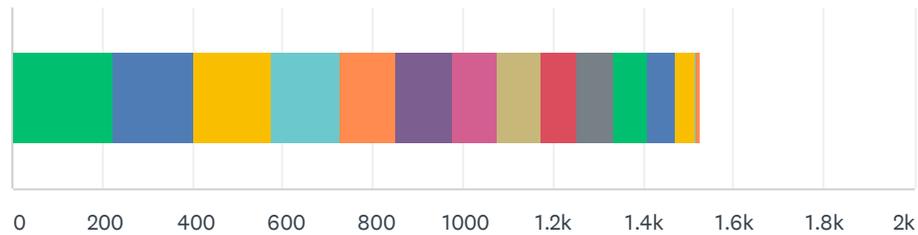
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	9.00	8.08	4.04

Q21 What do you think are the top CHALLENGES of your community right now?

Answered: 308 Skipped: 69



- Community safety/crime
- Good schools/quality education
- Access to affordable housing
- Good paying jobs and strong economy
- Access to affordable healthy foods
- Access to affordable, quality health care
- Strong community leaders and role models
- Clean environment
- Good places to raise a family
- Access to affordable transportation
- Racial and ethnic diversity
- Sense of belonging
- Access to community parks and other open spaces for physical activity
- Opportunities to practice spiritual beliefs
- Other (please specify)

ANSWER CHOICES	RESPONSES	
Community safety/crime (7)	72.40%	223
Good schools/quality education (10)	57.79%	178
Access to affordable housing (3)	56.82%	175
Good paying jobs and strong economy (8)	48.70%	150
Access to affordable healthy foods (2)	40.58%	125
Access to affordable, quality health care (1)	40.26%	124
Strong community leaders and role models (14)	32.79%	101
Clean environment (6)	31.17%	96
Good places to raise a family (9)	26.30%	81
Access to affordable transportation (4)	25.97%	80
Racial and ethnic diversity (12)	24.68%	76
Sense of belonging (13)	19.48%	60
Access to community parks and other open spaces for physical activity (5)	14.29%	44
Opportunities to practice spiritual beliefs (11)	2.27%	7
Other (please specify) (15)	2.27%	7
Total Respondents: 308		

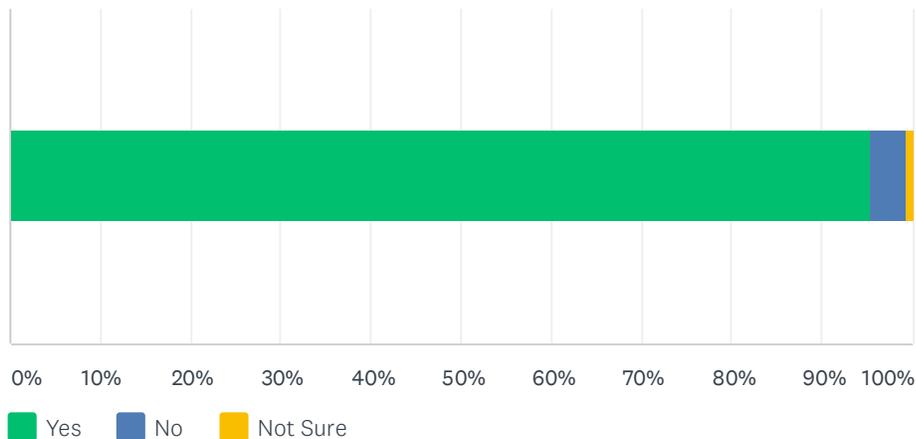
2021 Community Health Needs Assessment (CHNA)

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	7.00	6.92	3.88

Q22 Do you currently have health insurance?

Answered: 306 Skipped: 71

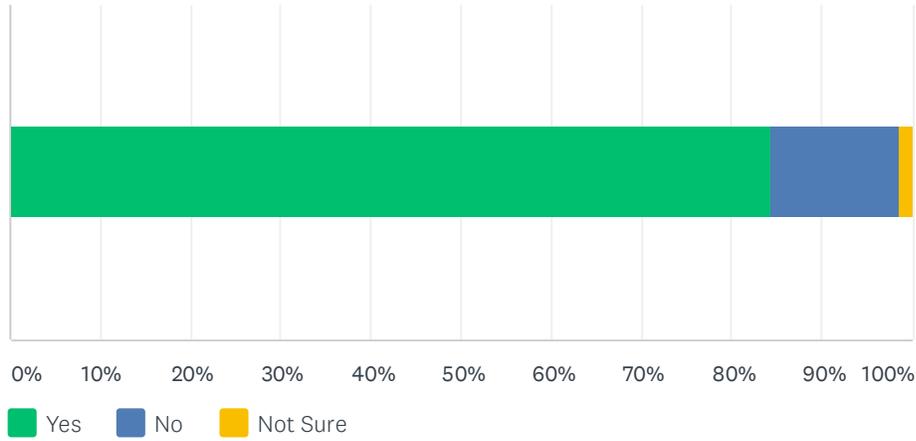


ANSWER CHOICES	RESPONSES	
Yes (1)	95.42%	292
No (2)	3.92%	12
Not Sure (3)	0.65%	2
TOTAL		306

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.05	0.25

Q23 Do you currently have dental insurance?

Answered: 305 Skipped: 72

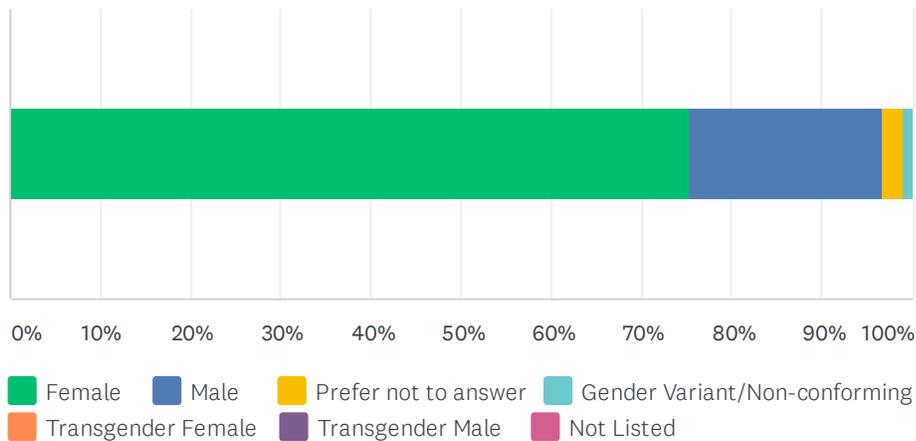


ANSWER CHOICES	RESPONSES	
Yes (1)	84.26%	257
No (2)	14.43%	44
Not Sure (3)	1.31%	4
TOTAL		305

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.17	0.41

Q24 With which gender identity do you most identify?

Answered: 303 Skipped: 74

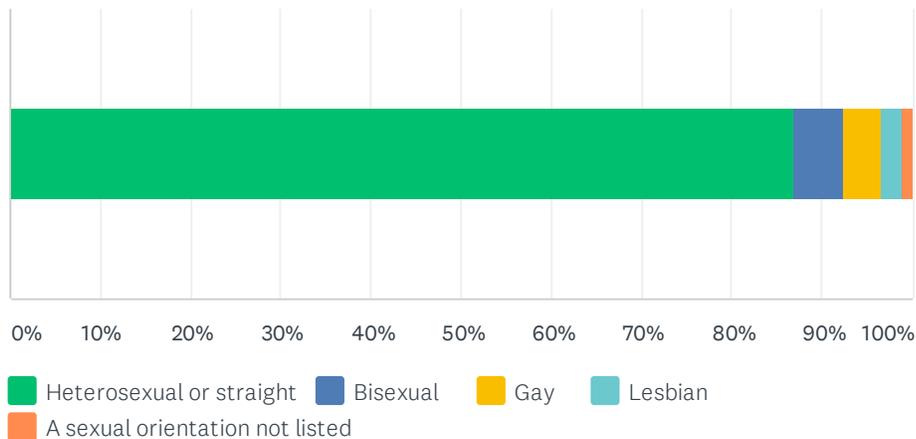


ANSWER CHOICES	RESPONSES	
Female (1)	75.25%	228
Male (2)	21.45%	65
Prefer not to answer (6)	2.31%	7
Gender Variant/Non-conforming (5)	0.99%	3
Transgender Female (3)	0.00%	0
Transgender Male (4)	0.00%	0
Not Listed (7)	0.00%	0
TOTAL		303

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.37	0.90

Q25 What is your sexual orientation?

Answered: 301 Skipped: 76

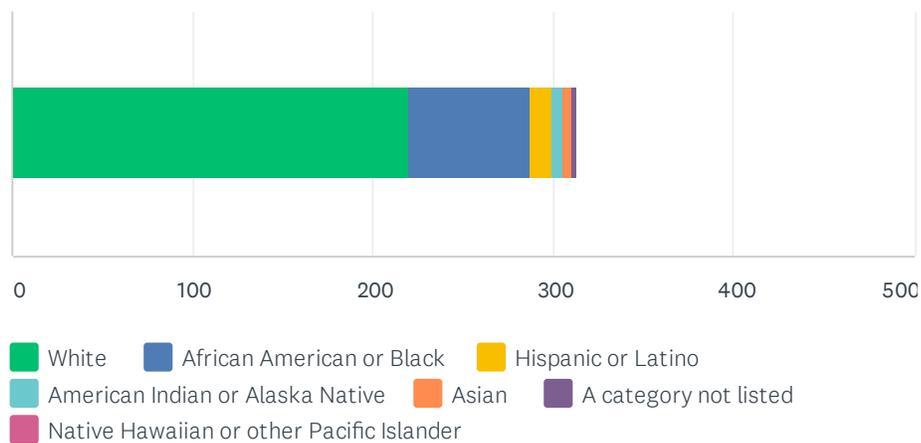


ANSWER CHOICES	RESPONSES	
Heterosexual or straight (1)	87.04%	262
Bisexual (4)	5.32%	16
Gay (2)	4.32%	13
Lesbian (3)	2.33%	7
A sexual orientation not listed (5)	1.00%	3
TOTAL		301

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	1.00	1.29	0.83

Q26 With which race/ethnicity do you identify? You may check more than one.

Answered: 303 Skipped: 74



ANSWER CHOICES	RESPONSES	
White (6)	72.61%	220
African American or Black (1)	22.11%	67
Hispanic or Latino (4)	3.96%	12
American Indian or Alaska Native (2)	1.98%	6
Asian (3)	1.65%	5
A category not listed (7)	0.99%	3
Native Hawaiian or other Pacific Islander (5)	0.00%	0
Total Respondents: 303		

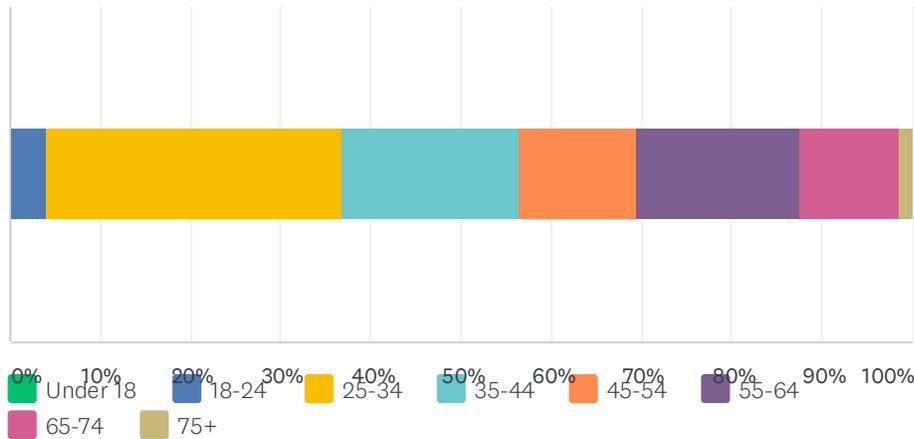
BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	6.00	4.74	2.09

Q27 What languages do you speak at home?

Answered: 276 Skipped: 101

Q28 What is your age group?

Answered: 299 Skipped: 78

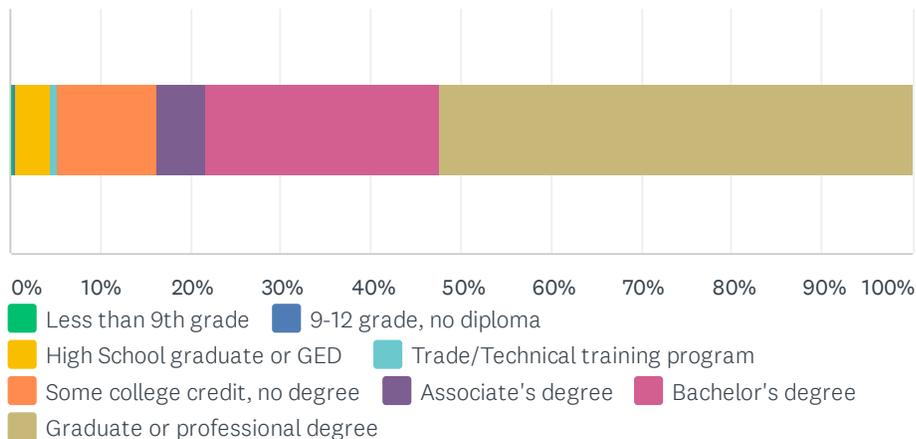


ANSWER CHOICES	RESPONSES
Under 18 (1)	0.00% 0
18-24 (2)	4.01% 12
25-34 (3)	32.78% 98
35-44 (4)	19.73% 59
45-54 (5)	13.04% 39
55-64 (6)	18.06% 54
65-74 (7)	11.04% 33
75+ (8)	1.34% 4
TOTAL	299

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
2.00	8.00	4.00	4.47	1.53

Q29 What is the highest grade or year of school you completed?

Answered: 301 Skipped: 76

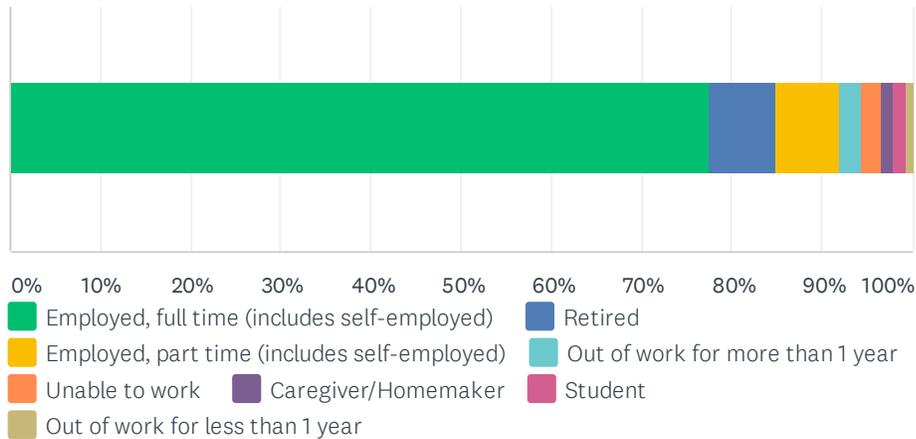


ANSWER CHOICES	RESPONSES	
Less than 9th grade (1)	0.33%	1
9-12 grade, no diploma (2)	0.33%	1
High School graduate or GED (3)	3.65%	11
Trade/Technical training program (4)	1.00%	3
Some college credit, no degree (5)	10.96%	33
Associate's degree (6)	5.32%	16
Bachelor's degree (7)	25.91%	78
Graduate or professional degree (8)	52.49%	158
TOTAL		301

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	8.00	7.04	1.38

Q30 What is your employment status

Answered: 299 Skipped: 78

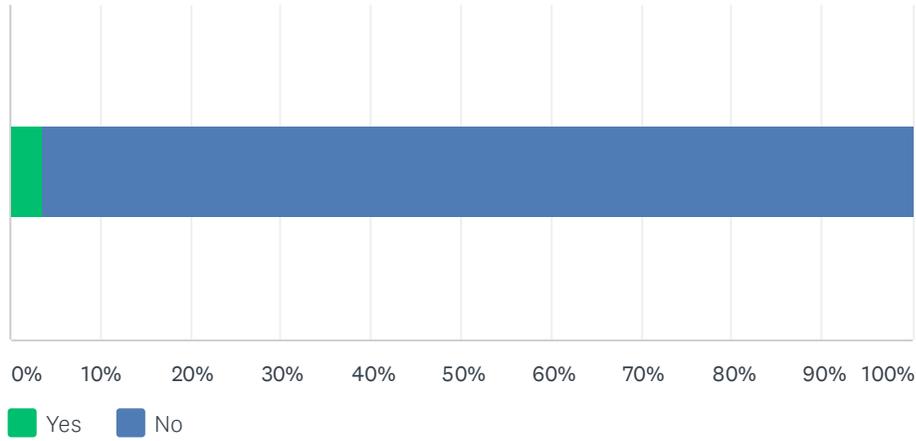


ANSWER CHOICES	RESPONSES	
Employed, full time (includes self-employed) (1)	77.59%	232
Retired (7)	7.36%	22
Employed, part time (includes self-employed) (2)	7.02%	21
Out of work for more than 1 year (3)	2.34%	7
Unable to work (8)	2.34%	7
Caregiver/Homemaker (5)	1.34%	4
Student (6)	1.34%	4
Out of work for less than 1 year (4)	0.67%	2
TOTAL		299

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	1.00	1.86	1.96

Q31 Are you a Veteran?

Answered: 297 Skipped: 80

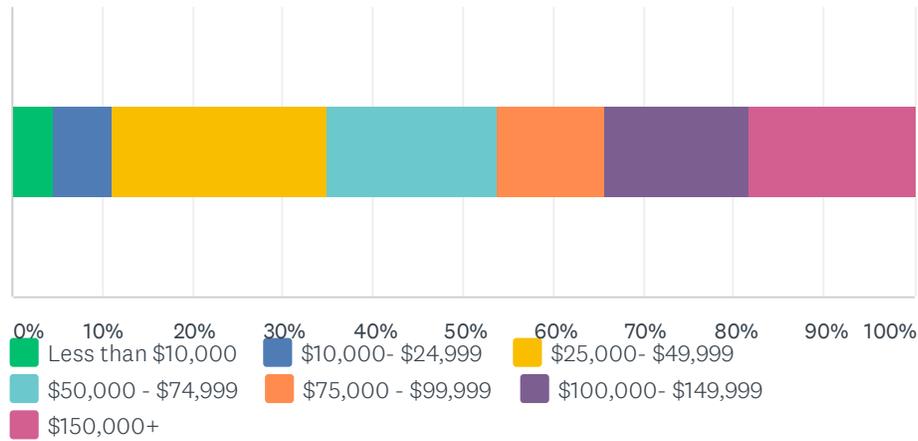


ANSWER CHOICES	RESPONSES
Yes (1)	3.70% 11
No (2)	96.30% 286
TOTAL	297

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.96	0.19

Q32 Which of these describes your household income last year?

Answered: 297 Skipped: 80

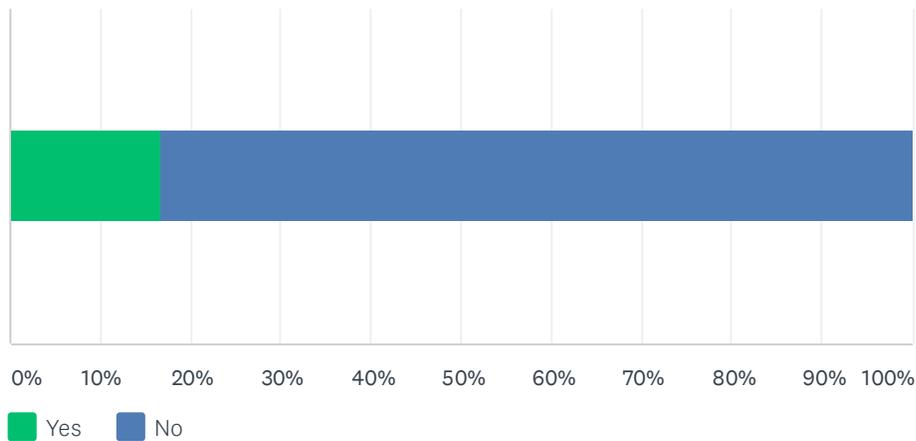


ANSWER CHOICES	RESPONSES
Less than \$10,000 (1)	4.71% 14
\$10,000- \$24,999 (2)	6.40% 19
\$25,000- \$49,999 (3)	23.91% 71
\$50,000 - \$74,999 (4)	18.86% 56
\$75,000 - \$99,999 (5)	11.78% 35
\$100,000- \$149,999 (6)	16.16% 48
\$150,000+ (7)	18.18% 54
TOTAL	297

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	4.00	4.48	1.76

Q33 Do you consider yourself to be a person with a disability?

Answered: 300 Skipped: 77

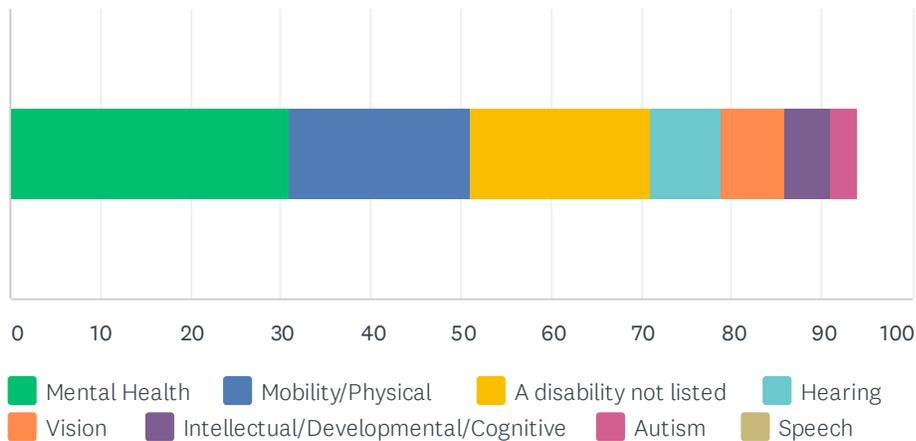


ANSWER CHOICES	RESPONSES
Yes (1)	16.67% 50
No (2)	83.33% 250
TOTAL	300

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.83	0.37

Q34 Please select the type of disabilities that apply to you

Answered: 72 Skipped: 305

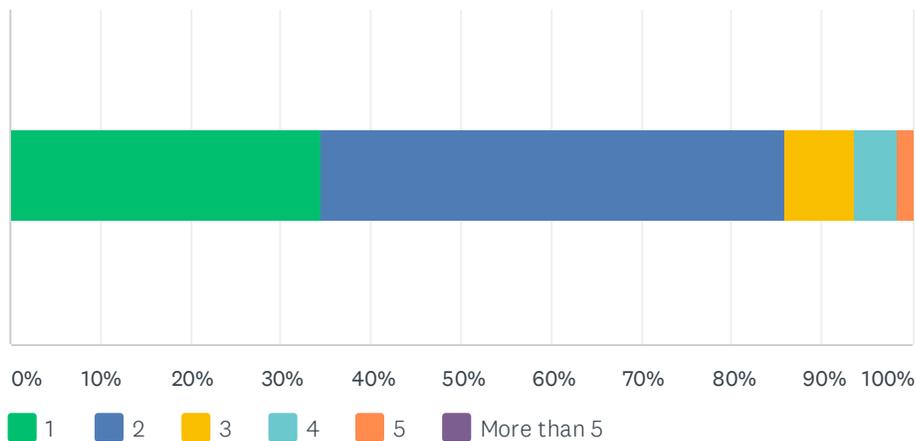


ANSWER CHOICES	RESPONSES	
Mental Health (4)	43.06%	31
Mobility/Physical (5)	27.78%	20
A disability not listed (8)	27.78%	20
Hearing (2)	11.11%	8
Vision (7)	9.72%	7
Intellectual/Developmental/Cognitive (3)	6.94%	5
Autism (1)	4.17%	3
Speech (6)	0.00%	0
Total Respondents: 72		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	4.50	4.97	2.01

Q35 How many adults (age 18+) live in your household (including yourself)?

Answered: 299 Skipped: 78

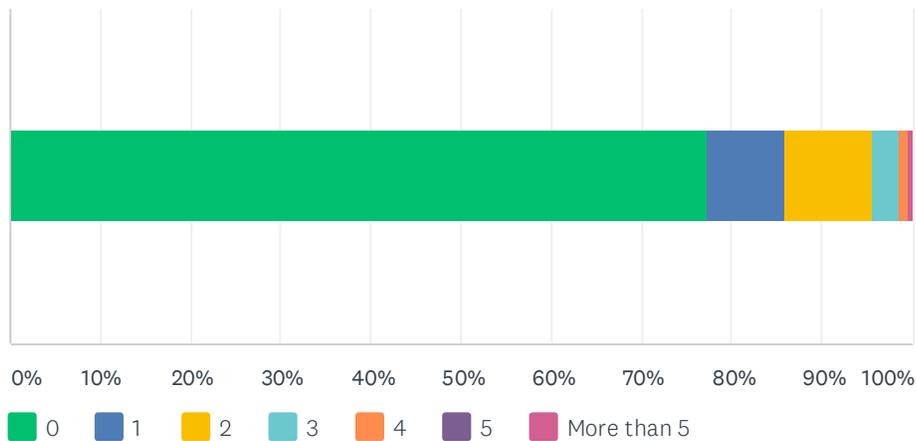


ANSWER CHOICES	RESPONSES	
1 (1)	34.45%	103
2 (2)	51.51%	154
3 (3)	7.69%	23
4 (4)	4.68%	14
5 (5)	1.67%	5
More than 5 (6)	0.00%	0
TOTAL		299

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	2.00	1.88	0.86

Q36 How many children under age 18 live in your household?

Answered: 300 Skipped: 77

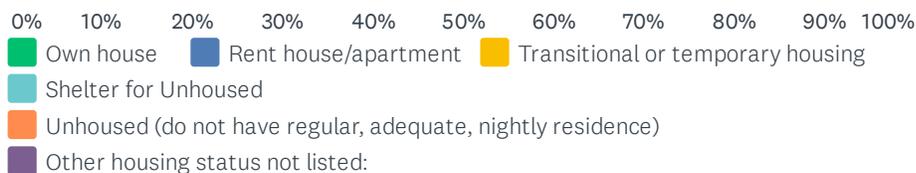
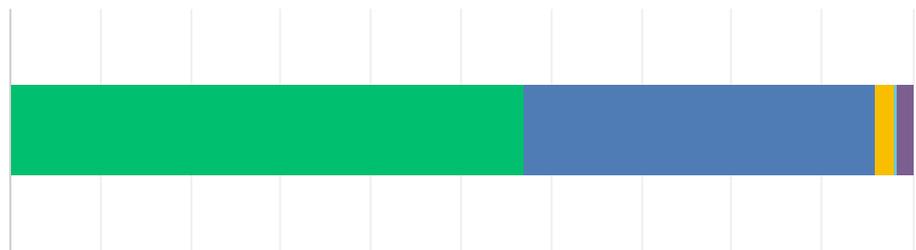


ANSWER CHOICES	RESPONSES	
0 (1)	77.33%	232
1 (2)	8.67%	26
2 (3)	9.67%	29
3 (4)	3.00%	9
4 (5)	1.00%	3
5 (6)	0.00%	0
More than 5 (7)	0.33%	1
TOTAL		300

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	1.00	1.43	0.92

Q37 Please indicate your housing status

Answered: 300 Skipped: 77



ANSWER CHOICES	RESPONSES	
Own house (1)	57.00%	171
Rent house/apartment (2)	39.00%	117
Transitional or temporary housing (3)	2.00%	6
Shelter for Unhoused (4)	0.33%	1
Unhoused (do not have regular, adequate, nightly residence) (5)	0.00%	0
Other housing status not listed: (6)	1.67%	5
TOTAL		300

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.52	0.80

Q38 If you were able to implement one, single solution to improve your health, what would it be? (No more than 100 characters)

Answered: 225 Skipped: 152

Q39 If you were able to implement one, single solution to improve the health of your community, what would it be? (No more than 100 characters)

Answered: 228 Skipped: 149

Appendix E

St. Louis Region CHNA Stakeholders Survey 2021

- List of Participating Stakeholders by Region..... 596
- Stakeholder Survey Questions..... 597
- Stakeholder Survey Results - West County..... 601
- Stakeholder Survey Results - North County..... 608
- Stakeholder Survey Results - St. Louis City..... 614



Participating Stakeholder Organizations

West County

- St. Louis County Department of Public Health
- Maryville University
- St. Luke's Des Peres Advisory Board Member
- City of Des Peres
- Event Exhibits, Inc.
- Kirkwood Fire Department
- Circle Of Concern
- Metrowest Anesthesia Group
- Rockwood School District
- Town and Country, Missouri Police Department
- St. Louis County Police
- Missouri Baptist University
- PreventEd
- Creve Coeur Police Department
- Jewish Community Center
- Eureka Police Department

North County

- Aging Ahead
- St. Louis Area Diaper Bank
- Our Family's Doing Yoga
- St. Luke's Hospital
- Alive and Well Communities
- Refuge and Restoration
- Cornerstone Realty
- Saint Louis County Department of Public Health
- Jewish Family Services of St. Louis
- PreventEd
- Asthma and Allergy Foundation-St. Louis

St. Louis City

- City of St. Louis Department of Health
- Youth In Need
- BJC Healthcare
- BJC Behavioral Health
- Affinia Healthcare
- Missouri Foundation for Health
- Alive and Well Communities
- iFM Community Medicine
- Places for People
- St. Vincent de Paul
- Gateway Region YMCA
- Hazelwood School District
- State Farm
- St. Louis Integrated Health Network
- BJK Peoples Health Centers
- Health Literacy Media
- Urban League of Metropolitan St. Louis
- March of Dimes
- Behavioral Health Network of Greater St. Louis
- Community Health-In-Partnership Services (CHIPS)
- PreventEd
- Operation Food Search
- Rise Community Development, Inc.
- Saint Louis Crisis Nursery
- Casa de Salud
- Missouri Department of Health & Senior Services

Stakeholder Survey Questions

CHNA Stakeholder Survey

The Patient Protection and Affordable Care Act (PPACA) requires each 501(c)3 hospital to solicit input from those who represent the broad interests of the community to inform the hospital's Community Health Needs Assessment.

Again this year, the area's health systems and hospitals are collaborating on this effort. Although in the past, we have conducted individual focus groups to solicit your feedback, this year we are asking you to complete an online survey for each community you serve. The survey should take no more than X minutes of your time and must be received by [DATE].

Thank you in advance for your participation in this important work.

CONTACT INFORMATION:

1. Contact Information

Your name:

Your organization:

Your title:

Your email address:

GEOGRAPHIC FOCUS:

2. For this survey, what part of the St. Louis region do your responses represent?

Crawford County, MO

Madison County, IL

St. Charles County, MO

St. Clair County, IL

St. Francois County, IL

St. Louis City, MO

North St. Louis County, MO

South St. Louis County, MO

West-Central St. Louis County, MO

Community Health Needs

3. Thinking about the [community identified above], please rate your level of concern about each of these health needs on a scale 1 (low concern) to 5 (high concern).

Accidents/injuries

Alcohol Abuse

Cancer

Dental Care

Diabetes

Drug abuse
Heart health
High blood pressure
Immunizations/Infectious Dx
Maternal/infant health
Mental health
Obesity
Reproductive/sexual health
Respiratory Diseases (Allergies, Asthma, COPD)
Stroke
Tobacco use

Collaboration around Community Health Needs

4. Thinking about [community identified above], how would you rate the potential of community partners to work together to address each of these health needs. Please rate each on a scale 1 (little potential) – 5 (significant potential).

Accidents/injuries
Alcohol Abuse
Cancer
Dental Care
Diabetes
Drug abuse
Heart health
High blood pressure
Immunizations/Infectious Dx
Maternal/infant health
Mental health
Obesity
Reproductive/sexual health
Respiratory Diseases (Allergies, Asthma, COPD)
Stroke
Tobacco use

Barriers to Accessing Health Services

5. How impactful are each of the following barriers to accessing health care among the populations you serve? Rate on a scale of 1 (little impact) – 5 (significant impact).

Cultural/language barriers
Difficulty obtaining medications
Fear (of doctors/health providers; not ready to address health issues)
Health literacy (e.g. don't understand how to access services or health instructions)

Lack of health care services nearby
Lack of insurance coverage/insurance not accepted
Scheduling services is difficult
Unable to pay co-pays/deductibles

Populations at Risk

6. Among the audiences you serve, which of the following populations are most at risk? Identify up to five.

Infants (age <5)
Children (ages 6 - 12)
Teenagers (13 - 18)
Young adults (19 - 24)
Older adults (65+)
Homeless
Immigrants
LGBTQ
Low-income populations
People with disabilities
Pregnant women
Refugees
Specific racial/ethnic group(s)
Those suffering from substance abuse
Unemployed
Veterans
Victims of violence

Impact of Social Factors

7. Which of the following social factors have historically had the greatest impact on the health of the communities you serve? Pick the top five.

Access to affordable healthy food
Access to good schools
Child-care services
Discrimination, including racism
Eldercare services
Environmental issues affecting including clean air, water
Food insecurity
Good paying jobs
Good schools
Poverty
Recreational locations within the community
Safe community (low crime, violence)

Safe, affordable housing
Social isolation
Transportation

Impact of COVID-19

8. Thinking about the COVID-19 pandemic and its impact on [the geographic region], which of the following have had the greatest impact on the health of the community as a whole? Pick the top three.

Difficulty managing home schooling???

Increased stress and anxiety

Difficulty access health services

Difficulty accessing childcare

Difficulty accessing healthy food

Difficulty caring for elderly, disabled

Increased feelings of loneliness and social isolation

Loss of community members

Loss of household income

Loss of housing

Overall financial hardship

9. What are the biggest gaps within this community to address any of the needs that you have identified?

10. What new health issues are you aware of in this community that may not be widely known, yet are a concern for the future?

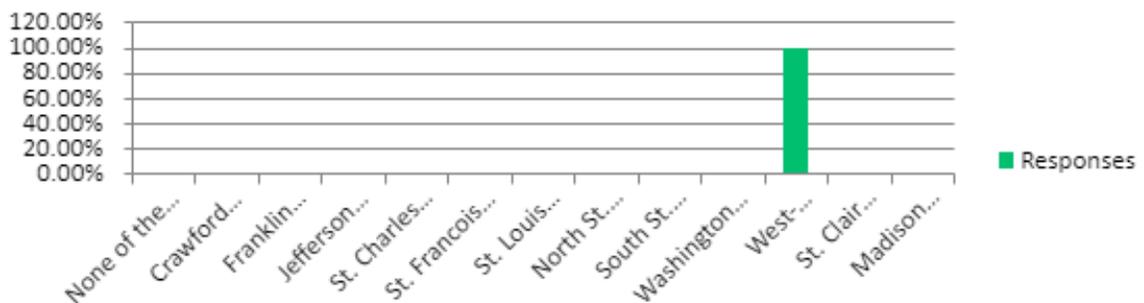
11. Think about health assets or resources as people, institutions, services, supports, built resources (i.e. parks) or natural resources that promote a culture of health. What are the most important health assets or resources within [this geography]?

12. How can all community stakeholders work together to use their collective strength to improve the health of [geographic area]?

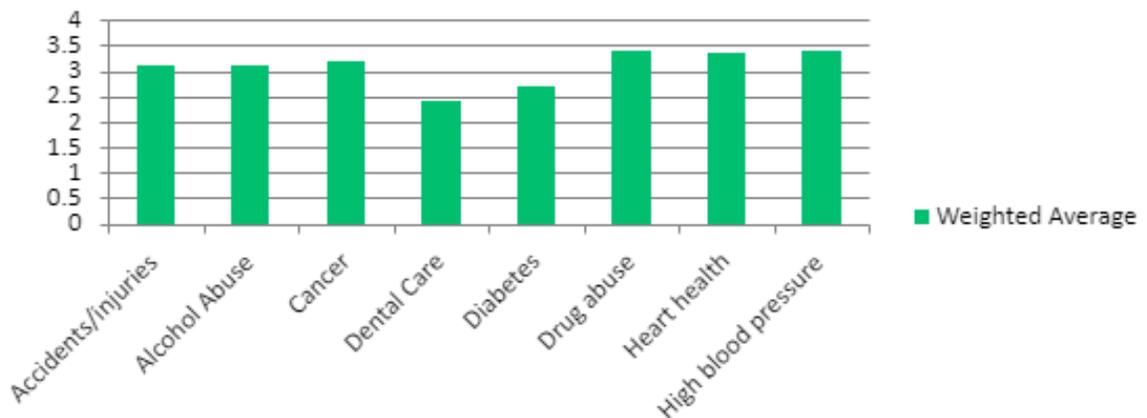
Stakeholder Survey Results

West County

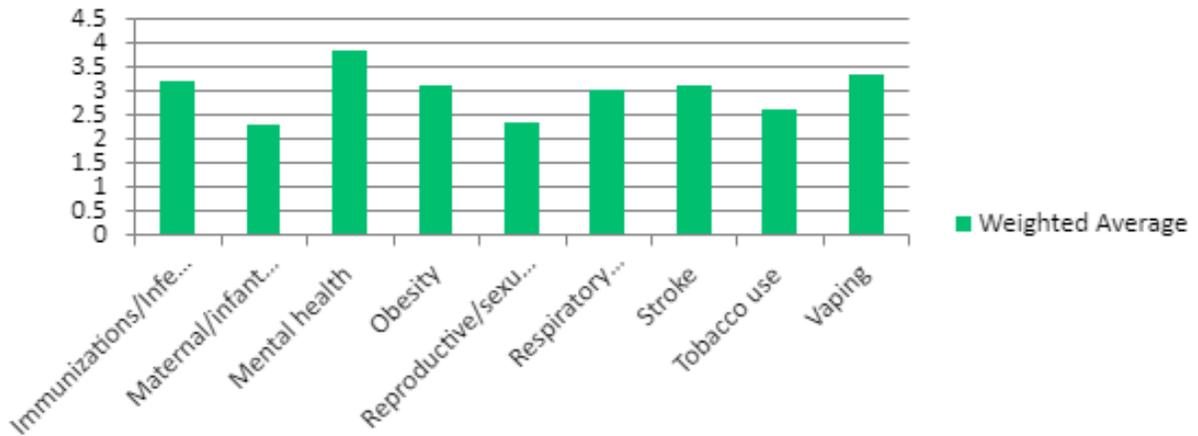
For this survey, what part of the St. Louis region do your responses represent? Please select only one response. If your organization covers more than one geographic area, please fill out/have a colleague fill out a...



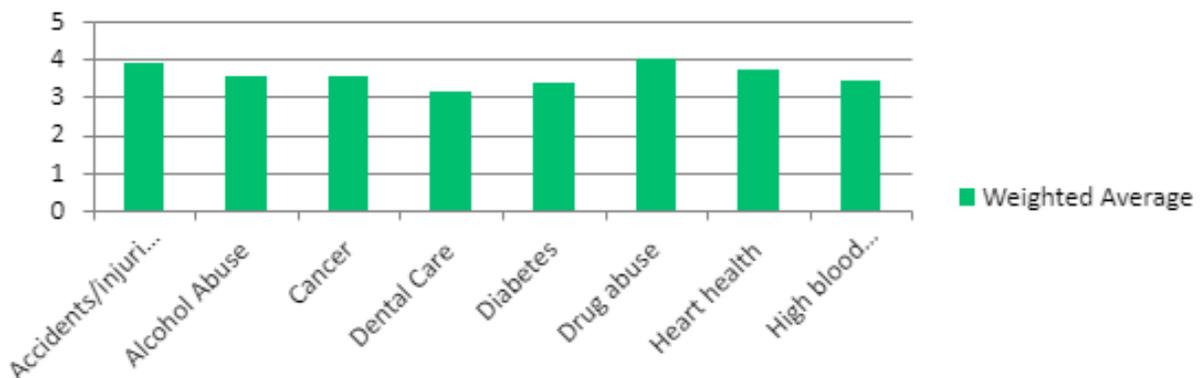
Thinking about {{ Q2 }}, please rate your level of concern about each of these health needs on a scale 1 (little concern) to 5 (significant concern).



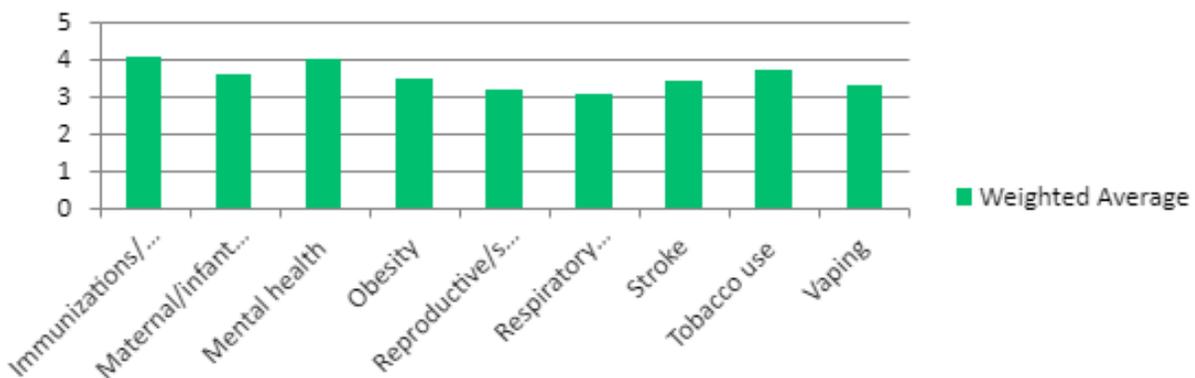
Thinking about {{ Q2 }}, please rate your level of concern about each of these health needs on a scale 1 (little concern) to 5 (significant concern).



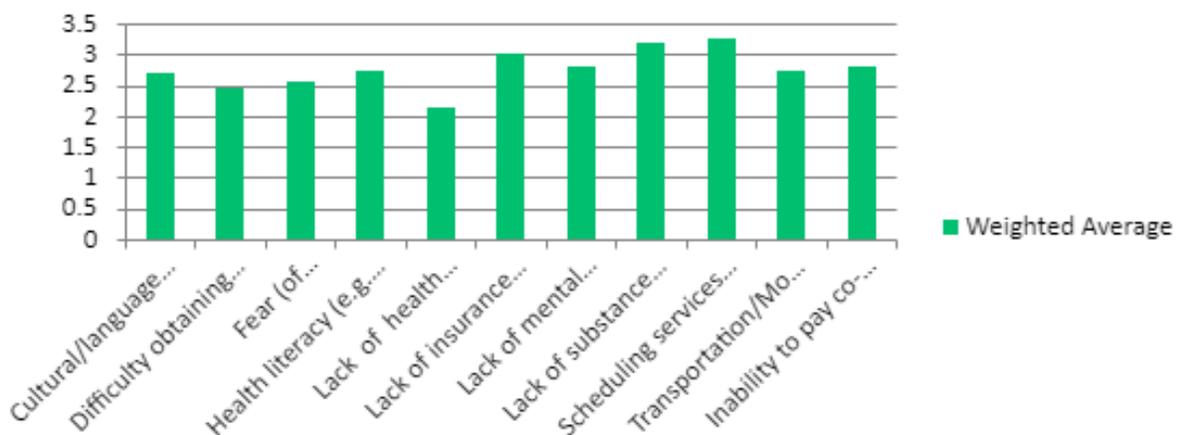
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



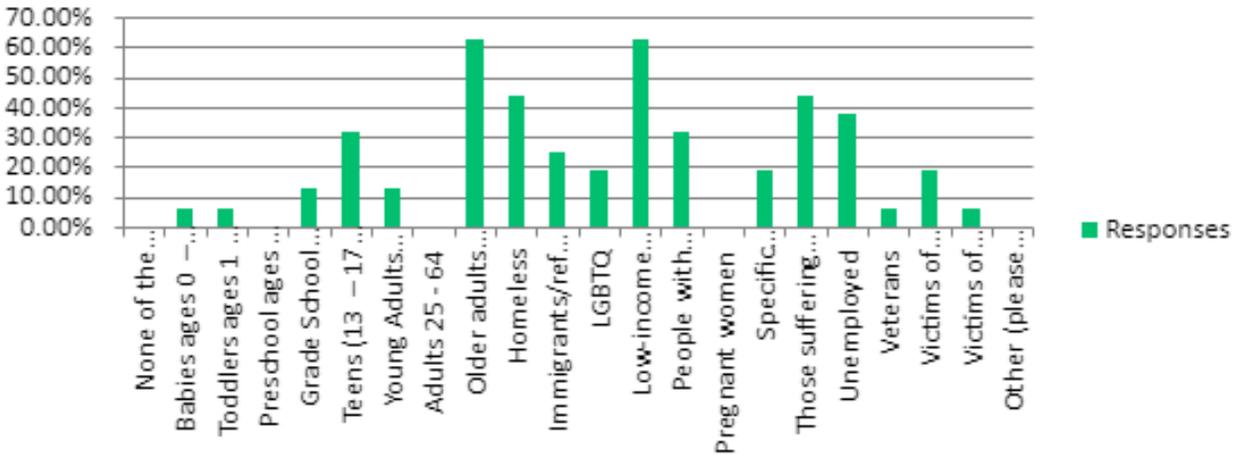
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



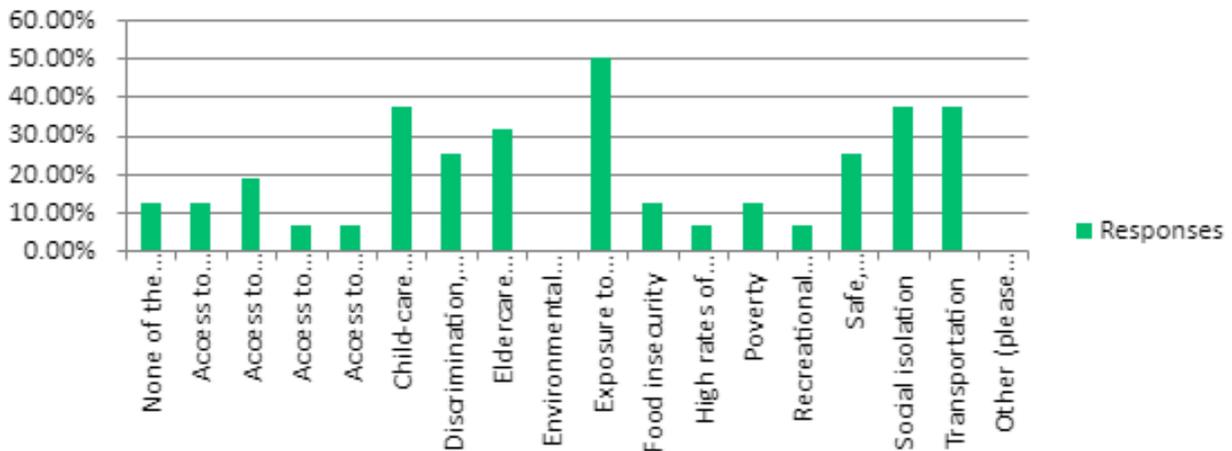
How impactful are each of the following barriers in {{ Q2 }} to accessing health care? Rate each on a scale of 1 (little impact) – 5 (significant impact).



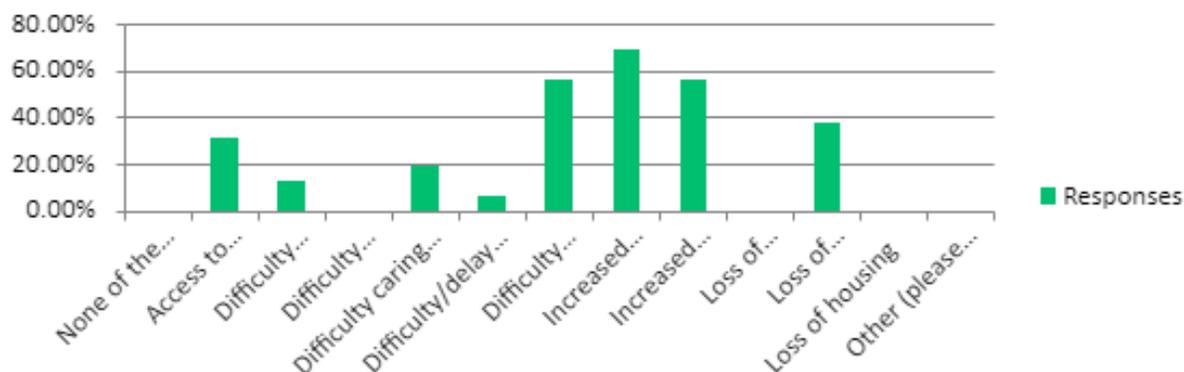
Among those you serve in {{ Q2 }}, which of the following populations are most at risk for poor health outcomes? Pick no more than five.



Which of the following social factors have historically had the greatest impact on the health of the communities you serve in {{ Q2 }}? Pick no more than five.



Thinking about the COVID-19 pandemic and its impact on {{ Q2 }}, which of the following have had the greatest impact on the health of the community? Pick no more than three.



What are the biggest gaps in resources within this community to address the needs that you have identified? Please mention the need along with the missing resources.

- Connection to larger equity issues and being part of efforts to address disparities in the region and make it an equitable region for all.
- I do not feel qualified to address this issue
- Transportation for the elderly.
- Income
- Dental services- accessing AFFORDABLE dental services is a huge need we see. Clients cannot afford to fix painful, and problematic issues with their teeth, which then lead to financial and physical hardship.
- Housing- affordable housing is west St. louis county is non-existent. And the requirements to rent at some locations (apartments or homes) are unrealistic ([i.e.](#) "income must be 4Xs the rent" or "750 credit score required" "no previous evictions"). This leaves a subset population "unrentable" even if they could afford it.
- Food available for all
- Mental health resources are available, however appointments are often a long wait
- Access to mental health care that is substantial. We encounter individuals on a recurring basis.
- Substance use prevention
- I feel like the ability and capacity of mental health resources could be better. Mercy & Highland Center seem overtaxed. BJC downtown seems to have the best program (in partnership with Wash U)
- Mental health services
- There is little in the way of affordable housing within this community; the current housing market has worsened this situation considerably. When families are forced to spend more than they can comfortably afford for housing, they become unable to afford other items such as appropriate medical care and food.

What new/additional health or social issues are you aware of in this community that may not be widely known, yet are a concern for the future?

- Substance use and mental health disparities; this community is part of the larger St. Louis community and need to play a significant role in lifting others in our community.
- I do not feel qualified to address this issue
- Care for the elderly
- We desperately need affordable housing, and landlords who are willing to rent to folks without perfect renting history.
- We also desperately need affordable healthcare. We have client who put small issues off so long (out of fear of price) that they become bigger (and even more dangerous/expensive) health issues.
- Human trafficking
- I think the impact of COVID 19, the isolation, the schools shutting down, the frequent quarantines for some will have far reaching mental/social health impacts for years to come.
- New program related to those in mental health crisis, coordinated at DePaul Health Center, but not conveniently located.
- Mental health concerns as well as an increase in substance use

Think about health assets or resources as people, institutions, services, supports, built resources (i.e. parks) or natural resources that promote a culture of health. What are the health assets or resources in Q2 that we may not be aware of?

- I feel you are already aware of the great benefit of being outside and promoting all parks and trails in this area.
- We refer to the free or sliding scale fee clinics at the local universities very frequently, and we get really good feedback from clients regarding these services.
- We also have a really great network of Saint Vincent De Paul Societies in the West St Louis County area. They are a huge help to our clients.
- Outstanding urgent care
- Police and fire districts work well together. Getting individuals to resources is time consuming.
- NAMI, BHR
- We have a lot of amazing green spaces which could be better utilized for free or low-cost programming such as community vegetable gardens, outdoor education, and conservation.

How can community stakeholders in Q2 work together to use their collective strengths to improve the health of the community?

- Work with regional partners, share resources, work as a cohesive region
- Being supportive each of other and willing to share the wealth of knowledge that exists in this area.
- Bettering the communication
- community stakeholders need to continue strengthening what they are good at and communicating those services to the broad public on multiple platforms.
- Vote in policy-makers who prioritize people over profit.
- Covid was a good example of collaboration expand to other issues
- We have many hospitals in the area, the resources exist already.
- Provide opportunities for agencies to share their resources with the community.
- Partnerships can be quite effective in addressing gaps in service or other concerns but it often takes leadership from the outside to help organizations envision some of those partnerships.
- Social media and print media campaigns
- Speakers in schools and high schools
- Speakers for parents groups
- Health care providers who typically do not accept Medicaid or ACA plans should start accepting these plans. There need to be more federally funded mental health providers to meet the tremendous need for these services. And excellent childcare that is available on a sliding scale basis is also needed.]

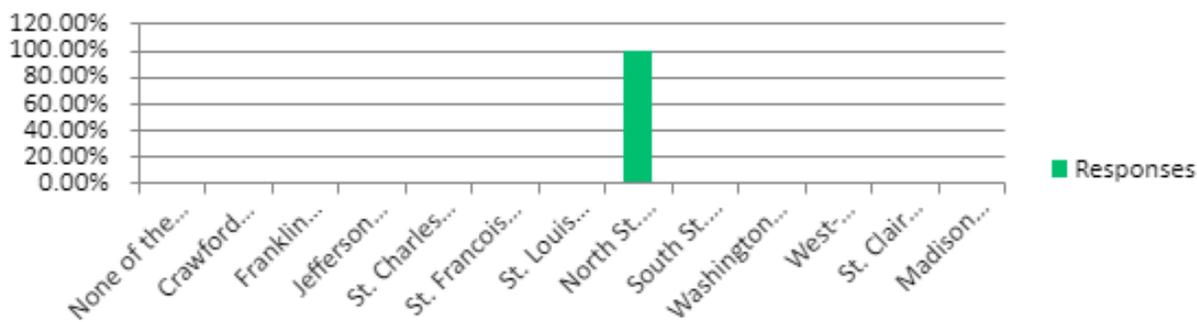
Within the Q2, which communities, neighborhoods or ZIP codes are especially vulnerable or at risk?

- 63088, 63069, 63146
- 63088, 63021, 63011, 63026, 63141, 63146, 63043
- Closer to city areas
- Eureka area, far west county toward Franklin County.
- 63132, 63146
- 63025
- 63121
- 63122
- 63131
- 63141

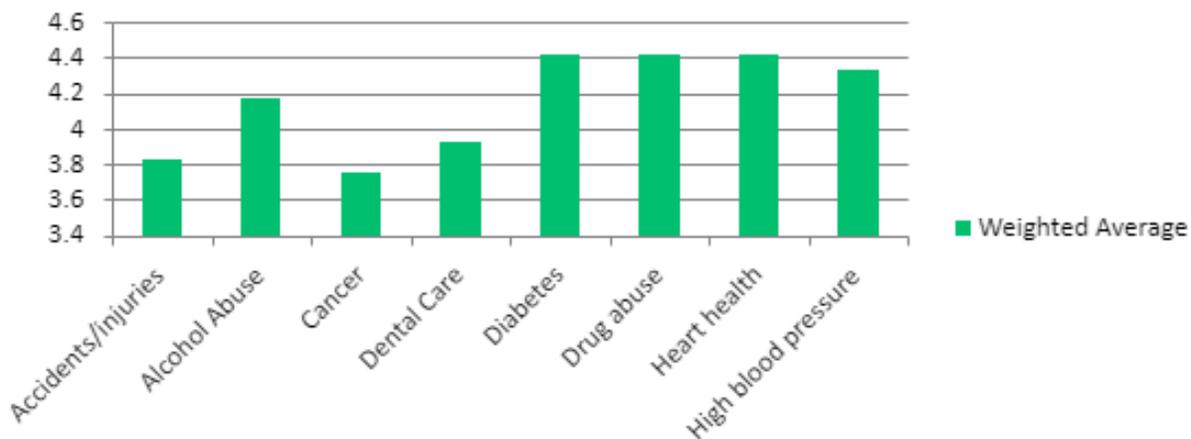
Stakeholder Survey Results

North County

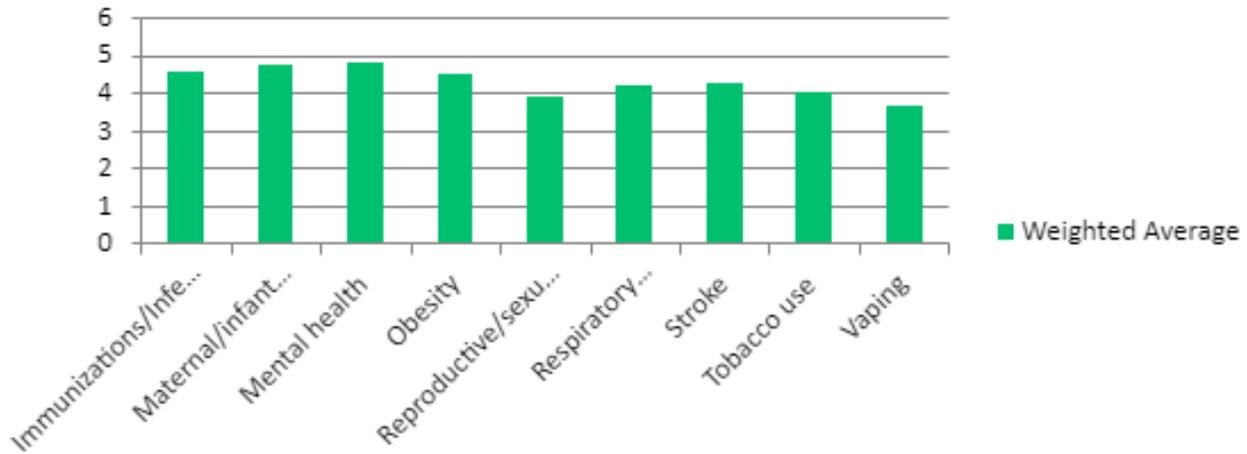
For this survey, what part of the St. Louis region do your responses represent? Please select only one response. If your organization covers more than one geographic area, please fill out/have a colleague fill out a...



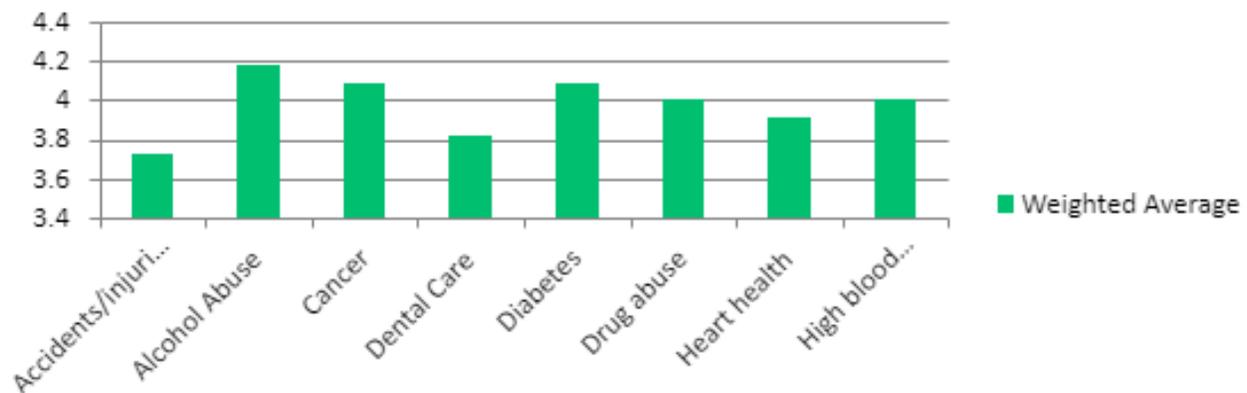
Thinking about {{ Q2 }}, please rate your level of concern about each of these health needs on a scale 1 (little concern) to 5 (significant concern).



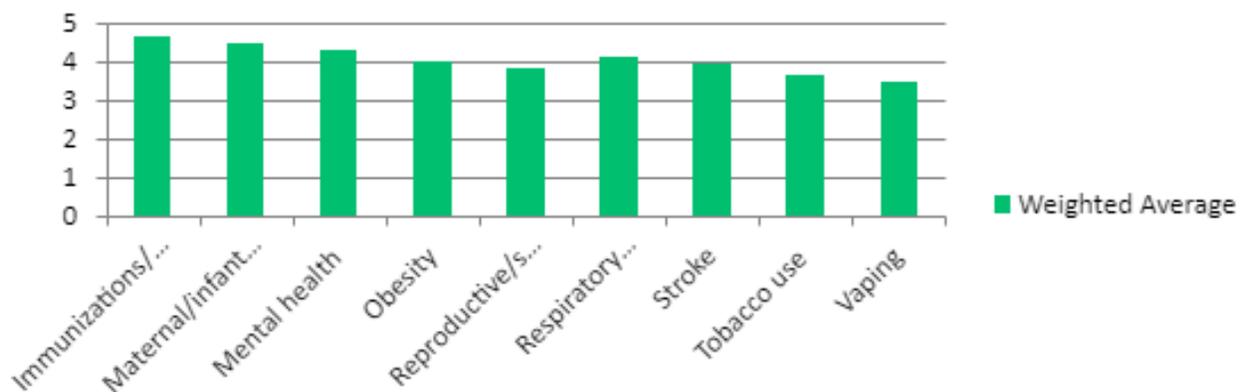
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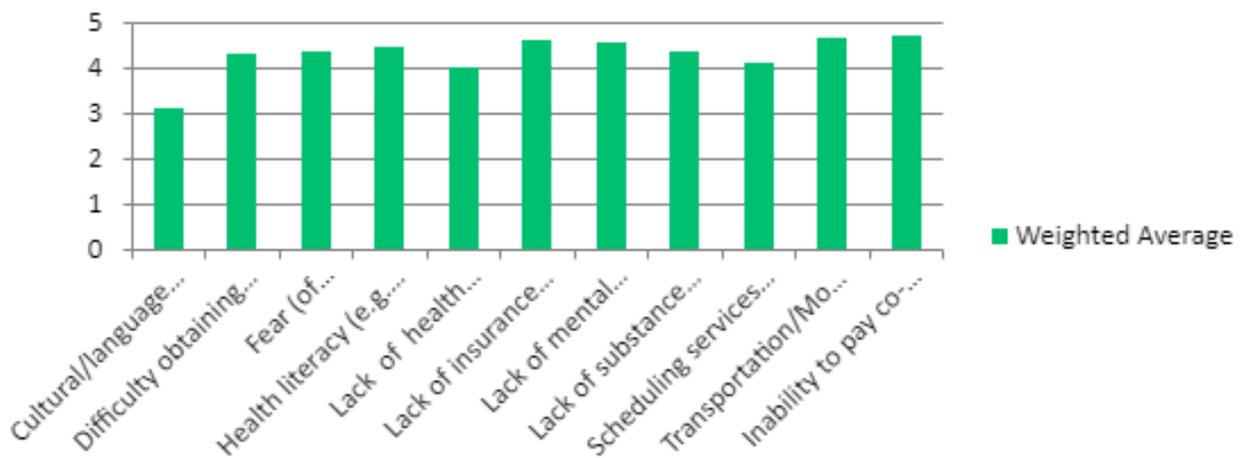
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



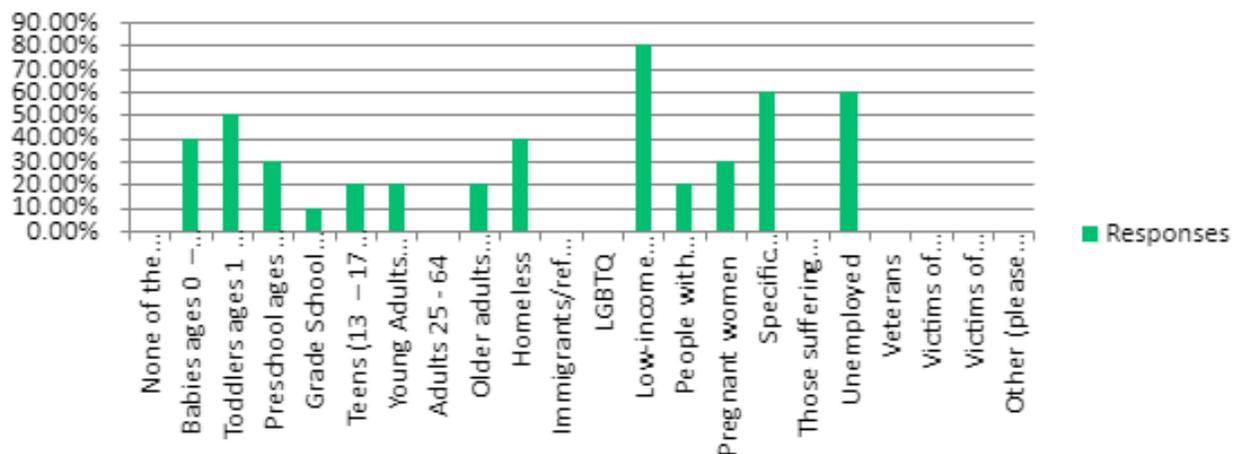
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



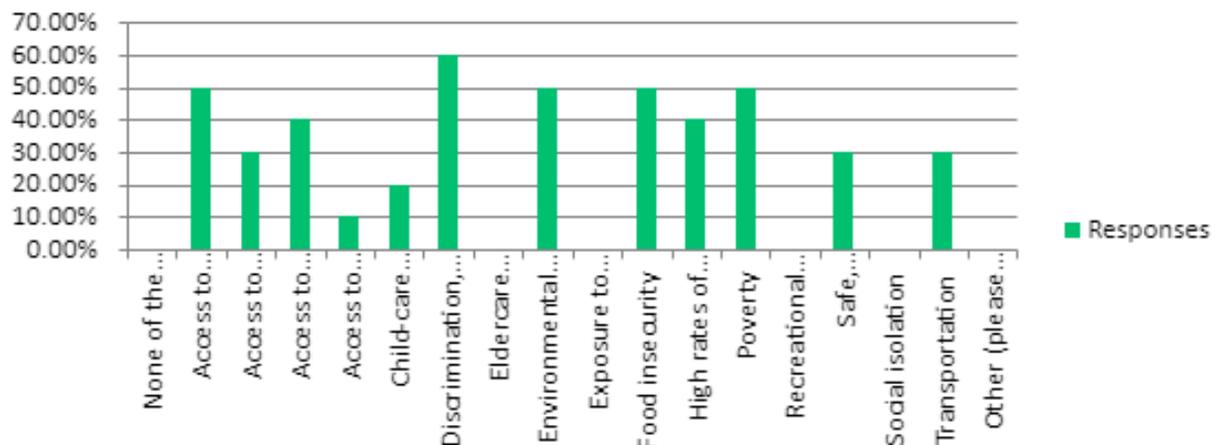
How impactful are each of the following barriers in {{ Q2 }} to accessing health care? Rate each on a scale of 1 (little impact) – 5 (significant impact).



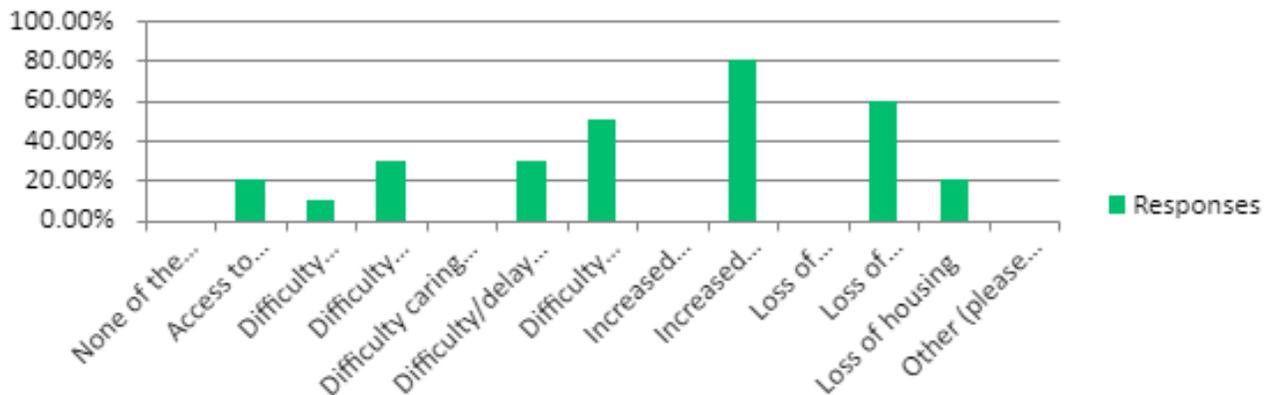
Among those you serve in {{ Q2 }}, which of the following populations are most at risk for poor health outcomes? Pick no more than five.



Which of the following social factors have historically had the greatest impact on the health of the communities you serve in {{ Q2 }}? Pick no more than five.



Thinking about the COVID-19 pandemic and its impact on {{ Q2 }}, which of the following have had the greatest impact on the health of the community? Pick no more than three.



What are the biggest gaps in resources within this community to address the needs that you have identified? Please mention the need along with the missing resources.

- Home repairs and the significant financial resources needs to maintain homes in the community. Older adults no longer have a steady/replenishing or increasing income to handle the eventual mishaps and catastrophes encountered in owning a home.
- Partnerships and Resources for community organizations already available
- Trusting healthcare providers to provide information, access to care, and insurance policies to cover their needs.
- Food deserts in some pockets of STL North County - Access to healthy food
- Things for Adolescents to do (especially during the pandemic) - Community Centers or Recreation Centers
- Mental health services (especially during pandemic) - Help with dealing with isolation, anxiety, and depression
- Affordable housing- Finding well-paying occupations to help with rising rent and mortgages
- In-home services to address asthma education and environmental assessments (IAQ) to identify the asthma triggers in the home
- Support for those with food allergies that are also food insecure

What new/additional health or social issues are you aware of in this community that may not be widely known, yet are a concern for the future?

- The rising cost of renting properties is a concern. A reduction in church or religious participation for additional financial assistance outside of social service agencies.
- School closings, childcare facilities not available, and school-based health facilities on site.
- Mental Health for children and adolescents during the pandemic
- Mental health techniques for Managing and Navigating social media for teens and adolescents
- Affordable housing
- The high incidence of asthma in African American children and poor housing (substandard). In addition, the need for housing codes to support the health and safety of renters e.g., like what has been implemented in the Kansas City.

Think about health assets or resources as people, institutions, services, supports, built resources (i.e., parks) or natural resources that promote a culture of health. What are the health assets or resources in {{Q2}} that we may not be aware of?

- The library continues to be a major resource to the community for information, supplies and community involvement. The St louis county parks and municipality recreation centers.
- Churches, school-based health, and community.
- Working in collaboration with community partners to address health issues collectively is greater than working in silos. For example, utilizing the schools with health centers as a resource provides another opportunity to effectively address the school-aged group

How can community stakeholders in {{Q2}} work together to use their collective strengths to improve the health of the community?

- Create a free basic care substation.
- Identify how their work can complement are act as a resource with others.
- Access to care placed in a directory. Community meetings
- Collaboration among organizations for systemic changes

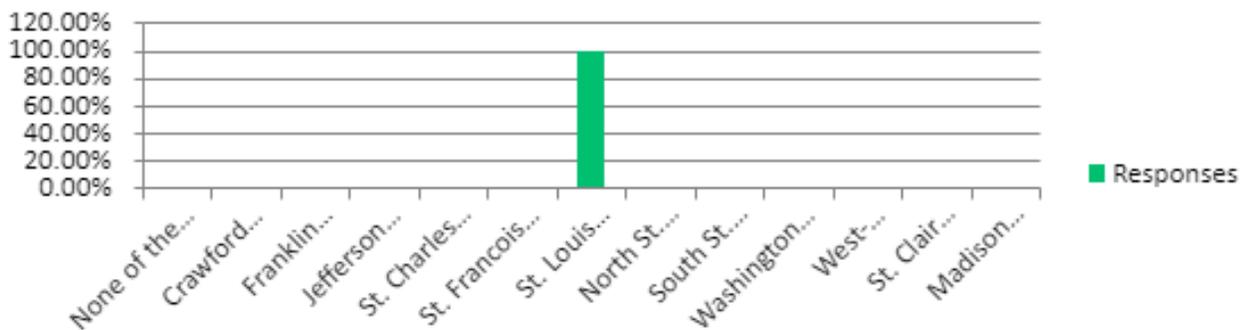
Within the {{Q2}}, which communities, neighborhoods or ZIP codes are especially vulnerable or at risk?

- 63136, 63135
- Normandy, Jennings, Ferguson, and Pine Lawn.
- Promise Zone communities.

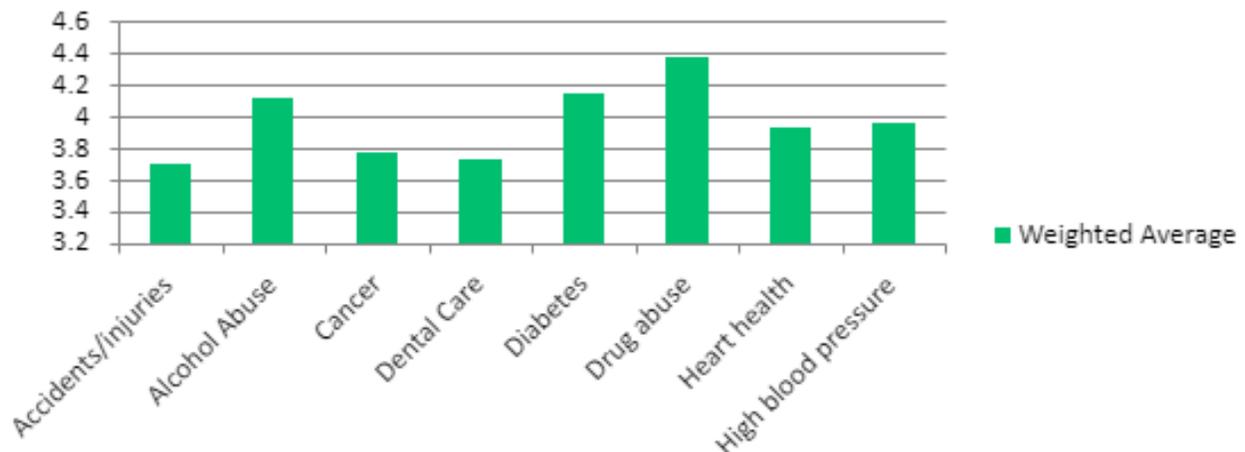
Stakeholder Survey Results

St. Louis City

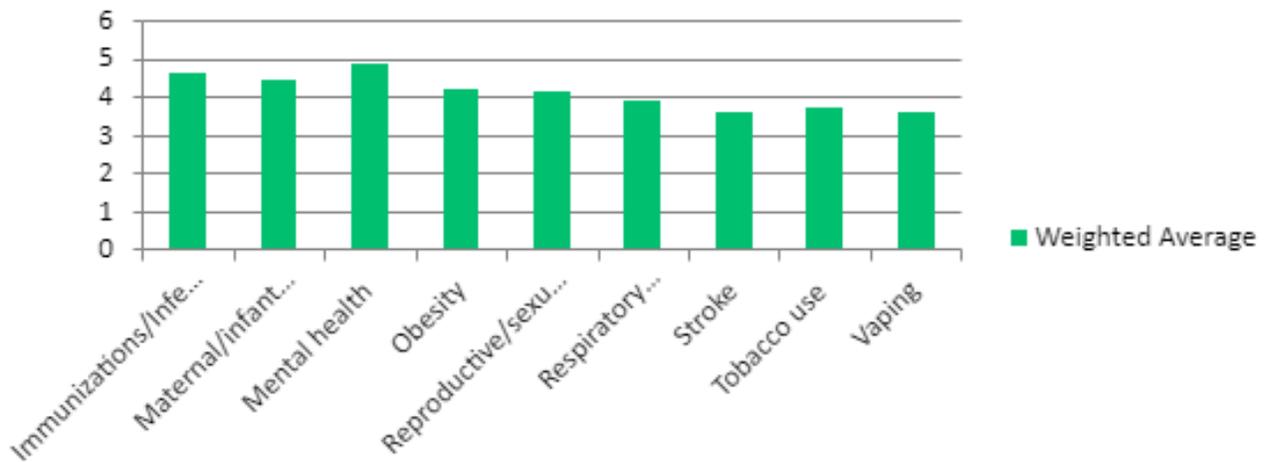
For this survey, what part of the St. Louis region do your responses represent? Please select only one response. If your organization covers more than one geographic area, please fill out/have a colleague fill out a...



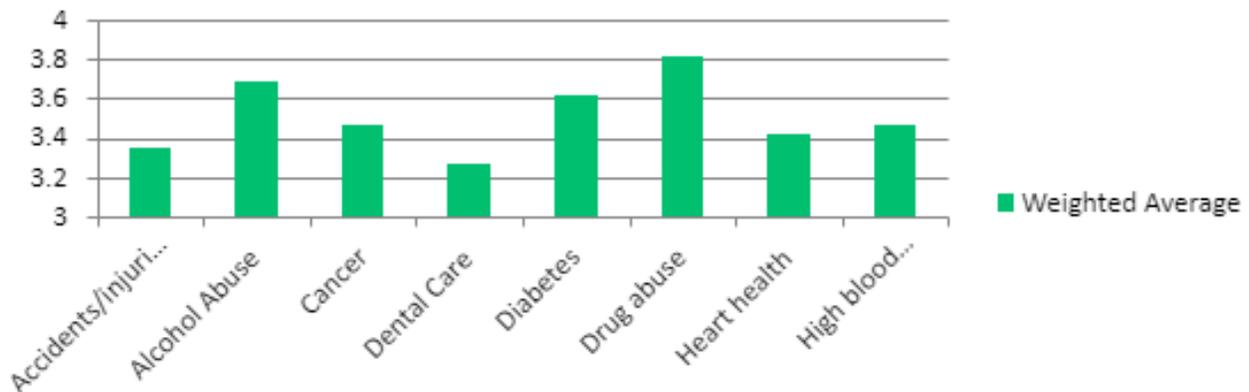
Thinking about {{ Q2 }}, please rate your level of concern about each of these health needs on a scale 1 (little concern) to 5 (significant concern).



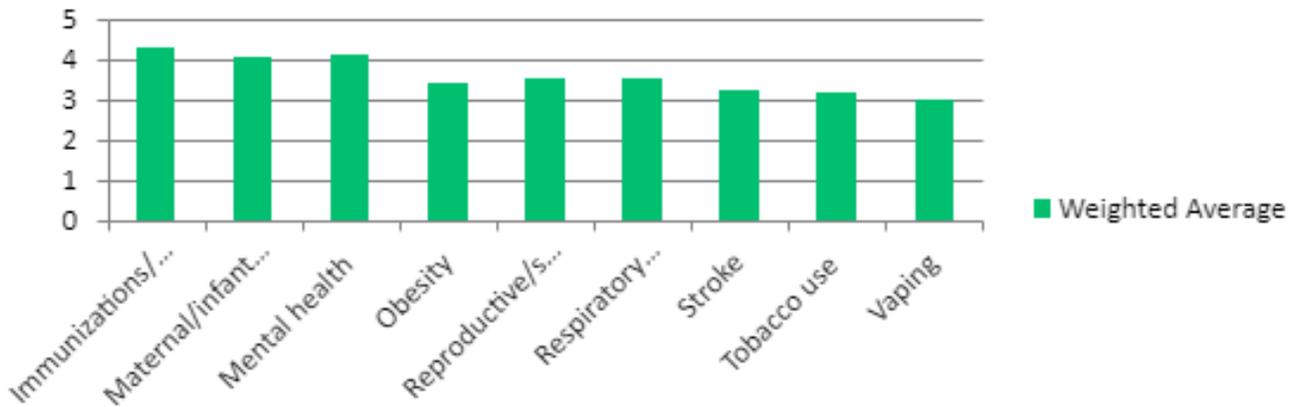
Thinking about {{ Q2 }}, please rate your level of concern about each of these health needs on a scale 1 (little concern) to 5 (significant concern).



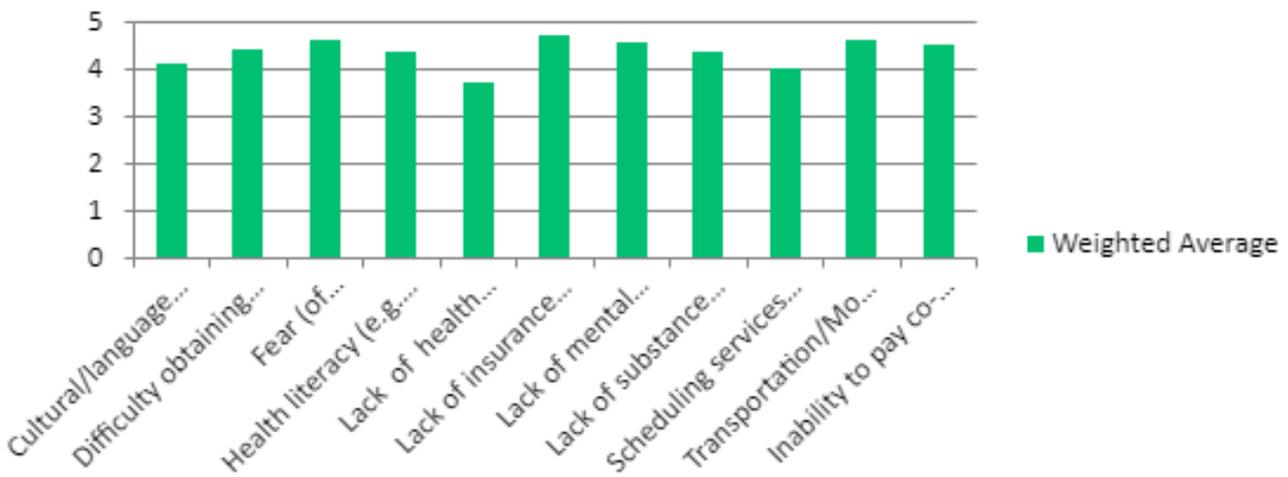
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



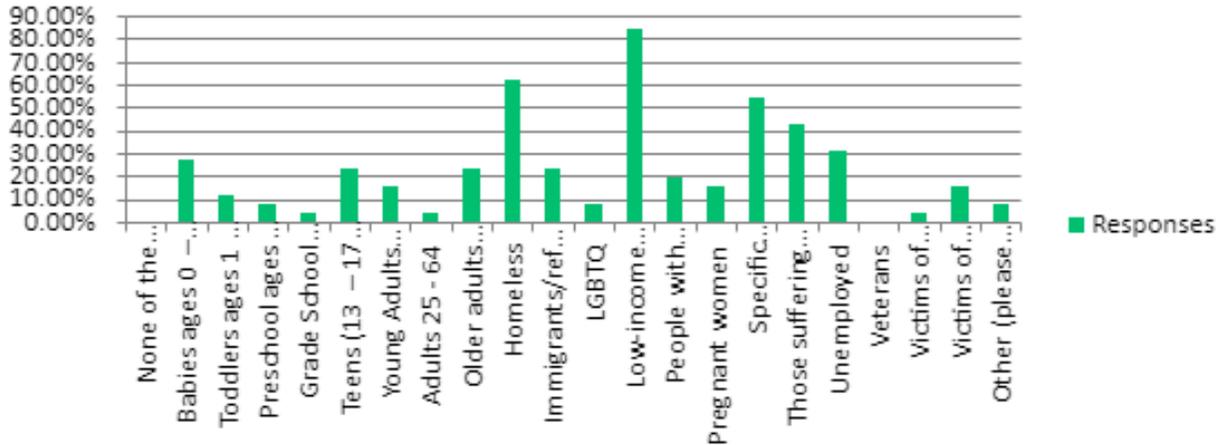
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



How impactful are each of the following barriers in {{ Q2 }} to accessing health care? Rate each on a scale of 1 (little impact) – 5 (significant impact).

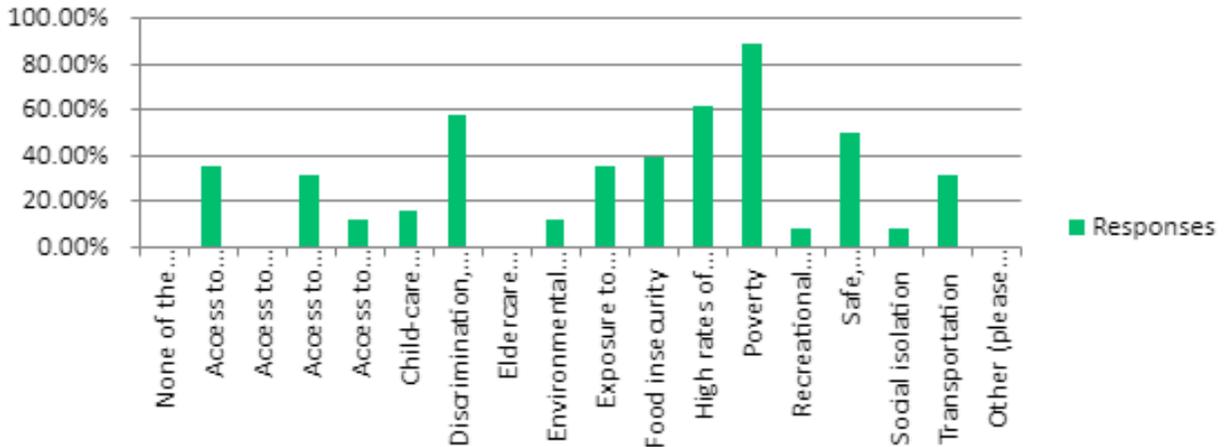


Among those you serve in {{ Q2 }}, which of the following populations are most at risk for poor health outcomes? Pick no more than five.

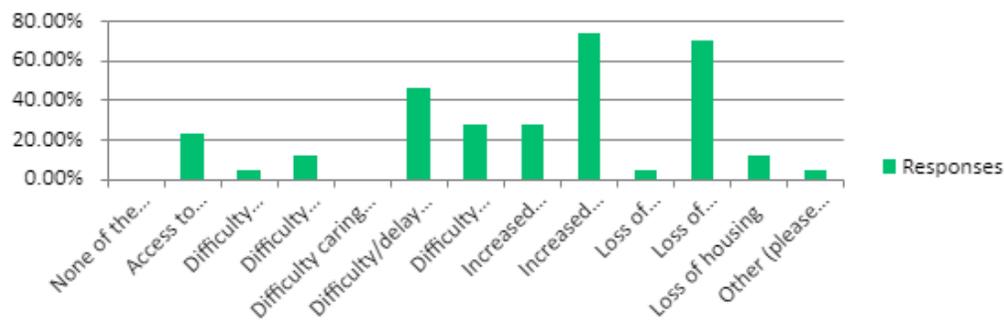


Respondents	Response Date	Other (please specify)	Tags
	1 Jun 22 2021	Uninsured or underinsured	
	2 Jun 22 2021	(People of Color	

Which of the following social factors have historically had the greatest impact on the health of the communities you serve in {{ Q2 }}? Pick no more than five.



Thinking about the COVID-19 pandemic and its impact on {{ Q2 }}, which of the following have had the greatest impact on the health of the community? Pick no more than three.



Respondents

Response Date

Other (please specify)

Tags

1 Jun 28 2021

(Lack of trust/confidence in "the system")

What are the biggest gaps in resources within this community to address the needs that you have identified? Please mention the need along with the missing resources.

- School located clinics- Health services in the evening and on weekends and located in the communities-
- Culturally and linguistically competent care, especially for under and uninsured immigrants.
- Housing- transportation- internet services-
- The greatest issue is employment connections for those with minimal education to marketplace needs.
- Adequate transportation, housing, and access to healthy food.
- Medicaid Expansion will continue to leave many without health insurance so ERs will likely continue to bear the burden of health care for the uninsured. Opioid epidemic continues to be growing. Homelessness and lack of stable housing also continues to grow
- Mental health, alcohol, and substance abuse - treatment Behavioral Health Funding
- access to technology...phones in particular
- Implicit Bias and institutional racism's effect on overall individual health, and desire to be seen in a traditional medical setting.
- Living Wage jobs
- The generational poverty has created a sense of hopelessness and isolation. Investments in neighborhoods that have not received these investments in decades is critical to break these cycles. It will require layers of investments, not just from hospitals, but others as well.
- Un- and underemployment. Lack of available and accessible jobs
- lack of fiscal support for pre-admission outreach of vulnerable patients who need to transition from acute care (hospital) usage to ongoing community care, particularly for mental health and substance use services
- Coordination across service and inclusion of varied partners contributes significantly to all areas of resource gap across the City of St. Louis region. The same players get most of the resources and maintain power to choose which partners to work with. New partners are often not included.

- Difficulty managing remote learning – digital gap access to Wi-Fi and tools; also packed housing with lots of people in the household. If parent(s) able to find work, no one there to assist/supervise and no childcare. 2) Depression, stress, and anxiety. I don't know anyone who is feeling joyful. Lives have been turned upside down, people are isolated, jobs lost, people dying or folks not believing COVID is real, mixed messages and untruths. These populations already have enough trauma without the addition of COVID uncertainties. 3) Loss of household income/overall financial hardship. Essential workers, who tend to be our more vulnerable populations that are least able to "weather" these circumstances, are losing retail, restaurant, hospitality, etc. jobs that cannot be performed remotely. This subjects them to job losses and requirements of quarantining because they cannot avoid close personal contact.
- Areas within the city without access to good services and/or transportation to get there
- Coordinated care planning for those with multiple barriers/social determinants of health.
- The political divide between politicians across the lines.
- Gaps in resources are referral coordination among agencies, transportation coordination for residents in needs of different healthcare services.
- Resource: insurance coverage -Lack of Health Insurance, Grocery stores -Lack of affordable access to healthy food
- Better jobs and sources of income - Poverty limiting transportation and money for healthcare copays and stable housing

What new/additional health or social issues are you aware of in this community that may not be widely known, yet are a concern for the future?

- Mostly pre-existing social determinants of health, exacerbated by COVID. I would say that it's probably well known (maybe not?) that some of our youths will find it difficult to catch up on lost learning opportunities during their lifetimes. Greater levels of mistrust are brewing. Disparities between "haves" and "have nots" are increasing.
- The rate of disability in people of working age is very high. A lot of this may be preventable if the causes are diabetes, obesity, strokes, injuries from violence or unsafe housing, and other preventable causes
- I do see a need for culturally congruent and patient centered care. Understanding racial and health inequities. Reproductive justice for pregnant and parenting people- essentially perinatal care and not just prenatal care.
- The prevalence of alcoholism and drug use and the effects on families and the community is grossly underreported.
- Significant staffing challenges: we cannot hire all the staff needed and meet the required credentials
- Mental health, particularly community trauma, is a critical issue. Many people don't discuss or recognize the problem, nor seek treatment.
- Young people do not have safe places for fun and recreation. This added to the isolation of COVID is a recipe for increased depression and anxiety.
- Not new but Covid showed the need for increased mental health services
- The income gap is widening at a tremendous rate
- Despite the focus on health literacy that created Health Literacy Missouri (now Health Literacy Media, HLM) over a decade ago, efforts to integrate health literacy into health and social related activities are limited in the St. Louis region. Despite maintaining our base of operations in downtown St. Louis, the significant majority of our work is outside the city/state. Health literacy is not yet a priority and impacts the full spectrum of health and social concerns across populations and the lifespan.
- Access to Technology for school learning support
- Mental Health Needs of our Children as they return to school after COVID isolation and substandard learning for the past year. Very concerned about pre-K - 3rd grades and middle school/high school students
- Culturally and linguistically competent mental health care
- violence- child abuse and neglect-
- The lack of affordable house and subsidized housing is a key contributor to individuals' poor health outcomes
- maternal and child health...not new but may not be large focus now
- Housing and available healthy food sources of a wide variety.

Think about health assets or resources as people, institutions, services, supports, built resources (i.e., parks) or natural resources that promote a culture of health. What are the health assets or resources in {{Q2}} that we may not be aware of?

- There are too many to recount. I suspect you know most, if not all, of them. However, I would point out the significance of "non-medical professionals" for improved healthcare and public health: Peer Supports, Community Health Workers, Promotores, Doulas. The more we train, utilize, and compensate these non-medical professionals with deep roots in community, the better our health results will likely be. Engaging people in their health preservation prior to illness, the healthier our communities will be. Professionals in all other disciplines – non-medical – are essential assets for assuring health. Health in all policies, so that we don't have to constantly work around existing policies that are not healthful through massive healthcare interventions on the back end seem like great assets as well.
- Faith based organizations. Small businesses.
- Neighborhood councils, community development orgs, yoga/smaller exercise groups/studios
- St. Louis has very low vaccination rates
- All communities have strength and resilience that should be celebrated. Even in areas of high poverty, investments in public art and cultural institutions can be healing.
- Food Pantries
- Our children are in schools/families must be connected with schools... so let's rethink the role of schools in offering school health and mental health services.
- city parks- support from churches- free care for kids at the Crisis Nursery!
- There needs to be more community health advocates. People who live in the community and can be entrusted, while being incentivized can have a more effective impact.
- Safe and available outdoor spaces to walk, run, and general healthy movement.
- Behavioral Health Network as a planning / coordinating body to support the "safety-net" of mental health and substance use services for un/under-insured persons
- our ability to coordinate our efforts as a community...we need specific convener to bridge the gaps

How can community stakeholders in {{Q2}} work together to use their collective strengths to improve the health of the community?

- Share data and information while protecting privacy/confidentiality; Work for more for health and illness prevention rather than illness and healthcare intervention; Work collaboratively on social determinants of health that are often not viewed as the province of healthcare institutions and are often addressed in a disjointed, ineffective way; Seek racial truth telling and healing; Recognize that we are all in this together and work to help the most marginalized (which will help the marginalized, but will also help everyone); Share resources based on need (not equal or based on capacity to generate)
- Determine common goals and opportunities for cohesive/creative ways of communicating to directed audiences.
- This community historically has done a poor job of partnering and working together. That really needs to change if we are going to improve
- Form coalitions that represent regardless of race, color, creed, sexual orientation
- Expand the communication to resources preventing silos of supports-continued growth of mobile services, grow the school-based health centers supports

- Give residents decision-making authority about where investments should be made, and pair them with culturally responsive implementation teams to make the investments happen.
- recognize each other's strengths and share resources based on persons served not agencies - funding should follow the person
- Larger corporations and healthcare systems should financially support and partner with smaller grassroots non-profits who have direct connections with vulnerable populations - not just through grants/donations but through true supportive long-term partnerships
- Sharing the outcomes of this survey with all partners that have completed it would be a start, and a list of the organizations participating so they may connect for possible collaboration
- share the same information
- There is demonstrated benefit to coordinated and collective goals across the region and not siloed within organizations or providers. This region is too small to function alone or think people remain within one organization or health system
- Maybe it is time to step back, look at what we are doing...is it working, if not--- let's go in another direction.
- continue to fund programs that are getting great outcomes- not always looking for new programs-
- There must be a collective scorecard and shared vision. What are the goals that are measurable?
- Create focus groups composed of non-profit, corporate, government leaders and community members.
- Resources from the health care and corporate institutions commit to plan for developing a safe and productive community for low- and mixed-income families.
- We need a collective, response to support residents who are unhoused to gain safe, affordable housing
- Cooperation and open communication
- Break the silos and welcome new and different voices to the old, frequently stalled conversations.
- communicate efforts

Within the {{Q2}}, which communities, neighborhoods or ZIP codes are especially vulnerable or at risk?

- North St. Louis City and Southeast St. Louis City
- 63106, 63107
- 63106;63017;63103;63104;63118;63147
- North St Louis City and neighborhoods with increasing immigrants' communities.
- Low-income families of color, both in south and north St Louis, are especially vulnerable where crime and unemployment rates are high.
- 63102, 63106, 63107 63122, 63113, 63115, 63120 and 63147
- 63102, 63106, 63107, 63113, 63115
- North city and pockets of south city
- North City and South City
- North city is always listed however there is growing areas of need in South city as well
- 63135
- North St. Louis
- North county
- 63106, 63107, 63112, 63115, and the entire north St. Louis City.
- Note the following zip codes: 63147, 63120, 63107, 63112, 63113m 63106, and 63111.
- North ST Louis City- but really everywhere! Nowhere is safe for our children -

Appendix F

Ferguson Community Focus Group 2022

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Focus Group Summary

Ferguson Community Advisory Council

Conducted January 21, 2022
Webex



Your life is our life's work.

Participants

- Facilitator: Megan Drissell, Director of Community Health and Access, Mercy Hospital St. Louis
- Scribe: Ebony Street, Manager of Community Health and Access, Mercy Hospital St. Louis

- Dr. Art McCoy, PhD, Regional Business Council
- Gigi MacMullan, Refuge and Restoration Nonprofit, Dellwood
- Jason Acklin, Director of Operations, Salvation Army, Ferguson
- Mayor Ella Jones, Mayor of the City of Ferguson,
- Naquittia Noah, Councilperson for 3rd Ward of Ferguson
- Rebecca Zoll, President and CEO of North County Inc. Regional Development Association
- Jennifer Derner, Manager of Ambulatory Social Work for Mercy Clinic Outpatient Care Management
- *Katie Rayfield, Community Engagement Manager, East Region, Mercy*
- *Takisha Lovelace, Executive Director of Community Health Operations, Mercy*
- Sophia Easterling, Practice Manager, Mercy Clinics Ferguson and North St. Louis
- Joy Weidner, Cornerstone STL

Questions Asked:

1. How do you define a healthy community?
2. What things are present in this community that make it a healthy place to live or improve the quality of life of those that live and work here?
3. What issues are present in the community that make it difficult to be healthy or reduce the quality of life for those that live and work here?
4. Thinking about things that could be improved in order to be a healthy community, what do you see as the most urgent issues?
5. Are individuals able to access healthcare resources in the community?
 - a. Medical care
 - b. Dental care
 - c. Behavioral health
 - d. Substance use assessment/treatment
 - e. Pharmacy
6. What are the biggest barriers that keep people in the community from accessing resources? Are there some individuals who struggle to obtain access more than others?

Overall Themes



Q1: Defining a Healthy Community

- Collaboration and collective impact among organizations
- Positive quality of life for residents
- Safety from gun violence
- Well-maintained streets and sidewalks
- Neighborhood connectivity
- Mental health
- Positive relations with the police
- Capacity to solve disputes without police involvement
- Access to physical, mental and financial assistance when needed
- Equitable distribution of resources
- Equity in home ownership business ownership
- Community-centered decision making and autonomy
- Quality education, food access, transportation, employment, recreation and health care
- All social determinants of health are addressed
- Community engagement

“Excellent **collaborations**
among different
organizations
to address the **needs**
of the community.”

Click to add text

Q2: Community Strengths

- Strong leadership
- Grassroots organizations and outreach
 - There are people committed to outreach and connecting people to the resources available
 - Door-to-door approach
- Increase in resource availability in the past decade
- More organizations are aware that they should be in the community
- Demographics:
 - Great age range in Ferguson
 - Mix of people born and raised in Ferguson and new people moving in
- Decent employment
- Housing availability – houses have good bones and are affordable
- Access to resources: universities, businesses, social services, highways and public transportation
- Justice and police reform
- Quality parks

**“You have access to Mercy,
the Salvation Army, to Urban League,
to the highways,
to the Metrolink/Bi-state bus,
so decent access to transportation
and organizations all within.”**

Q3: Community Challenges

- Food access:
 - Grocery stores and quality of produce (not equitable across region)
 - Nonprofits bringing fresh food in from local growers, but need ongoing support/investment
- Violence & Safety:
 - Residents are afraid to take walks, spend time in parks due to gun violence
 - Domestic violence increasing
- Behavioral health:
 - Mental health and social work support needed now more than ever
 - Pandemic has made issues worse
 - Social workers are needed for wraparound services
- Economic Development:
 - More business in community to hire local people to increase economic stability and viability
 - People are in need of quality jobs to support themselves and families with benefits

“When you go into the **grocery stores** in parts of North County, the **fresh produce** offering is not what you find in the same brand of grocery store in other places.”

Q4: Most Urgent Issues

- Health promotion:
 - Many of the issues faced by the community require proactive outreach, focus on education, prevention and health promotion
 - People lack time, resources, support to be healthy, especially for the working class
- Mental Health:
 - People are struggling, there is a real impact on this community
 - Most common referral from SW at Mercy's clinic is for behavioral health – there are not enough resources
 - Not only need resources to respond to crises, but to prevent a crises and support people day-to-day

**“Behavioral health
is a very significant need in the area.
There are not a lot of resources for that.
There just aren’t enough providers available,
or they have long waitlists to get in,
or there are insurance issues sometimes.”**

Q5: Healthcare Access

- Generally, there is a lack of mental health resources
- Access to dental care is an issue because of insurance coverage and access
 - Even with Medicaid, not everyone has dental coverage
 - Benefits not often provided by employers
- Healthcare navigation:
 - Community members can struggle to navigate the healthcare system just because of lack of education/understanding about appropriate level of care
 - Go to the hospital ED to be treated instead of an urgent care or primary care provider, and end up with a huge bill
 - There is a lack of awareness, but also coverage and transportation are factors

“Dental is an issue for some people. Even some people who receive Medicaid, if they're not at a certain age there are no dental benefits...there are major issues with people having access to dental care.”

Q6: Barriers & Equity

- Phone and Internet:
 - Many people who don't have phones because they can't afford it
 - Makes it difficult to connect with services, including their healthcare
 - Increasingly you need internet to access resources
- Transportation
 - Without easy access to transportation, more likely to end up at the hospital or miss a follow-up appointment for your health care
 - More difficult to get to the store or access the other things needed for day-to-day
 - True especially at night – transportation is more difficult

“I think **transportation** is a barrier, so sometimes **resources** may need to be placed **strategically** in the **neighborhood** where the **greater need** needs to be met.”

Ferguson Community Advisory Council

CHNA Focus Group

Transcript

1/21/2022

Roster:

Megan Drissell, Director of Community Health and Access, Mercy Hospital St. Louis

Dr. Art McCoy, PhD, Regional Business Council

Gigi MacMullan, Refuge and Restoration Nonprofit, Dellwood

Jason Acklin, Director of Operations, Salvation Army, Ferguson

Mayor Ella Jones, Mayor of the City of Ferguson,

Naquittia Noah, Councilperson for 3rd Ward of Ferguson

Rebecca Zoll, President and CEO of North County Inc. Regional Development Association

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Jennifer Derner, Manager of Ambulatory Social Work for Mercy Clinic Outpatient Care Management

Katie Rayfield, Community Engagement Manager, East Region, Mercy

Takisha Lovelace, Executive Director of Community Health Operations, Mercy

Sophia Easterling, Practice Manager, Mercy Clinics Ferguson and North St. Louis

Joy Weidner, Cornerstone STL

MD: Before we jump into the questions, we have ground rules for the focus group, which is always a little bit of a different experience online, but a lot of the common ground rules are the same. Generally, I will ask that everyone keep their mics muted when you are not speaking. This group is already so good at this already, I feel like we are being to become more familiar with existing in this online world. So just be mindful of your microphones and any background noise when you're not speaking.

We want to encourage good listening practices, so only one person speaking at a time just so that we can hear everybody. Um, again I think this group has been wonderful at taking turns and navigating this, but if we do need to go to hand-raising and I can call on folks, we can do that, but I don't expect that we'll need to.

We do want to hear everyone's ideas and opinions, there are no right or wrong answers, and we want all of your opinions, whether positive or negative. Please be honest, this feedback is important to, again, not only to what Mercy's strategy is in the community, but we coordinate with other community partners, and we all are trying to achieve this collective impact. So what you help us understand about the community will help us drive for regional efforts around health in St. Louis.

Um, I may have to move the discussion forward to respect everyone's time and make sure that we can hear from everyone and get to every question that we have in our time together. So, without further ado, let us go into the first question.

MD: How do you define a healthy community? What does healthy community mean to folks here on this call today?

JA: Excellent collaborations among different organizations to address the needs of the community.

M: Love that. That collective impact, partnership and collaboration through and through, is what makes a healthy community. What else?

EJ: This is Mayor Ella Jones, when the residents in the community are able to live a good quality of life and they don't have to always be concerned about shots fired, um, poor driving conditions on the road, neighbors interacting with one another, able to solve disputes without having a police involved, uh the mental health of the community, the beautification of the community. So all of that contributes to a healthy community.

MD: That's beautiful, Mayor Jones. It sounds like what I'm hearing there is that for you, health isn't necessarily just disease status, right? It's the safety and the happiness and the living conditions, and the social connectedness of the people who live there.

EJ: Correct.

MD: Wonderful. Does anyone else have an idea of what makes for a positive quality of life in a community? What lends to that health and happiness?

RZ: So I think... this is Rebecca... I think that a healthy community is one where the people that live there um, have access to uh physical, mental, and financial... assistance where needed and that they can have a good quality of life in regard to their physical, mental and financial needs. And I think that that also a healthy community is one where the people, that the leaders that make decisions around those resources are ones that are doing so in a way that they hear all voices within their community, and they are looking at those resources and how people can access those resources in a very equitable manner.

MD: Yes, for sure, that equity piece is so important when we talk about, you know, health for all, access for all. Any other thoughts about what a healthy community means to you? How will we know when Ferguson or when St. Louis is truly a healthy community?

GM: I was also, to piggy back off of Rebecca, equity in the form of home ownership, um, business ownership, and you know, the community having the opportunity to be the decision-makers.

MD: Wonderful. I will warn you that I am an adjunct professor and am used to leading discussions with college students, so I am very accustomed to silence, and am I will be very happy to give you silence to think and process too. So if we go quiet for a little while, just feel free to sit in it and if you have anything to offer please jump in, but I want to make sure people have time to think and share, too.

AM: I'll just add, that, something that just hasn't been mentioned, just for the sake of your recording, when you said measuring, um, a healthy community addresses all of the social determinants of health. I would use that as the benchmark, so your education, safety and peace, food, jobs, transportation, recreation, employment, safe housing... many of those things have been mentioned and of course healthcare. But it addresses the social determinants of health in a positive way. So then one sentence I

would say is that a healthy community is one that continually creates and improves the environment and the people, the citizens, it serves through the social determinants of health.

MD: That's wonderful. Thank you for that. Kind of synthesizing what a lot of people have shared, Dr. McCoy. Um, and that kind of comprehensive vision of the community. And it sounds like, from the comments I am hearing here, is that what ultimately, what health and success looks like, is defined by the community itself. Is that accurate? That really it's kind of, the community members are the ones that are driving what that definition and that ultimate goal point looks like.

EJ: To me, yes. Because without the people interacting with one another, and creating that environment for growth and stability, no one from the outside can come in and do that for the community. They can assist, but the ultimate responsibility lies upon the people who make up that community.

MD: Great. So thinking about this particular community, so the community of Ferguson, or we can think more broadly about North County or the St. Louis region, what things are present in this community that make it a healthy place to live? Or currently improve the quality of life of those that live and work here? So what are our strengths as a community?

AM: A strong mayor, and good leadership [laughs].

MJ: Thank you! [chuckles]

MD: I love that we can use this platform to lift each other up, too. It's okay to be proud of what we have, including our wonderful leaders.

NN: Yeah, I would agree to that, this is Naquittia, as well as um, you know those people who are in place that outreach, I mean just, you know, you all serve as the health center, but there's a lot of outreach to the community that's important to let people know that these are the resources. Because a lot of times we'll hear, or I've heard, "well I didn't know about this, I didn't know about that." So you have to have people who are instrumental and who are willing to go out there and do the outreach to let people know. And you do have to, you know, take the grassroots approach, and go door to door sometimes.

MD: So there are a lot of organizations who are willing to go out, and be in community to communicate and to move things forward.

RZ: So one of the pretty dramatic shifts I've seen over the past decade, is that, I do think there are more resources um that people can access, right, within their own communities right now that didn't exist for a long time because most of them, they were very much St. Louis City focused. But as the need shifted out to the North County area, those services didn't necessarily shift with that. But now, that we certainly now have more resources in our area that we've needed and I think more organizations uh are aware that they have to be in the community. They can't, they can't, they need to be where people live, and they need to take services to where people live. From an access perspective, so I think, I've seen a shift that's good, that's a positive shift. And I think in that Ferguson area and Dellwood area there's a lot more services close to home that people can access between you know what the Urban League has brought, and Boys and Girls Club now, and then of course having the Mercy Center right there, and everything like that, um, as well as some other social services that were needed and wrap around services that were needed.

But I do think one of the things that is still needed if you look from a ... I think we need more businesses in our community that can hire more local people that live there to just increase the um, economic stability and financial viability of the residents that live in the community. So that there are, what we consider in the world of economic development, quality jobs that support people, that people can support

themselves and their families, and they have benefits like health insurance and things like that that come with them. So um I do, so one hand I love that we've gotten more of the services that people need in order to improve their quality of life, um, especially for those that are, that have definitely left behind as, as, others have not been. But at the same time, I do think that the more we can bring jobs to our community that help employ the local people that live here, that helps, that helps the whole community. So, one of the things in that conversation that I really think we have to address then is the safety within our communities, and the perception about the lack of safety in our communities.

MD: Great, thank you for that insight Rebecca. I think what you're pointing to then is that there's, on one hand, again that progress that you're seeing and noting, and all these improvements and additions and that movement, but then also noticing... it can also emphasize for us where the gaps are that keep us from being where we want to go.

RZ: I know that that's not specifically very health-related that you were talking about, but I do think that the lack of those types of things in our community does impact um how people view the community they live in, and there mindset and their, their mental health.

MD: Sure, and to clarify, any of your feedback or input does not have to be explicitly health-related. We can spend this whole call talking about housing or talking about, you know, business development, and we're here for that. We want to hear really the full picture of what's happening and what the needs are, and as we developed kind of our definition of a healthy community, it's all encompassing of the living conditions in that community. So I think that's a very valuable insight for us here. So please, don't hesitate to share even if it's not maybe at face value related to health services.

Anyone else notice any notice any positive trends or improvements that you've seen in the community or any of those assets or strengths that you want to call out and appreciate here before we move to our next question.

AM: I think it's important to note, so, so, you have a great age-range in Ferguson. You know, average age is about 35, 34-35. You have decent employment, so there's not a high concentration of unemployment disproportionately to Ferguson, according to data that's pre-pandemic 2019, so that could have been affected by the pandemic. Because you have an influx of African-Americans so it's majority African-American now so, which was most impacted by COVID. But that's I know on the side of the trackers. But I would say you have great home availabilities, you have some refurbishing, community redevelopment, which I think is positive, and I think you definitely have a high population of people who live in Ferguson being from Ferguson, so there's a great degree of people who were born, they are not necessarily leaving there as much, but you also have some influx of people who are coming that's new. You have the university that is next to it, so there's a pretty decent array of business with Emerson, University of Missouri- St. Louis, the, of course, the Buzz Westfall Center, and so forth. Um, and I think you know the rest, you have access to some major players. So you have access to Mercy, the Salvation Army, to Urban League, to the highways, to the Metrolink/Bi-state bus, um, so decent access to transportation and organizations all within. So those are the positives I would suggest.

MD: Thank you.

RZ: Art, to play on what you're saying too, I think we would be remiss to say that that area, I mean, literally sits between University of Missouri – St. Louis and St. Louis Community College – Florissant Valley. Um, so two major educational institutions that serve that area as well as, right now there's such a huge focus from our trade schools and from our trade, trades throughout our metropolitan area on really trying to look at things in a more equitable fashion, and diversify their workforce offerings and trying to,

trying to attract um young people from our communities in North County to look at those as career options. So I do think that those are positive, those are positive, um, I think the more we can work toward connecting, connecting our residents and our young people with those opportunities is important.

AM: Agreed.

MD: Thank you both. That's a great comprehensive list of those assets that this community has. Any other final thoughts on um this question, of the things that currently exist that make this community a healthy place to live, or that lend to the quality of life.

AM: I know that Mayor Jones is being super humble on this one, but I just have to say that the reform, the reform of even in the justice arena, with the police department, oversight of the police by the mayor, supervision of seeing representation in the captains, non-frivolous tickets for having trashcan lids off, umm.. things that make the community not feel necessarily, as opposed to some parts of the community feeling targeting, while keeping other parts of the community feeling protected... that work is being done, and it's important to acknowledge that that work is being done, and concerted efforts have occurred to listen and respond. And I think that that's a part of a healthy community and that's a huge positive.

EJ: This is Mayor Ella Jones, and I want to thank you Dr. McCoy and Rebecca because I didn't want to say anything. I am using this as a feedback for myself to see how we are progressing and how people are viewing Ferguson. So thank you.

AM: It is much deserved.

RZ: Absolutely, Mayor. I want to just expand a little bit, because this really does lend itself to healthy communities overall when it comes to quality of life. And Art mentioned housing, but I think it's very important when you look at the housing options within the Ferguson area as well as most of North St. Louis county in regard to what's happening regionally, and there's still.. the good news is for those that live, live in North County as well as people that would like to live in the area and actually invest as from a wealth building perspective into home ownership, that um we do have really nice houses and really good housing stock, in regard to getting people in the homes, getting them access to that, that are still affordable for people. And, and when you look at much of the metropolitan area that is just no longer true. You can't necessarily cross the river anymore into Saint Charles and find good, good affordable housing... or certainly not West county and everything when you know, I mean, they're not, most of the signs out here in the Saint Charles area that are popping up... I mean, oh, houses being built in the low you know \$400-\$600,000 range, but the reality is, is that for families getting started, especially young people getting started, those...that puts them in jeopardy to go into price points that high right? And so, when you look at the housing stock that's really available, and the, and the, you know...the housing in north county was it's maybe older but it's got strong good bones, right? And, so, I really think that that's a huge plus for North County, and a huge positive for people...there is affordable housing there that people can access, even when they're young and starting a family...on a good mental, from a good financial perspective start that that process.

MD: That's incredible insight, and I think a strong point that coincides with the information and data that we have throughout the region that emphasizes the point, that affordable housing isn't easy to come by in all of our communities.

We're going to switch a little bit from our strengths to some of the barriers or some of the challenges that we face. So what issues do we see that are present in our community that make it difficult for folks to live a healthy life or that reduce the quality of life in our communities? And

**again, we can think as macro or micro as we want, in certain areas or in our region as a whole?
Would love to hear folks' thoughts.**

SE: This is Sophia. I feel like the access to grocery stores, for one, in this area, or um, the quality of groceries in the stores. It's the issue.

RZ: I don't think that statement could be made strong enough, quite frankly. Absolutely. And I'm not, I'm, I'm thinking more of all of the North St. Louis county area, not just Ferguson, when I say this absolutely. And even when you go into the grocery stores in parts of north county, the fresh product offering is not...it's not what you find in the same brand of grocery store in other places and I find that pretty appalling, quite frankly. And and so I do think that that is a huge problem in our area and especially when it comes to people health, is not having easy, fast, access in much of the area to food at affordable prices.

EJ: Well I would like to add to that. We can't lift this up enough. I would just like to cite an incident that was at the local grocery store here. Our Councilwoman went in there and the fresh produce was horrible. It was not fresh, and the conditions in which the produce was housed was mold, dirt and mildew. And, she brought, I mean, and it was very powerful for her to take the initiative, to address this situation on her own by going to the manager, talking to the manager, and letting the manager know that she wants quality food for her and the residents in the Ferguson area. And this particular grocery store immediately heard her and decided to clean the whole place up, and put in fresher produce for the people. So this is a ongoing situation not only in Ferguson but all around, however it becomes our responsibilities as residents and leaders to continue to bring these matters to the grocery store owners, the president of the grocery store, uh he recently, several of the mayors and representatives on the state-level had a meeting with Schnucks, and expressed to them the very same thing. The food, and the quality of the food in North County, is not the same as South County. So this is being worked on a consistent basis.

Another thing I would like to lift up, is that it needs to be more than one store, you know. Schnucks has the monopoly at this time. However, there are other avenues that are coming up, such as the St. Louis Metro vegetable bus, the St. Louis market – it's a very good concept, it's a non-profit, it's a reconditioned bus, that has been turned into a mobile vegetable stand. And it travels around from the various communities to bring fresh fruits, vegetables and meat from local growers. However, that nonprofit cannot continue to do that if we don't seek funding for it. Um, the YMCA had the Metro Market bus come to Ferguson, stopped at the Urban League, but that's \$50,000 a year to have that bus come through. So, it is helping out people to get fresh fruits and vegetables, but also it becomes very important that we who are leaders continue to get that type of market continued funding so it can come out through the communities, and it has expanded to Spanish Lake, Pine Lawn.. because it's a very good concept. And the fresh fruits and vegetables, they are very inexpensive...because I shop on the bus myself, so it's very good for the community, but we need to work to make certain that concept is still going to be able to operate in our communities for years to come.

RZ: Agreed, Ella. Having residential conversations with different people, when you ask about issues, you know, I think the gun violence and the safety aspect has to be mentioned here. Because when people are afraid to get out of their house and even take walks to get exercise, you know, maybe especially if they can't afford to go to gyms. Basically they go home, they go in, and they don't go back outside because they're afraid of what's happening in their neighborhoods, and they don't want their kids to be out in their yards playing or anything like that. I got to tell you, that is a huge, that impacts health, because, you know, you're not being active at all.

SE: I agree, I actually went to the YMCA the other day, just because you know, to let them know we were up the street and say hello, but also, there weren't many people there. And it was 6 o'clock, it was after, you know it was dark, but there wasn't many people there working out or being active, so I agree.

RZ: well I think as Mayor Jones pointed out for the Metro Market, which by the way does have good produce, um, the I think that again, if we can find funding for our local YMCA too, so they can help more people be able to utilize it... I mean honestly, they've invested millions of dollars, they have all new equipment, it's just quite a remarkable um facility now in our area that the community can be uber proud of.. but they, already they give a lot of um, I don't know if they're called grants or scholarships so that families can use them. But you know, their money, they need more money too, right? They've got a campaign so that they can get more so that they can help more families. And um, you know, I think that that kind of, even more access to facilities that actually exist in our community is just going to become more and more important. But again, I think that we have to kind of address the gun violence and the fear in our community because of um, public safety concerns.

NN: I agree. You know, you know in Ferguson has such great parks. I mean I frequent the parks a lot, you know, and I, you know, I can honestly say I'm thankful that I'm not afraid you know. And I hate to hear that you know, because Ferguson has such great parks, and they're so close within walking distance to so many neighborhoods that you can walk to. So I hope that I residents get out and enjoy the parks and what Ferguson has to offer. I mean, as we all know Ferguson is under a consent decree and we're going above and beyond to recruit the best officers to police our community, you know, but I, you know, that saddens me to hear that because I am always out as the weather permits, walking, picking up litter, visiting the parks. And we want to promote that within our community.

RZ: I think when you look throughout county this goes back to assets but we actually in north county have more pocket parks and then the great rivers Greenway trail systems and things like that through our community are huge assets that again you know more people can utilize uh so I that's not an issue it's actually an asset from the other slide but I did want to, did want to lift up what you just said.

MD: And feel free to share things as they come up even if they not relevant to this current question. We want to make sure we capture everything, and I apologize, I did have to turn my video off to help maintain connectivity of my computer. But please continue.

AM: Along with what's been said, and having a grandmother-in-law that still lives in Ferguson, as well as my godparents with their mental health and social work support for domestic disputes and violence. That's important - mental health providers and social work providers. My grandmother in law is a retired social worker and she's 87 and she lives right, uh in the subdivision right next to where it is now the Urban League, right by the quick trip. But for many years she served Ferguson as a social worker, but now she refuses to leave, she loves her house, she loves the community, and she still feels safe. But she knows that there are family members, that are new families ,younger families, and so forth that they definitely need help navigating life with disputes and so forth... so I would say mental health and social workers.

MD: Thank you for that call -out.

EJ: Thank you Dr. McCoy, because not only that but during this pandemic, it becomes important that we check on our senior citizens and I have an initiative of doing wellness checks. And we were out on Monday in the Nesbit Newton area just knocking on doors because many of the residents in that area are

seniors. And they were very happy to know that the mayor and several residents were interested in their wellbeing by knocking doors, offering them masks and sanitizers to keep the virus at bay. So that has been something I've been working on in Ferguson, however, it takes a lot of volunteers. But, we will continue bring up the topic of social workers. Uhh, been working Washington University to have social workers to come and work with our police department. So that is in the works. And, it's very important that the leadership of any municipality understand that in order for your people to live a good quality of life, you are going to have to have social workers present in addition to all the wraparound services you have. Especially since this pandemic, it is very heartbreaking that the number of calls for domestic violence is going up. So all of that has to be addressed, and it has to start with the leadership working in collaboration with Mercy and Washington University, Emerson, and all the other entities that make up Ferguson. If we want to be a good community, we must also have to have good corporate neighbors. The businesses in the area who are willing to invest. And one thing I have to say positively about Emerson, we are building a new pocket park in the third ward, not too far from Emerson, and everything is being donated. Emerson Family YMCA purchased all the playground equipment, Emerson itself provided the pavilion, the union is getting together – all of that has taken the strain off the city's budget, but yes we have the businesses, the unions, everyone who is in leadership positions, coming together and saying yes, these children need an outlet to play and here are we helping you to provide this for children. So, it basically comes when all of us working together as a team. When we work together, there's nothing we can not do. We can only do the great things are yet to be discovered. That's all I have. I don't want to be preachy.

AM: That's outstanding. That is outstanding.

MD: That is such wonderful news to hear, and thank you for sharing that. It's a great testament to that investment and collaboration you're speaking to.

JW: And to piggy bank on Mayor Jones, you know I've talked to a lot of people in the area and they're like, "oh, I didn't realize," "oh, I didn't know there was a need," "oh, I didn't know," and so, I think Mayor Jones talking about collaboration, that's where it's going to come from. It's going to come from all of us collaborating together and offering resources that we have available, or know that are available in the area, and really starting to put it together and create a solution.

MD: That's fantastic. I want to continue this thread of thought, but want to move to the next question, which takes you know, this discussion about things that could be improved, or areas of potential collaboration and engagement, and obstacles we can remove...what do you see is the most urgent of all of these issues? Of the things we talked about or maybe some things that we haven't yet brought forward that are urgent issues for us to address in the community? Where is the most urgency here?

JW: I think the urgency is in the medical part of it, more on the line of wellness, versus "I need to get in there now because I don't have medication or I don't have this." Staying on the education basis of wellness, and you know, getting it before, you know, it's bad enough to have to do those things. And so I think that is also brought, you know, forth by education.

MD: So if I'm understanding you correctly, it's really thinking about how we're engaging in prevention and health promotion to really be proactive and supporting health in the community?

JW: Yes

MD: Wonderful. Any other urgent issues we see?

RZ: I'm sorry, I don't mean to keep taking over, Megan. But our, um, one of our work, scopes of work, is collaborative conversations, and there's a mayor's cohort that actually Ella sits on--thank you, Ella --and every meeting discussion comes back to the fact that right now there, there's just huge, huge mental health concerns, and it's in it it's impacting everything in our community. So I think uh trying to address in all ways the mental health concerns in our area. Our mayor's cohort is actually forming a special mental health task force to try to look at what is happening in our area, and what you know where the gaps are and how they can help, um I'm hoping somebody from Mercy will serve on it -- just putting a plug out there for some help! But I do think only because almost every group that I'm meeting with right now, whether its employers or the Mayor's or, you know, I mean not just people in healthcare, not just our leadership that talks about it in healthcare, but our faith-based community, this is what they're bringing up, is that the people are really struggling right now. And it is impacting so much of what is happening in our community, so I think mental health is one of the big, big, big things from a healthy perspective.

JW: I agree, Rebecca.

NN: I agree.

JD: This is Jennifer Derner with Mercy. I was going to say that one of the common, probably been the most common referral, for the social worker at the Ferguson clinic-- she started two months ago-- has been the need for, you know, behavioral health issues or need for counseling resources. And so since the behavioral health specialist got into place, she was able to refer those patients, a lot of those patients, over so that they could be getting some direct therapy. So, I agree that behavioral health is a very significant need in the area. Um, and there are not a lot of resources for that. And um, I can tell also tell you, I manager our OB social workers, and so, you know, they're finding, especially since the pandemic, there are not enough resources for pregnant women who are experiencing perinatal mood and anxiety disorders, or post-partum women with post-partum depression. There just aren't enough providers available, or they have long waitlists to get in, or there are insurance issues sometimes. So that is a very significant need in the community across St. Louis.

RZ: And I wonder if we have to start we have to start even approaching the situation differently in regard to looking at how, how do we intervene earlier? how do we get, how do we let people know so once they're presenting they're not in full blown crisis, right? Well I mean so that the police aren't getting called to even more and more and more and more domestic situations because of mental health concerns and issues and things like that. I mean I don't know what... I don't know how people do that, I, you know, I'm not the expert, but I do wonder if at some point we have to start looking at not just, "how do we treat the people that are presenting that are in in a crisis," right? Like full blown crisis. How do we get to people and let them know to come for assistance or that we can come to them for assistance or whatever? That looks like earlier rather than "okay, things have now exploded," right? I mean that's what, that's what I think maybe some of the conversation needs to be around, and maybe that goes back to the educational component where we're trying to help people understand how to be healthier and how to start looking at what's happening within them physically and mentally and go, "oh, I can ask for help and that's OK, and "I should do it now rather than wait a week or wait two weeks or wait three weeks or wait three months or wait..." does that make sense?

JD: It totally makes sense, Rebecca, and it, it's just like everything. Like healthcare, like all services, tend to be very reactive rather than proactive. And I think, you know, what we have to look at is trauma. Right? And so, you know, catching people before there are crises, how are we addressing, uh, the trauma that people experience in their lives, and that comes from a lot of different things, and sometimes its not this gigantic thing that happens to somebody, right? Sometimes it's not like one large experience.

Sometimes it's the trauma of not wanting to go out of your house because you, or even being afraid in your house. I remember when I worked at Mercy JFK clinic for three years, and I had a patient who came who lived down around Cope Brilliant, and she was afraid to even be in her apartment or in her house, whatever she lived in. Because you know she was afraid a bullet would come through, let alone go outside of her house. And so the trauma of even living in that feeling of unsafety all the time, even if you haven't had a direct experience. So how do we get into the community and help them with coping skills? And how do we look at other things, not just talk therapy? How are we using, you know, body break based exercises and helping people to be able to cope, before they get to those crises, in addition to connecting them in when they need professional services?

SE: I also think that, for the working class, getting off work and trying to - because the question is how can we improve the health of the community – how to have to work out and find time. You know, um, that's another issue that I hear some of our patients talk to the doctors about. You know, getting off work, trying to get to the gym, or do the things to get their health together, putting in the time.

MD: Thanks, Sophia. And I do have, I've been keeping an eye on the chat, and um, Joy had shared “talking about wellness information and introductions to services that are offered,” and Naquittia mentioned “our youth” and “pro-active self-care and wellness beginning with our youth.” So Naquittia and Joy, I don't know if you have any last thoughts on that, or if Jason or Dr. McCoy if you have anything to offer. I'm looking at our time and we have less than fifteen minutes left, so I want to get to our next questions here. But definitely want to give space if any last thoughts about, you know, prioritizing the most urgent issues in community....

Okay, and it looks like Rebecca is dropping off. Yes, thank you for your engagement, your feedback, and we'll be sure to keep you all engaged in this work as we move forward.

And with the last bit of our time here, I want to talk about two concepts: access and equity. So as a healthcare ministry, Mercy specifically, a lot of our resources that we have direct control over are our healthcare resources, and as we've evolved, we're learning, you know, how to partner and engage and collaborate and invest in ways to support all of these other social needs. **But thinking about this community and access to health care, are there any specific pain points or obstacles to access these different types of health care that come to mind? It sounds like perhaps behavioral health and substance use assessment and treatment, mental health services may be at the top of that list of maybe having obstacles, but any thoughts about the issue of access to healthcare?**

NN: Well I know that dental, you know, you know is an issue for some people. Even some people who receive Medicaid, you know, if they're not at a certain age there are no dental benefits, you know. I've heard that, I deal with Medicare Advantage as well, in one of my roles, and so you know, I know that dental was, you know, there's major issues with people having access to dental care.

MD: Thank you.

JA: In my experience, I'm not sure this is relevant. Some of the individuals we've worked with in the Pathway to Hope Program, the access for them would be a hospital, as far as the emergency room, you know, as far as the ER. However, we know that once they get that care they're charged the bill. So I mean, I think the only access sometimes for the population we serve is, like um, the ER. However, then they get educated later that there are those other avenues to get access to you know, so, but that's just like a costly thing for them. So I mean there is access, but I think it's more about educating them before they get stuck with the bill, you know, going through it like that.

MD: Yeah, so that navigation of where do you go? What level of care do you need? What resources are available? And what might be most affordable for your needs? That's a great point and it's certainly very well aligned with access.

Dr. McCoy, thank you for your time. I see you're signing off.

Any other thoughts about this access to healthcare resources piece?

Okay, we'll move on to our final question. And this is related, but just what are the barriers that keep people from accessing resources? Maybe where I'd like to direct our attention is, you know, are there some individuals in our community who struggle to be connected to resources more than others? And this could be health care resources, but also social services or other resources in that community. Whether that's, you know, food, or health care, or recreation. Are there certain individuals that are maybe more vulnerable or who struggle the most to get that access?

JD: I think so, phones can be an issue, or you know phone minutes. We find minutes challenging to reach patients sometimes because they're phones are off because they can't afford to buy any minutes. And if you think about, you know, how much time sometimes we as social workers or community health workers spend on the phone trying to get through to advocate for patients, or to link them to some type of service, you know, they don't have the time, they don't have the sometimes that phone access of the minutes to be able to be on the phone with those community agencies waiting on hold. You know to try and be able to access services. I think that's one barrier that people experience and certainly, you know, Internet use is up there because a lot of places now you have you have to go online to access those things.

JA: I will say transportation. A lot of folks may not have the transportation that we probably all have on this call to get to those resources as needed. So as I stated before, the nearest thing for them to go to maybe in their neighborhood is to the local hospital, and that might not be an urgent need. But I mean, I think what we deal with is transportation. And then sometimes the follow up care, you know, they may not have transportation to follow up with a doctor, or to get to that local, you know, supermarket, you know, to get the food they need, and things of that that nature. So I mean, I think sometimes transportation is a barrier for them, so sometimes those resources may need to be placed strategically in the neighborhood where the greater need needs to be met.

MD: That's a great point, Jason, and definitely something we see regionally, right? That's not unique maybe to a particular area, but folks in all sorts of different communities around St. Louis might be disconnected because of inequitable access to transportation.

NN: Yes, I agree with us totally. Especially at night and in these extreme temperatures, if you have an emergency, you don't have any money, even if you have like Medicaid or Medicare Advantage plan, you know, it's hard to be transported. You know, how do you transport yourself to a hospital or urgent care in in north county? Like I had to go to urgent care on Tuesday --I was in an auto collision --and I went to one urgent care and they were like come back at 5:00 o'clock, you know, then so I uhm went to another one and it's closed down, I didn't know that, so. I ended up over at the hospital, well it's an urgent care slash hospital, Northwest on Hanley Rd, and I was there for an auto collision, for like five hours. You know because everyone is sick with COVID symptoms or coughs or flu symptoms or whatever. And you know, so when I left from my there now I'm coughing, so you know, what I learned from that experience is, you know, is that not only do we need more urgent care health centers in north county that are open later, but when someone is going to be seen about, you know, an auto incident or collision, we shouldn't even be in the same area as someone with COVID symptoms because the risk of you know, of getting sick is so high. Does that make sense? Like I didn't even need to be around the people who had those

symptoms, I don't know, you know, if that makes sense. It's just, it was just surprising, and like I said the wait was long again, because, we know, everyone was sick, is sick, or getting sick, or you know the virus is being transmitted. But if I could have just went to a part of the hospital or the urgent care for what I needed to be treated for.

MD: Yeah. So Naquittia what I hear you kind of reflecting on, is how this pandemic has affected well, one, access, you know with the volume of the patients, and then also just kind of being able to be treated for what you're needing care for in a way that's appropriate for you, with kind of the influx of volume with COVID, and how that's affecting waiting spaces, and waiting times, and everything that goes along with that. That that can be a barrier to appropriate care for folks in the community. Thank you for sharing that.

Um, you know, and again we have a little less than five minutes left, so I am going to stop sharing my screen here, and kind of open up our conversation for some final thoughts. You know, again, this --if I can get my camera to start functioning now that I'm not sharing my screen--- you know the purpose of this kind of exercise and this conversation is for us as Mercy to better understand what's really happening and changing in the community--where the needs are. So that you know what the processes is, we take this data along with data that's been collected in partnership with, again, our other partners in regional health—the health department and other health systems—to assess where need aligns with our capacities and our resources to fill in gaps. So it's all about collective impact and leveraging the strengths that we have towards the barriers that exist for people. So if there's anything else that could be added by our community stakeholders—and it looks like we've got Naquittia, Jason and Joy on right now—if there's anything that you all would offer to us at Mercy, some final thoughts on where you would like to see us pay attention or things for us to consider in this process, I'd love to hear that from you.

JW: Well I can say from our. you know. interest in the Ferguson community, you know, we've learned an awful lot. And I tell you what it comes down to, after being, you know, asking around, talking, you know, having relationships with people, that's what it is. It's relationships with people, and not to see, you know, see Megan one time and then all of a sudden next time we come you see Joy, you know, they wanna see continuous same faces, same people, same, you know. And they continue to learn and you know gather more information about us as well, you know. So, you know, I was at a meeting, you know, in the Ferguson area and they said, “well I didn't see you last time,” you know, and it's like so they won't talk to me, you know. So I mean I think it is relationship-based and I think they wanna see continuous people. Like Mayor Jones said, we work a lot with Mayor Jones you know, it's relationships, and I really believe that 100%. And you know that's our input of you know having been there and and experienced a lot of bad before word finally turning into you know having some really awesome things happen and so that's my input.

MD: Thanks, Joy. I think that's important to remember, the power of presence and trust, and working with community, not just showing up and doing what you think needs to be done. It's working in partnership with the folks that are there, and leaning into their expertise. So thank you for that. Thank you.

NN: I would like to say, I was just going to say that Joy said it all. It is relationship because that's why we were elected, I mean we have to understand the community that we're serving in. I'm in agreement with you know, people being independent, you know, and but everyone is not me, everyone is not Ebony, that everyone is not Jason, you know. And so it goes to relationship and being on the ground in this community so people know you, know I'm your council Rep. I'm with you working towards the best of this community and I just want to say right, with this is the first meeting that I've been able to make, I

have a new jobs so this job allows more flexibility, so I just want to say, you know, I am here, I'm always here, I always try to make my presence known. Because I like to meet people and that's something that I really like about working with miss Ella, that she has really supported us on, so um but thank you for this and I'm done.

MD: Naquittia we're so glad to have you here and so happy that you'll to join us more frequently. It's always a pleasure. Jason, did you have some final thoughts for us?

JA: Yeah, real quick. Everything is great what you're saying.. Too one other key is to be transparent when you're dealing with the community. As much as possible, you know, let them know up front, you know, what you can do, what you cannot. Do you know I'm saying? I think that also establishes trust, you know. We don't undermine the intelligence of the community that we serve at all, you know, that when you're transparent with those you serve, you will get more of a level of respect. They'll say hey, you know, I know Megan can do this for me 'cause she said this, you know? So I trust that she told me now then let me go along this journey and find out in the end world that she wasn't able to do that. I think transparency is always key also establishing those relationship when you're dealing with the families in our community as well, too.

MD: That's perfectly said, Jason, thank you. Thank you.

Well, I appreciate that you all are the hardy three that made it through our hour and a half. Thank you for all of your feedback, for your presence, for trusting us with your, you know, with your perspective, and for sharing that honestly with us. As I said, this information, your feedback, will that will be integrated into a report and a kind of a reflection on the current state of our community that will be shared back with this group. So not only will I share the minutes, you know, again, they'll be kind of aggregated, it won't be assigned to people names, but you'll see that back to you for some additional feedback before it's put into the final report. And then that needs assessment will be shared and reviewed with this committee and once it's complete, which will be...I'm looking at my schedule here... in May. So in May I will have the final report, but you'll see pieces of the data and our progress in the meantime. So any final questions or thoughts before we end today? I know we're over, and again thank you all for your time.

NN: I do! It's Naquittia again, I'm sorry Megan. Could I have those questions that you posed that we responded to, can I share those on my social media? Just like take a picture in the snippet and cut it out? I'm gonna leave the Mercy logo because it's your question, and I was able to take a picture of two of them, but are you willing to share those, because those...these conversations are ones that we should all be having and I just like to share, share, share.

MD: I would love to. I can send you, I'll send you just those slides so then you can have them as photos. I'll send them as pictures so you won't have to even worry about the pictures you took, you'll be able to use the ones I send you. And I'll send those out to you today, so you'll have that for your social.

NN: Thank you.

JA: Yeah, can I get a copy Megan.

MD: I can send it -- I'll just send that out to the whole group -- so that you're welcome to share, how about that?

JA: Thanks:

MD: Yeah, of course, Jason. That's a great idea. Great consideration for the people you serve, too. Ok, folks, everybody stay warm. Be safe, and I look forward to hearing and meeting and collaborating with you all again soon.

Appendix G

Meacham Park Community Focus Group 2022

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Community Health Needs Assessment

Stakeholder Focus Group

Ground Rules

1. Keep your mic muted when you're not speaking.
2. Practice good listening - only one person talks at a time.
3. It is important for us to hear everyone's ideas and opinions. There are no right or wrong answers to questions – just ideas, experiences and opinions, which are all valuable.
4. It is important for us to hear all sides of an issue – both the positive and the negative. Please be honest!

How do you define a
healthy community?

What things are present
in this community that make it a
healthy place to live
or improve the **quality of life** of
those that live and work here?

What **issues** are present in this community that make it difficult to be healthy or **reduce** the quality of life for those that live and work here?

Thinking about this discussion of things that could be improved in order to be a healthier community, what do you see as the most **urgent** issues?

Are individuals able to **access** healthcare resources in your community?

1. Medical Care
2. Dental Care
3. Behavioral Health
4. Substance Use Assessment/Treatment
5. Pharmacy

What are the biggest **barriers** that keep people in the community from accessing resources?
Are there some individuals who **struggle** to obtain access more than others?

Meacham Park Neighborhood

CHNA Focus Group

Transcript

3/28/2022

Roster:

Laura Bub, Director of Community Health and Access, Mercy Hospital South (Scribe)

Megan Drissell, Director of Community Health and Access, Mercy Hospital St. Louis (Facilitator)

Officer Gary Baldrige, Community Service Officer, Kirkwood Police Department

Harriet Patton, President, Meacham Park Neighborhood Improvement Association

Wallace Ward, Councilman, Kirkwood City Council

MD: A couple of ground rules to start with this morning, and this won't be as important because we have such an intimate group this morning, but please keep your mic muted when you're not speaking – it just kind of cuts back on some of the echo. If at any time you have some difficulty with your audio, please let us know. So Mr. Ward, if you lose your audio again, please stop us and wave your hand, so we can go back and make sure that we're being heard on your Webex.

You can unmute yourself at the bottom task bar, there's the audio button you can click on. There's also a way to make a "reaction," so you can raise your hand, you can send a thumbs up or another little emoji. So it's another way to communicate if you're having issues with your audio. We asked that only 1 person talk at a time. Again, I'm not really concerned about that with this group, but we do want to hear everyone's ideas and opinions.

There are no right or wrong answers, and we don't only want the positive opinions here. It's important for us to hear all sides of an issue, both positive and negative. So we ask for your honesty. We find that, especially with healthcare organizations, especially historically, we tend to kind of stay in our lane and we do what, you know, health organizations are expected to do, which means we can have some blind spots of where we're missing services in the community. So, that's why we have these conversations, as we want to know what we might be missing.

The last thing I will say just to the ground rules is that while we're speaking about health and a healthy community, I really want to invite us to think broadly about what that means to you and to the people that you serve. We're not just talking about health care. Although healthcare is important, and we'd love to hear opinions about that, but whether it's housing or public safety or education or recreation, family, connectivity, mental health, all of it, we want to hear about the total holistic wellbeing of people. So, again, any insights you have, it doesn't have to be, you know, necessarily right in our wheelhouse for us to be able to connect and make connect resources to issues.

MD: For the first question, we'd like to kind of convene around and get some insight into, **how do you define a healthy community from your perspective? So what kind of things do you look for, or do you see, or are you trying to create when we're thinking about healthy community?**

HP: Does it matter who goes first or second? Okay, well, I see a healthy community being a community that has resources that will benefit them and meet the needs of the people who reside in the neighborhood. We did a survey in 2015, and we learned a lot about how the residents feel and what were things that they were concerned about. One, they were really concerned about activities, recreation, and healthcare. Since Meacham Park clinic has no longer been housed here in Meacham Park, I hear families saying they do not have transportation from Meacham Park to the JFK Clinic. One of the agreements was to provide a shuttle from Meacham Park to take residents to the clinic, but that never happened. As a result, we see a lot of residents who are in need, have not successfully found a vehicle to assist them. So what happens is we see Gary Baldrige and his group come and pick them up when they're having a heart attack, they have not been evaluated, haven't seen a doctor for 10 years, some longer than that. And it's, uh, it's a big story and when I hear it, I'm willing to say, well, what have you done? What are you willing to contribute? And how can work together on this?

And I find that people who are of low income and low means, they not so openly to share their shortcomings. People would have something like COVID, but they would not call or seek assistance in getting tested, or even get medical evaluation. And so that has been a big problem for a very, very long time. And it seems to be what we found as helpful is the 1:1 advocates. And that's lots of labor, lots of money, and lots of time. And as a result, it's one of the things that's never come to fruition.

MD: That's great. Great. Thank you for that.

So what I'm hearing there is first of all, a healthy community to you is all about having the resources that people need in the community and then from that, you kind of pointing to some of the ways in which that's not currently present in the community with access. And with, you know, being able to be more preventative with health care, because they are lacking in some of those resources and support and education. Is that accurate?

HP: That's correct, right.

MD: Does anyone else have a different perspective or anything to add on how we're defining what a healthy community means?

WW: Well, I guess, first, I think we need to define it, to be more clear about what it is we're discussing. So, Meacham Park is a neighborhood, not a community. It's part of the greater Kirkwood community so I think it's important that we, we talk about that for me, a healthy neighborhood, in this instance, would be one that has pretty general diversity, and that means age, gender, ethnicity, education, economics. All of those things help it to be a more healthy and long and enduring neighborhood. Um, it's also one that has a lot of connectivity, neighbor to neighbor, block to block, and involvement on those levels, because those help you to identify and correct those individual problems more easily. If you've got health care issues if you've got, uh, uh, mental health issues, substance abuse, all of those things get identified and more resources can become made available when you have that kind of inner connectivity. So I guess that's where I want to go.

MD: That's great. Thank you, Mr. Ward. And yes, I think that's an important distinction to make, you know, when we in public health and in hospital, and our hospital needs assessment, we can define community as a neighborhood, we can divide community by any sort of, uh, regional factors, so it could be St. Louis, it could be the metropolitan area. The community could even be the state, right? So, I think for this conversation, that's helpful for us, where you're kind of oriented and how we want to draw that boundary and think of Meacham Park as a neighborhood really integrated into this larger community that

we're talking about. And how we're thinking about resource access and connectivity on that broader scale. So thank you for that. That's wonderful.

Officer Baldrige, do you have anything to add? As far as how you define a health community from your perspective?

GB: No, I think I'm good. They said it all.

MD: Okay, I am going to move on to this next question then. **So, what are some things that are present in this community this neighborhood that make it a healthy place to live, or improve the quality of life of the people that live there? What are some aspects that we see around the Kirkwood community, or in the Meacham Park neighborhood, or, you know, even regionally that are the good things happening?**

HP: Some of the healthy things we see in our community is 1, we still have 4 churches that are still have their doors open. A community without churches and God, is almost saying no community. But we still have four churches here in our community. We still have other activity, we have Stonecrest, which is an organization that provides housing. Stonecrest is managed by Ms. Quincetta, and she joins us in organizing and suggesting better resources or needed resources. And we also work with the YWCA, with Ms. Tasha Fondren, with the early childhood center, and we work with Kirkwood School district in a big way. We're so happy they're here in Meacham Park! They are utilizing the Turner School and the school was not, uh, demolished. At one point they had talked about demolishing it, but the good news is that it never happened. The neighbors really did never wanted it to be demolished. And when it was identified, the structure was very structurally strong and better than most buildings even then at that time.

Also I'd say a healthy place will be a place where we can organize and our voices be heard. Some of the churches opened their doors when we had the Department of Justice account, when there was issues in our community and we weren't being heard. And they did an analogy, so um, it's so many things that go on in this small community that many people have no idea. However, I can say that the fact that we are speaking, our voices are being heard, and there's there is a reply, a response, to some of the things. At one given point we were having a lot of complaints about the police department, and we put together a sheet that if you had a policing issue, you did not want to identify your name, you can fill it out and submit it there and it had a tag number and you can go online and we do it. So, we have some response to community needs and improving the quality, um. The children, one of the things we're looking forward to now is to utilize the playground, Meacham Park Memorial Playground, in a more organized effort. Um, we'll be talking about having everybody getting involved in keeping the park clean, keeping social activities in the park that's age appropriate and safe. And Gary comes every year with the hot dog days with the kids, and they really look forward to that. And sometimes they do bicycle repairs. And those are the things that make a community say we care about you and we will participate.

I really like working with the police department. I want to share with you, when we have our monthly meeting, Kirkwood Police department have been coming since we were at Kirkwood Inn. And they bring a police report of the sorts of activities that have gone on. And they open up to, um, residents requests, they are allowed to ask questions and they're allowed to receive an answer and it's been very productive.

And those are some of the real good things, now, the mental health issue, we've never had a resource that will address the mental health and drug addiction and drug overdose, and I've been asking if we can get Narcan in the neighborhood and I did speak to Gary and that is in progress. So when our neighbors have issues they tried to tell me and I tried to follow through. And I find Gary to be very resourceful.

Not some of the time but all of the time. I tell the truth, Gary is open and he do reply, and yeah, we had an issue here one day, and uh, the city manager got up, and got out of his chair and came out here and addressed it. And the issue was that residents, uh, had a no parking sign outside of the door where their mother would have to come in and out in a wheelchair and that they couldn't park there. That sign was moved, but before Gary came, they was screaming and hollering that they want to hurt somebody and it was a terrible situation. We de-escalated it and we were able to get a resolved and we didn't take long. A matter of fact, it was done within 24 hours. And I Harriet Patton believe in sending thanks, and I had that family to send a thank you note because they resolved it and we didn't get front page news on the murder. It means a lot, so there's some good things to be shared. And, uh, I think that we should share those as well as the things that that breaks our heart. And when these young people are overdosing on drugs. That is very sad and if it will just in Meacham Park that would be one thing, but it's nationwide and we know that.

MD: You've got a lot to say, I mean I think again, here, it sounds like some of the really great strengths of this community are some of the institutional, the institutions that are present, the agencies that are present, and just the individuals that already have laid and continue to lay the groundwork for collaboration and working together and moving things forward. So, it sounds like there's a really great foundation there for a lot of a lot of the work that you're talking about.

Is there any anything else that we would add about? What are the strengths of this community, or what are the things that are going well or that are contributing to folks health.

WW: I think that it's, it's a neighborhood in transition. It had historically been, you know, probably the best way to put it would be a grouping, a large grouping of families who had been there for an extended period of time. A lot of those families have younger folks have moved out of the neighborhood and we see more people who don't have that long history of, uh, neighborhood connectivity moving in. That brings with it both good and bad, and so I think, you know, I don't know if you know much about the history of the park, but it's been about 27/28 years ago when Kirkwood annexed Meacham Park, it was unincorporated St. Louis county. And it underwent, uh, major redevelopment utilizing a, uh, TIFF program with the commercial development of Walmart/Target, a shopping center there and moneys from that would use to build a number of new homes. To offer upgrades or remodeling on every home within that neighborhood. And of course, we did, we created the park that Harriet had mentioned, the Memoria Park, upgraded the street lighting, a number of things happened with the infrastructure over there to make it a healthier neighborhood to live in. So those have those have had some positive effects, uh, in general, for folks living in Meacham Park.

MD: Great. Thank you. Mr. Warren. And I would say, yes, I mean, with Mercy our framework for understanding the historical significance in the development of Meacham Park is really through the eyes of the Sisters of Mercy in their long involvement there, but it's always great to reinforce what that looks like, especially thinking about Kirkwood as a whole.

WW: Yea, and we do, and when Harriet mentioned Stonecrest apartments, those are publicly subsidized apartment units. They are under the control auspices of St. Louis County housing authority.

MD: Thank you.

Officer Baldrige, do you have anything to add on? Some of the assets or strengths of the community in your time working in your role?

GB: They said it all.

MD: Thank you so much, love that. It's nice to go last when you have got two very wise folks speaking ahead of you, too.

Okay, so the next question is on the flip side of this. **What issues or what obstacles are present in the community currently that make it difficult to be healthy or reduce the quality of life for folks in the community? What are the challenges?**

HP: I spoke with several of the young people, one fellow was 49, one 57, other was 25. Most of all, they shared with me, they do not have health care insurance. They do not have access. They're unemployed, we have medical conditions that have gone on and not being a bad evaluated, monitored or treated. And as a result, the other people that the ambulance has to be called, and the only care they receive is an emergency room. And we know preventative, that's not a good measure to establish. The one fellow said this, he said the dental services are really needed. General education and say, we don't have nowhere to go for a dentist. We don't have no money. The Meacham Park clinic used to provide dental service, and an assortment of services for health care needs, and without that clinic, we are lacking that and the people who need it do not have a vehicle or an advocate to step up to the plate and help them.

I've learned this very well in health care services. People who are low income, or poor, or lower means have a hard time asking for help. When they tell the story, it's so sad, you can hardly listen to it. But with the Sisters of Mercy, when Mercy was out here, they listened to everybody. They even went sometimes door to door. They did home health services in the community, right? And the community, that is all missing in our community. And I see lots and lots of negligence when it comes to healthcare needs for the residents of Meacham Park. I would think that Medicaid would be assistance and Obamacare but it comes right back to the fact that if you are low income, don't have transportation, don't have money, and some of them don't have a high school education. So you're looking at a boundary of disparities that lend itself to negative. And when we, um, face it, I usually am the one to call Mercy. I usually call Sister Roch, she's been taking care of some of the issues, but we need a universal system with that.

MD: Harriet, you're reiterating that health care access, insurance, preventative care, transportation, dental care, even getting on Medicaid. If you qualify, those are all challenges. And Harriet, you've mentioned this before, too, that the opioid epidemic has impacted the community and that is, again, something we see broadly as you mentioned, and I think it has only been made more severe by the pandemic for folks – mental health and substance use disorder concerns.

Anything else to add? Mr. Ward or Officer Baldrige, about the challenges that you see facing the community?

WW: Yeah, Gary, you want to go 1st or I can go it doesn't matter.

GB: All you, sir!

WW: Oh, okay. You surrender too quickly.

Well, you know, this is a real beehive of issues for me. You know, as I said before, it is a neighborhood that is in transition, and one of the things that had, the reason you had the number of churches you have down there (and actually we're down from three, past denominations that left the neighborhood), at one time there were better than 900 people living in that neighborhood. So it's come down considerably from that. The number and, uh, the remaining churches in the neighborhood had relied and still rely to a certain extent on folks who don't live in the neighborhood anymore, traveling back in, and those numbers are diminishing and dwindling. And so, I think you're going to see continued failure of the churches, in part because they never learned to do outreach to a new set of residents. It relied on that family, you know,

revolving door kind of process and so that's failing. So the, the impact of the faith in the neighborhood is reduced. Um. The neighborhood still is a victim of a couple of families that have a long history of being dysfunctional with raising responsible human beings. They still represent the, the vast majority of the crime issues that we have out there in that neighborhood. I think we had a drive by last week - Gary, you might be able to confirm that one way or the other. Um, but those, until we can rid ourselves of those families, and the problems, or help them, uh find the resources to eliminate the problems that they that they have as a family, which then spills over to the, to the rest of the neighborhood, it's going to continue to be a difficult place for people to have a very, totally healthy, high quality of life.

One of the things that I've viewed as the most problematic for that neighborhood is that it continues to self-segregate, long after most of the almost all of the barriers that existed racially are now gone. So the schools are integrated, jobs are integrated, healthcare is available throughout the region to you, regardless of your economics status. Um, but yet folks still want to try and drive everything that happens back into that neighborhood. And that, as I said earlier, that denies them the opportunity to have the resilience that may come with being part of the greater community.

MD: Thank you for that. Officer Baldrige, did you have anything to add on this end speaking from your role?

GB: Well, I really like what Mr. Ward stated about um,.. we have probably 5%, or really even less, that accumulates for the majority of our criminal element issues down there that, you know, 98% plus of the neighborhood is wonderful. Fantastic.. And then we have the 2% or so that cause the majority of the issues, and always seems to bring in the outside element of, of unnecessary trouble. That's not even really conducive with the neighborhood. But that's probably not neither here nor there relative to what the focus of this group is for the lower economics is always an issue. Sometimes we walk into houses with the paramedics and it's like, um, probably someone hasn't been in there for years, uh, any kind of clean cleaning or hoarding issues, or things like that. So, um. However, I do think the bridge between the neighborhood and the rest of the community is probably wider and of more well travelled now than it's been in my 18 year career here. I think the majority of the residents are at a point to, um, I don't think they feel that the city is as nearly as much of an adversary as the feelings used to be.

MD: Right. Thank you for that. Any final comments before we go on to the next question here. Some wonderful perspectives.

So thinking about this total discussion of things that could be improved **are there any really urgent issues that come to mind that, you know, if we could pick 1 or 2 things that we would love to see address more urgently. this is what it would be, what we need to prioritize?**

HP: The first thing I always think of is housing. I believe adequate housing. They need adequate health care they need adequate social services, added recreation that's age appropriate. We've been looking and trying to find out what we can do that would address the senior citizens because generally the meetings are at 6:00 o'clock and we find that they prefer not to come out after dark so, we have something that addresses the senior citizens because it's more senior citizens in this community. The one thing that I always have remembered when we talked with Saint Louis county, they told us to encourage more young families to move into Meacham Park, build their houses and raise their kids here and get involved. And if we can do a big push on housing, get more new houses built here, and get young families here, and get activities in that age appropriate that address a family, that will welcome them to the neighborhood, I think that can make a difference. Because after you get so many, like, I think we looked at just the other day, it's not many people 87 and 90 years old in Meacham Park now, but my neighbor across the street is 87, and she is more energetic than most people at 10. She teaches, she reads, she goes to Sunday school,

she goes to church, she goes to the parks, she goes in the homes and helps people and so I think that if we can build that community with more young families with positive energy. One of the residents that moved out here, approximately 10 years ago, she said we need this statement. She said when we said we want to go to meet and talk, she said the real estate company told her they are redlining this area, don't move into Meacham Park. The criminal activity is terrible. It's a terrible place to live. And she said, she couldn't believe that they would tell them that. And then I never, I never got a chance to go and talk to the real estate person, but I never forgot that she said that was being told to people wanting to move to meet him park. And she was Caucasian with a family, and that's what they told her. Don't move to Meacham Park. And I'm hearing it on the down low, that people are being told, 'Don't move to Meacham Park.' and so we have not seen a lot of new construction. However we're encouraging that. And if Mercy can be instrumental in helping us build the community, whether it be new housing for families the young families that can move in and raise their families and make this a better place for everybody. I mean, that would be happy for everybody.

Housing, and then there's a lot of empty lots out here, some empty buildings. And so if we can build up this community so it's a welcoming place for everybody to come where the grass is cut and the yards are clean the houses are decent. Like you said some of these houses you go in and hurt your feelings and that's a nice way to put it.

MD: Outside of housing, and those concerns Harriet outlined, are there any other urgent issues that you folks see as priorities to address?

HP: Healthcare. Healthcare is urgent. Because if you go up and down the street and interview 10 people you may have one or two that have health care that's 80% that do not, that's not a good figure to assess.

WW: I believe that the biggest issue right now is crime. The criminal element in there as we spoke before, it's a small group, but it's also a small neighborhood. And so it has had a really significant impact to live there in the perception of people who don't live there, so we need to figure out a way to eliminate the serious criminal element. Then there's the more annoying element that occurs inappropriate things that are happening in the park. You know disrespect for folks with the volume of your music and the content of your music, those kinds of things. You know, young couples don't want to raise their children in that environment. So it reduces the demand for housing there.

But having said that there are, there is a new home inspection over there, and the new people are moving in and as more folks transition out there, there will be more opportunity. Man, but, you know, at the same time folks who live in the neighborhood persist in portraying themselves as a neighborhood full of just down and out folks. You can't have it both ways, you can't be a destitute neighborhood and profess that you are and then expect other folks to say well, I want to live there. So that's important. So I think, that's a roundabout way of saying, what we need to do is quantify where our problems are. Stop talking in generalities about the circumstances that people live in the community. We really need to have a survey of folks in there so we can find out how many people really don't have insurance or access to healthcare. How many people have come, let's call them emotional family issues, you know, if we can, that might be too. But I just think quantifying the negatives that exist in the neighborhood is the way to start, more comprehensive surveillance-like that data would be great.

MD: Thank you, Mr. Ward. Officer Baldrige, anything to add?

GB: I'm good.

MD: All right, thank you so much.

HP: Before you go to the next question... Officer Baldrige with the Kirkwood Police Department, and the Kirkwood police have been bringing us a police report on a monthly basis for the last 20 years, and they don't tell us that things are so bad. Am I telling the truth, Officer? When they give us a written report or they give us a verbal report we see things are getting better, they tell us things are getting better. they have a comma they have an officer that rolled into the neighborhood and like you said, maybe one or two people give a bad name for the entire community. But there was an improvement in crime, it's not the crime rate, now it's not the same as it was ten years ago.

GB: Harriet, I would definitely agree that there is an improvement. Maybe it's been a lack on my part being that we haven't had the Meacham Park neighborhood improvement meetings for the last two years due to obvious reasons. I do publish the weekly crime reports in the Webster Kirkwood times which I'm sure you get delivered but it's just that the same criminal element, or the potential criminal element exists throughout the entire city, it does seem that on occasion we do have a typically little bit more violent crimes against persons in the Meacham Park neighborhood. Juveniles with guns, evidence of the guns, we find casings on the road and things like that. However one of our biggest hurdles is always when we get down there and we, even when we interview the victim, they don't want to tell us who did it, which is a hurdle in our investigation when we have witnesses that don't want to be witnesses, and we have victims that don't want to be victims. And then two days later, they decided to handle it themselves amongst each other, which only leads to the potential for innocent bystanders to be injured. So um, how we bridge this gap and how we solve that problem, that I have no idea on. We've been, that's that's an element of criminology that's been going on for centuries.

MD: Thank you, Officer. Grounding us out there and drawing those connections, speaking to your lived experience and how the department is working through that.

The next question I have, I know we've addressed in some of these other responses and really it's just trying to get a little bit more specific **when we think about access to healthcare, what's available, what's not available, and what obstacles are there?**

I know you mentioned that access to medical care can be difficult for some, access to dental care can be difficult, not only maybe because of dental practices in the area, but because dental insurance or dental coverage are difficult to find. Behavioral health and substance use also, just whether it's present or whether it's covered in the pharmacy. And Mr. Ward you've spoken to the fact that there might be some of these resources available, and they just might not be able to connect to them for whatever reason in the community. But anything else you want to say here about any one of these health care resources in the community of Kirkwood at large, or how the members of the neighborhood of Meacham Park are really connecting and about to connect to each of these health care resources?

HP: Another thing that came to mind, when the Department of Justice came, they suggested that because the people are not willing to report crime, they should have surveillance cameras be placed in locations in high crime areas, and I never did hear the final decision on that. There were supposed to be surveillance cameras in Meacham Park Memorial Park that if someone was committing a crime we could address it as a community. We had a little boy that stole a bicycle and we had them checked the surveillance cameras and they found out who the little boy was, and they wanted to put him on probation, but the group (I think the boy was about 10 or 11) and the group that was working with the park, we decided that we would prefer that he got some community service and some redirection. Working things that way seems to be favorable but that never really stayed solid because we need the connection with not just the residents, not just the individuals who are involved, we need resources that can really identify and seek solutions and put some solutions into action. Because these kids, if you ask them what activity they're doing for the

summer when school's out, they're playing in the street. That's an unsafe place to play. When we ask about what activities are going on in the park, well generally, we do a back to school rally that's a one day out of the summer activity, and um we had a group put together that said, why don't you have the park upgraded, because the park was in such bad shape at one given time, that we finally got that addressed. However, it's time to spruce the park up, make it attractive and a welcoming place for our kids to come and have activities to occur. We suggested that we work a plan that would put in an enclosure in Meacham park so that there would be activities year round, in the summer, winter, spring, and fall and they could have some indoor activities. They can go there, have indoor activities, and when they're having activities for the kids. We're missing all that. There used to be a bus that would come here and take the kids roller skating, used to be a bus that would take them on field trips. Some of them had never been to Springfield, and just, activities. We're lacking activities that are based here, that address the needs here, and address it so that it's feasible. Because at one given time, the kids were mostly going to Spry, and that was a youth program and our families were saying if you've got five kids, that's more than you can afford to pay. So it's just many cases that have come up that way with no solutions that are helpful if you're a parent and you've got five kids and the camp costs \$100 a week, well you're not going to be able to afford it. And then that same parent, I'm not calling any names, the same parent couldn't read the writing so they couldn't fill out an application. These are the kinds of stories that never get told, but I hear it and I see it, and I find it difficult to make things work in their favor, so I seek solutions and assistance from professional people who identify services available. Some of these people could benefit from court advocates. Some of them can be a good fit for advocates from the system to get on the right track. Because a teenager, teenage parents, are still a kid trying to raise a kid.

WW: Harriet, how many families do you think you have that are in that circumstance?

HP: Well, I know when we do Adopt a Family, we have 20 to 30 families every year. Every year.

WW: Well I understand that, but I said how many are really in need.

HP: Well I would be easily to say that 20 to 30 families, because what we do, we have a committee and that's their job, to seek out the less fortunate. And it's confidential information, and so we don't go and tell everybody their names in this, but every year we have 20, 30, and this year we even serve 40 families in need.

WW: and those families aren't accessing New Horizons or Camp Kirkwood or any of the other options that are available?

HP: To the best of my ability Wallace I don't see that happening.

WW: Because there's no financial hurdle for those two programs.

HP: Well, there's some financial hurdles when you go to the programs that charge and then you got to fill out an application and even the school district is seeing this. They're seeing these problems, and even sometimes, the school district will call me. You know, these things are personal, but they real. They are personal, but they are real. And I see it only because I'm the association president, and I hear it, and it's just.. This year we paid two or three families rent so that they wouldn't get put out. And we put it is a hardship, and they had to have the partnership form filled out, and it asked, What did you need? And they couldn't even fill it out. We had to fill it out and submit it. So the needs are here.

WW: Okay. How many members are there in your association? How many families or members?

HP: Since Covid our association numbers have been running low, but we run a good 30, 35.

WW: 35 families?

HP: Uh huh, in our association. And one of the things I spoke with, and we have a diverse group, we don't have all blacks or all whites or all nothing. We allow at our meetings the voices to be heard, it doesn't matter what the subject is, we give you a chance to voice your opinion. And that's one of the things that's really helping us to be the best that we can be. And do the best that we can do. And when I go and have conference with sister (Roch), I share that with her. And she, too right now is looking into getting an endowment for scholarship for African Americans to go to college.

Our Martin Luther King was done virtually, did you get to see it?

WW: No.

HP: Did you, Megan? What about Laura?

LB: Sorry I was double muted. Are you talking about the video you shared with us?

HP: We had three students, the one little girl was making a 3.9 grade point average. And we have been given scholarships every year to African American students who achieve, and they are selected by a committee. Jeff Blair, who is the owner of I See Me Bookstore and, um we give those students to get a letter of endorsement, they get, um, the grade point average, and they all the transcripts are submitted, and they write an essay, and they're selected by a committee, and we give them a scholarship to send them off to college. We don't give it to them in their hand. We give it to the school that they verify that they are enrolled. And we pay their tuition, pay it on tuition, and we've been doing that and that's been a real helpful tool to encourage the young people to do. And plus, it builds a helpful relationship between Kirkwood School District and Meacham Park.

MD: Harriet, I'm going to jump in just momentarily I think, because I'm hearing a lot of different things in this conversation- all very good things-and kind of back up a little bit. We had started talking about some of the resources in the park and maybe what are additional surveillance or resources in the park would be helpful for the families, which really was tying into this greater conversation of what resources are available to families, are families are aware of the amount of resources that they might have available to them? And if not what other obstacles or barriers might be affecting navigation? So, what I think this is also pointing to is your earlier comment of just having a more comprehensive picture of what the need is, what the need is and quantifying those things. So that we can assist in kind of connecting people to the appropriate level of resource and navigation that they may need. So just out of respect for... Oh, go ahead.

WW: Well one of the other issues that we've had in that neighborhood is that we have a lot of benevolent not for profit organizations who try and provide services to the members of the neighborhood, but there's often a lot of duplication and overlap period of those services, so we, I'm involved in the Kirkwood social justice foundation, and the role of that foundation was to bring all of these groups together and say OK, share with us what you're doing in Meacham Park. And you find out that, one the best examples I like to give, is that of backpacks. I can't tell you how many groups give backpacks to kids at the beginning of the school year over there in that neighborhood, but it's got to be that every kid can get four or five backpacks because everybody gives a backpack, and so that seems like kind of a wasted effort. Those resources should be minimized to just get adequate number of backpacks and then the monies and energy could be used for other things that are problematic for kids in that neighborhood. The issue of scholarships for graduates - it seems to be much more important to have the fine foundational effort at a preschool level. Let's give you the money there so that when you come through you can qualify for your own scholarship

for college, or even if you want to go to trade school. But you know I just think that we make a mistake of being able to capture a few kids who are successful coming out the back end, and a great many coming through here never qualify for college, so I think getting all those resources, all of the nonprofits together, so they can bring assistance to the neighborhood, getting them in one room and getting some kind of an organization of efforts.

MD: Right, thank you for. That efficiency piece. I mean, that's one of the reasons we do this work is that it draws hospitals and other stakeholders out of our silos together to have conversations. So again any of the information that we glean from our focus groups and from our stakeholders is shared and discussed in dialogue with the health departments, with other hospital partners, and with other stakeholders, as a part of this greater partnership for healthy Saint Louis. So the idea is that we're all working together and hopefully eliminating some of those silos. I think the idea of being more strategic and efficient with resources makes a ton of sense in any community or any neighborhood.

Is there anything we want to add as far as that health care access piece? I think a lot of these parts were spoken to earlier but if there's any other insight to offer we'd love to hear it.

WW: Yeah, that's a tougher one, although, you know for the young people we get some access through the school system. And we have some things that we have available out there in preschools. Another foundation I'm on, we partnered with some folks for dental care, so kids are getting some screening there, but for seniors it's a little more difficult to access for them.

MD: Yeah, especially with transportation. I know that can be difficult. Even if you have a car, office hours and working hours, all of that can be difficult.

WW: although they can access OATS or Call a Ride and that's free of charge.

MD: Valuable resources. Anything else to add as far as access to healthcare piece, Officer? I know that may not be necessarily always the first thing in your wheelhouse, but I know you're, you also are connected to those needs when they come up for the community.

Ok, you're good. Awesome. So, we'll move on to our final question and then we'll start wrapping things up. This has been a theme throughout this entire conversation, you all are way ahead of it, but thinking about **the barriers that keep people from accessing the resources that already exist. And are there some people, when we talk about equity, who struggle to obtain, or get that access more than others?** So are there specific populations within the neighborhood that struggle more? Are there specific barriers that again, keep people from the resources that might otherwise be available to them? Whether its technology, awareness, transportation, age, those kinds of things.

WW: Hmm.

HP: I'm still at the same point, these people who in Meacham Park, and we have done a door to door survey, we put flyers, we put the announcement of the COVID testing on every door in Meacham Park, we've gone every door and survey them, provide them with survey information, and the level of participation is low.

And as far as, like, we speak about the backpack giveaway. We have been doing that for 20 years straight, this is not new for us. And the other agencies are welcome to come and join us. And I find it not problematic for kids to have three or four backpacks, because some of them tear them up in the month. That's what the teachers told us. We say now, and if we have extra we give maybe two backpacks to the boys and girls and I know that to be true. And the different organizations continue to try and build, and I

feel comfortable that if it's five organizations out here, we all do what we can do, and give the best shot and we may get you, but someone else may get the other, so you see what I'm saying. You miss one person, you get the other, so I don't think we are doing too much of anything.

Because I see the neighborhood, we looked at a lawn service, people need lawn service. Do you know how much it costs for lawn service? And when you drive around and find people haven't cut their grass or cleaned up their yard, and if you demand they clean up their yard, it's a hardship.

WW: You know, I don't want to engage in a debate, I don't think it's the forum for that. But I think that you should be more outcome based. So if you're going to give back packs to the kids, you have to earn that back pack. Earn access to it by bringing a report from your teacher that says you turned in 90% of your homework. I won't hold them to 100%, 100 would be ideal, but there's no, there's no, if anything, I would think that unlimited access to backpacks might in some ways, accelerate the destruction of the backpack, because now I'll just go get another one. You know, I don't want to get too far, But I think you know, using those kinds of efforts to improve the outcomes for children is the true benefit. Just giving them the backpack is of little value as far as we get out the backpacks.

HP: it's not just the backpacks, we have education, recreation, and fun. And that backpack is something they they earn they come to that point. We have an educational booth, we have a recreation booth, none of them ever had a chance to pet a farm animal. That's an enrichment that a lot of kids never get. So yeah.

WW: So Harriet, don't misunderstand me. I'm not opposed to public access.

HP: I don't think that you're opposing, I just want to clarify. I just want to share with you that we think that the kids should earn their backpack. That's why when, because this is how it went down, people were thinking, they just can come to the park and walk up and get a backpack and go. Well, no, they have to register. They put their name on the registration. Say they want to join and participate in activities. And now one of the things, when you start signing kids up to do community activity, there's some more legal legalities they go to that. You have to know the people who are working with the kids we have, we have used our best judgment. And doing things that are simple open, and there's less liability incurred.

WW: So that's fine. I'm just saying, Harriet. I think if you've got organizations have resources, why duplicate them?

HP: Well, maybe that's what they want to do. I've accepted that some people want to sing, some people want to dance, and then some they want to dance, want to dance by themselves. Everybody don't want to come together with you, and we, we've been told that so many times – 'we don't want to come with you. We want to do our own thing.' And what can you say? All right. Okay. Do your thing.

MD: I appreciate this conversation. I do think it's an important one when we're thinking about a neighborhood that may have very specific needs or very target needs in the community, and so how can we funnel resources efficiently through that community to the people who need it most. I think that's really valuable, but I do want to kind of redirect us here to kind of the bigger picture of the barriers when we're talking about folks that are in need, if there are resources that do exist to meet their needs.

So, if we're thinking about the question of families that are needing some activities in the summer for their kids, and Mr. Ward, you're referring to some programs that are don't have financial barriers for those families. So what is the disconnect there? What are some of those barriers that keep people in need from accessing resource that exist for them? And again are there folks that are struggling more than others to get that access? Any thoughts?

HP: Megan you know what I suggest you do? I suggest that you talk with the Kirkwood School District and get their opinions about that very question, because we in the community, we do not have that direct connection like the school system have with the kids their parents.

MD: Yeah, I know it was a hard time of day for our school representatives to join us. We did have some invited to the call so I'll follow up with the questions to the school.

Mr. Ward or Officer Baldrige, do you have any thoughts on this question?

WW: Yeah, well, kids have greater access to the school district now than ever before. They, they run a lot of different programs where principals come into the neighborhood and teachers come into the neighborhood and visit the kids at home. So so I, I'm not seeing that as a real barrier. I, I see, probably if there's anything there's disclosure for this conference for some kids to get to activities outside of the Meacham Park neighborhood. There's been this long effort at self-segregation that is problematic. Um. The school district just moved its headquarters into the Meacham park neighborhood. uh, this this month, so access to the superintendent, or any of the staff members is no longer a problem. Um, I didn't think it was a problem in the past, but now geographically it's no longer a problem. So I don't that is an issue. Um, I think, um, the biggest barrier to the to, to the resources is self-contained, I think it's the individual's there unwilling to access. There are there any number of things that are available to folks in the neighborhood, and they're aware of them and they just, they choose not to access them.

MD: Interesting, thank you for sharing that. We do see that frequently in community of people again, that's difficult to ask for help or they kind of want to do things their own way. Um, and so, yeah, we, we see that in many neighborhoods and communities that we work in to.

Great insight. Officer Baldrige, any final thoughts to add?

All right, so this is the last question we had to end, but I do want to open it up for any final thoughts from this group, and again, just to express gratitude for spending a good chunk of your morning on a Monday with Laura and I having a candid conversation.

We will follow up by sending out a follow-up report. We'll put kind of the notes together and a transcript together and we'll put some slides out to send back to you all. So you can kind of hear back what you shared, and it's a, it's a dialogue. So, if there's something that comes to you in the aftermath that you'd like to share out with us, please feel free to email me or Laura and provide that input. We'll also be able to share with you the full community health needs assessment and link out to that for both of our hospitals. So you can kind of learn more about what this whole process looks like, what this is a part of, and will be able to continue the conversation of what the input turns into as far as the implementation plans and programs that our hospitals are able to collaborate with and strategize on in the community with our other partners. That process is further down the road in the fall of this year. But this is a step along our way!

Any final thoughts?

Thank you very much.

WW: Great great, thank you. And if there's one resource you could bring to us but I think it would be really valuable that would be a scientific poll of the community.

MD: Okay, great. So we can continue to do this work.

WW: To get a clear picture. Hopefully I've given you something that was of value.

MD: We appreciate your time, your feedback was super valuable, and again I'm sorry that we couldn't all be in person together. We're getting closer to that place in the hospital when we can have full normal meetings and so hopefully soon we'll be able to meet in person in the community. We appreciate your service to the community as well thank you all.

Appendix H

Mercy Hospital St. Louis
Community Health Council
Prioritization Process & Results
April 2022

Community Health Council

Mercy Hospital St. Louis



Your life is our life's work.

FY2022, Q3

April 15, 2022

Agenda

- Welcome / Introductions
- Prayer
- Community Health Needs Assessment
 - CHNA Timeline
 - Data Review
 - Prioritization

Prayer





CHNA and CHIP

Timeline & Deadlines

April 2022

- ✓ CHNA Prioritization
- ✓ Finalize CHNA draft for Board Approval

May 2022

- ✓ CHNA Board Approval – May 16
- ✓ CHNA dissemination with key partners and stakeholders
- ✓ Begin outlining program logic models and metrics

June-July 2022

- ✓ Publish CHNA on Mercy website
- ✓ Finalize CHIP draft using template
- ✓ CHC approval of CHIP – July 21

August-September 2022

- ✓ CHIP Board Approval – August 15
- ✓ Begin dissemination with key partners and stakeholders
- ✓ Publish CHIP on Mercy website

Deadlines:

- ✓ CHNA must be completed and Board-approved by **June 30, 2022**
- ✓ CHIP must be completed and Board-approved by **September 30, 2022**

Community Health Needs Assessment

Mercy Hospital St. Louis

Fiscal Year 2022



Prioritization Process – Strategy Grid

		Magnitude of Need	
		High	Low
Resources	High		
	Medium		
	Low		

Community Profile

St. Louis Community



	Total Population	Median Household Income	Bachelor's Degree or Higher	Total Housing Units	No Health Care Insurance
St. Louis City	301,578	\$43,896	36.33%	176,729	10.8%
St. Louis County	1,004,125	\$67,420	43.65%	440,960	6.1%

- **St. Louis City** - A total of 308,174 people live in the 61.74 square mile area for a population density of 4,991.9 in the City of St. Louis, according to the U.S. Census Bureau American Community Survey for the 5-year estimated timeframe of 2015-2019.
- **St. Louis County** - A total of 996,919 people live in the 507.43 square mile for a population density of 1,964.66 in St. Louis County, according to the U.S. Census Bureau American Community Survey 5-year estimate for 2015-2019.

Community Profile

Demographics – Sex & Age



Female

Male

St. Louis City

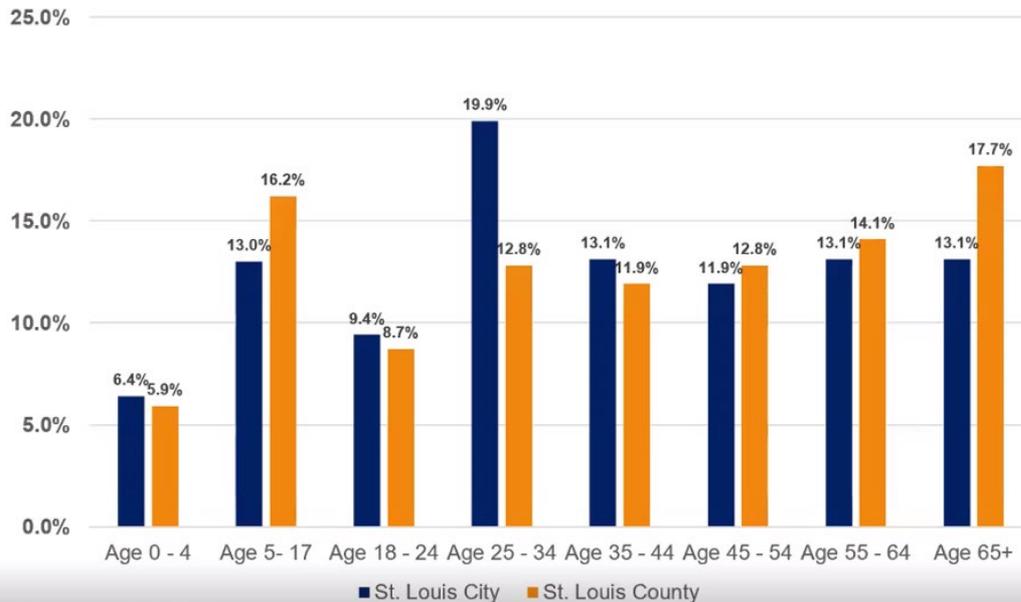
51.6%

48.4%

St. Louis County

52.7%

47.4%



Community Profile

Demographics – Race & Ethnicity

	St. Louis City	St. Louis County
White	46.5%	67.9%
African American	46.4%	24.2%
Asian	3.4%	4.3%
Native American or Alaska Native	0.3%	0.2%
Native Hawaiian or Pacific Islander	0.1%	0.04%
Other Race	1.0	0.9%
Multiple Races	2.4%	2.5%
Hispanic or Latino	4.0%	2.9%

Population by Combined Race and Ethnicity:

St. Louis City, MO

- 46.2% Non-Hispanic Black
- 43.6% Non-Hispanic White
- 4.0% Hispanic or Latino
- 3.3% Non-Hispanic Asian
- 2.2% Non-Hispanic Multiple Races
- 0.3% Non-Hispanic Some Other Race

St. Louis County, MO

- 66.0% Non-Hispanic White
- 24.1% Non-Hispanic Black
- 4.3% Non-Hispanic Asian
- 2.9% Hispanic or Latino
- 2.3% Non-Hispanic Multiple Races
- 0.3% Non-Hispanic Some Other Race

Community Profile

Socioeconomics – Financial Security

\$43,896

Median Household income in St. Louis City

0.50

Income Inequality - GINI Index Value in St. Louis City

21.8%

% of Persons in Poverty in St. Louis City

35.9%

% of Children (under 18) in Poverty in St. Louis City

\$67,420

Median Household income in St. Louis County

0.49

Income Inequality - GINI Index Value in St. Louis County

9.7%

% of Persons in Poverty in St. Louis County

13.8%

% of Children (under 18) in Poverty in St. Louis County

\$55,461

Median Household income in Missouri

0.46

Income Inequality - GINI Index Value in Missouri

13.7%

% of Persons in Poverty in Missouri

18.7%

% of Children (under 18) in Poverty in Missouri

Community Profile

Socioeconomics – Uninsured & Disability

10.8%

Adult Population Uninsured
in St. Louis City

5.0%

Uninsured Children in
St. Louis City

5.0%

% Population with Disabilities
in St. Louis City

6.1%

Adult Population Uninsured
in St. Louis County

3.1%

Uninsured Children in
St. Louis County

12.0%

% Population with Disabilities
in St. Louis County

9.4%

Adult Population Uninsured
in Missouri

5.6%

Uninsured Children in
Missouri

14.6%

% Population with Disabilities
in Missouri

Community Profile

Socioeconomics – Affordable Housing

45%

Renter Occupied Households
in St. Louis City

27%

Renter Occupied Households
in St. Louis County

26%

Renter Occupied Households
in Missouri

Percentage of Households where
Housing Costs Exceed 30% of
Income



● St. Louis City (36.07%)
● Missouri (25.53%)
● United States (30.85%)

Percentage of Households where
Housing Costs Exceed 30% of
Income



● St. Louis (27.17%)
● Missouri (25.53%)
● United States (30.85%)

3.9%

Eviction Rate in St. Louis City

4.1%

Eviction Rate in St. Louis County

2.9%

Eviction Rate in Missouri

Community Profile

Socioeconomics – Transportation

27,929

Households with no motor vehicle in St. Louis City

27,119

Households with no motor vehicle in St. Louis County

165,906

Households with no motor vehicle in Missouri

7.5%

Carpool in St. Louis City

6.8%

Carpool in St. Louis County

8.6%

Carpool in Missouri

8.8%

Public Transportation in St. Louis City

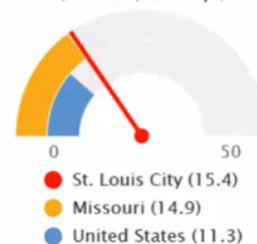
2.3%

Public Transportation in St. Louis County

1.3%

Public Transportation in Missouri

Motor Vehicle Crash Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



Motor Vehicle Crash Mortality, Age-Adjusted Death Rate (Per 100,000 Pop.)



Community Profile

Life Expectancy

County: St. Louis

VALUE
78.0
 Years
 (2017-2019)

COMPARED TO:
 MO Counties

 U.S. Counties

 MO Value
 (77.3)

 US Value
 (79.2)

 Prior Value
 (78.2)



County: St. Louis City

74.0
 Years
 (2017-2019)

 MO Counties

 U.S. Counties

 MO Value
 (77.3)

 US Value
 (79.2)

 Prior Value
 (73.9)



Community Profile

Equity & Health Disparities

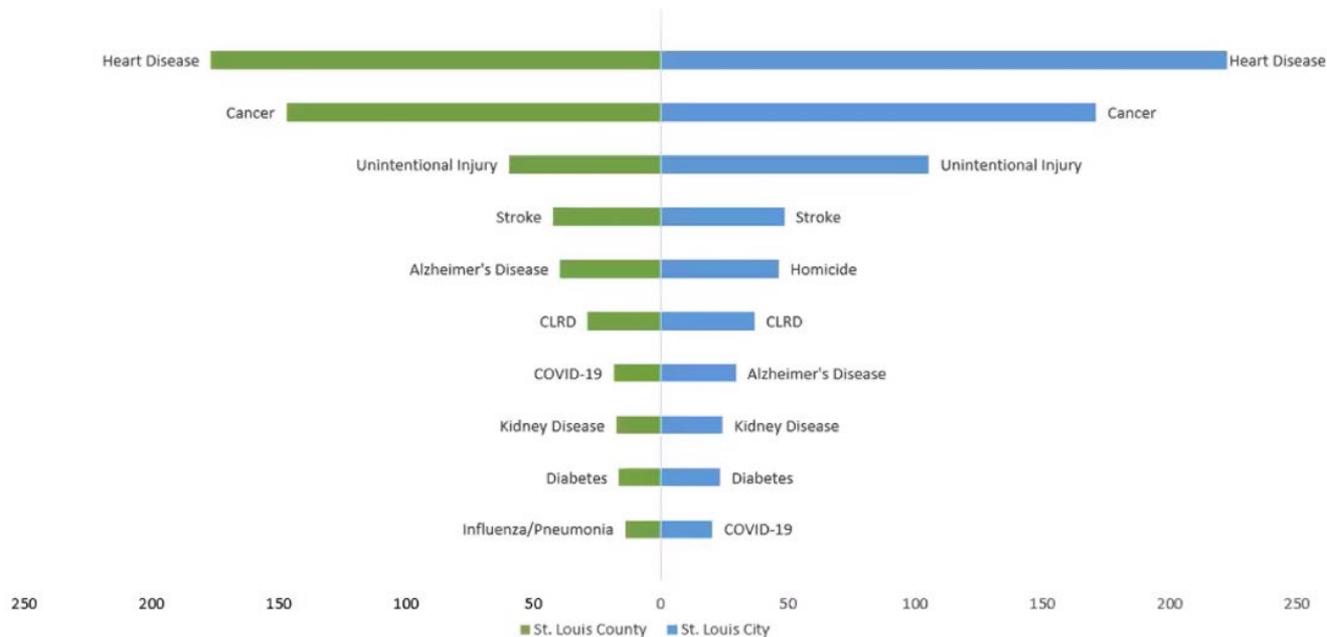
- Health disparities according to race exist for nearly every health indicator and outcome across the St. Louis region
- St. Louis is the second most segregated hospital market in the United States, with Kansas City following in third (Lown Hospitals Index, 2022).



Community Profile

Leading Causes of Death

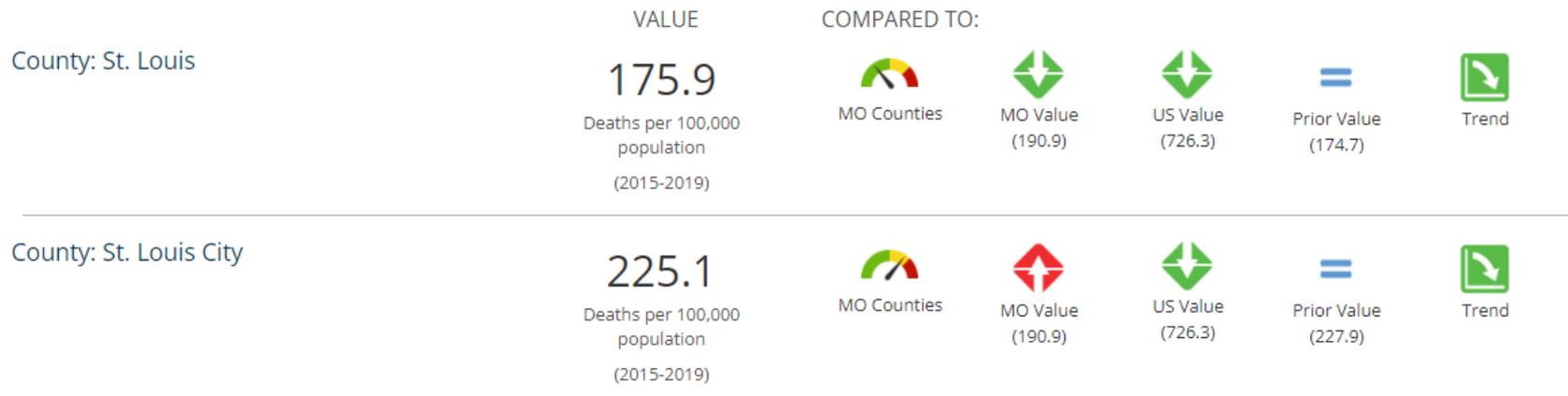
10 Leading Causes of Death in St. Louis County and St. Louis City, 2016-2020



Community Profile

Heart Disease

Age-Adjusted Death Rate due to Heart Disease



Community Profile

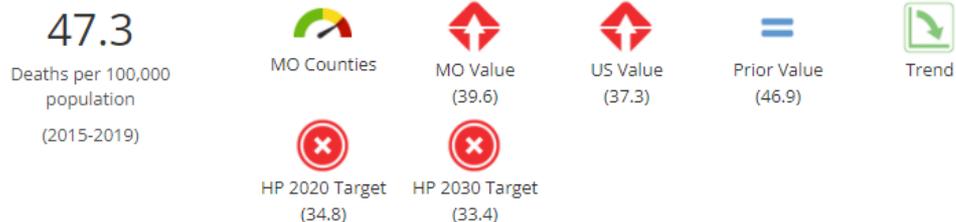
Stroke

Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)

County: St. Louis



County: St. Louis City



Community Profile

Cancer

Age-Adjusted Death Rate due to Cancer

County: St. Louis

VALUE

154.7

Deaths per 100,000
population
(2015-2019)

COMPARED TO:



MO Counties



U.S. Counties



MO Value
(166.3)



US Value
(152.4)



Prior Value
(159.5)



Trend



HP 2020 Target
(161.4)



HP 2030 Target
(122.7)

County: St. Louis City

179.3

Deaths per 100,000
population
(2015-2019)



MO Counties



U.S. Counties



MO Value
(166.3)



US Value
(152.4)



Prior Value
(193.1)



Trend



HP 2020 Target
(161.4)

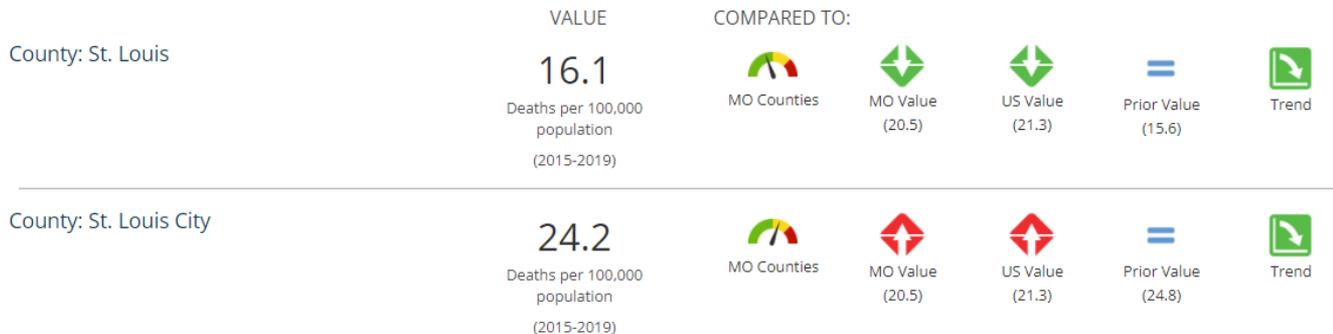


HP 2030 Target
(122.7)

Community Profile

Diabetes

Age-Adjusted Death Rate due to Diabetes



Age-Adjusted ER Rate due to Long-Term Complications of Diabetes



Community Profile

Asthma

Age-Adjusted ER Rate due to Asthma

County: St. Louis

VALUE

65.3

ER visits per 10,000
population
(2014-2016)

COMPARED TO:



St. Louis City
Value
(124.2)

County: St. Louis City

124.2

ER visits per 10,000
population
(2014-2016)



St. Louis City
Value
(124.2)

Community Profile

Alzheimer's Disease

Age-Adjusted Death Rate due to Alzheimer's Disease

County: St. Louis

VALUE
35.8
Deaths per 100,000
population
(2015-2019)

COMPARED TO:



MO Counties



MO Value
(31.6)



US Value
(30.2)



Prior Value
(33.0)



Trend

County: St. Louis City

26.5
Deaths per 100,000
population
(2015-2019)



MO Counties



MO Value
(31.6)



US Value
(30.2)



Prior Value
(24.5)



Trend

Community Profile

Maternal, Fetal & Infant Health

Infant Mortality Rate

County: St. Louis

VALUE
6.6
Deaths per 1,000 live births
(2009-2019)

COMPARED TO:



MO Counties
(2008-2018)



MO Value
(6.4)



US Value
(5.7 in 2018)



Prior Value
(6.6)



Trend



HP 2020 Target
(6.0)



HP 2030 Target
(5)

County: St. Louis City

9.6
Deaths per 1,000 live births
(2009-2019)



MO Counties
(2008-2018)



MO Value
(6.4)



US Value
(5.7 in 2018)



Prior Value
(9.8)



Trend



HP 2020 Target
(6.0)



HP 2030 Target
(5)

Community Profile

Maternal, Fetal & Infant Health (cont.)

Babies with Low Birth Weight

County: St. Louis

VALUE
10.3%
(2019)

COMPARED TO:



MO Counties
(2018)



MO Value
(8.9%)



US Value
(8.3%)



Prior Value
(10.3%)



Trend



HP 2020 Target
(7.8%)

County: St. Louis City

12.3%
(2019)



MO Counties
(2018)



MO Value
(8.9%)



US Value
(8.3%)



Prior Value
(13.0%)



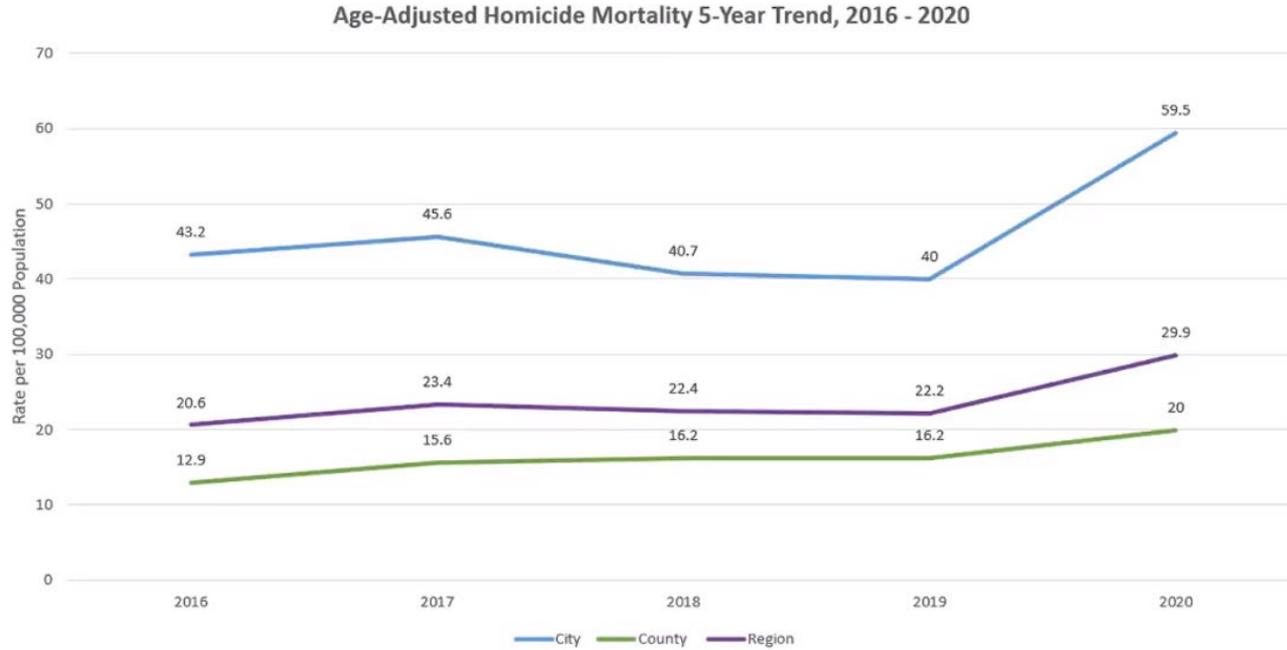
Trend



HP 2020 Target
(7.8%)

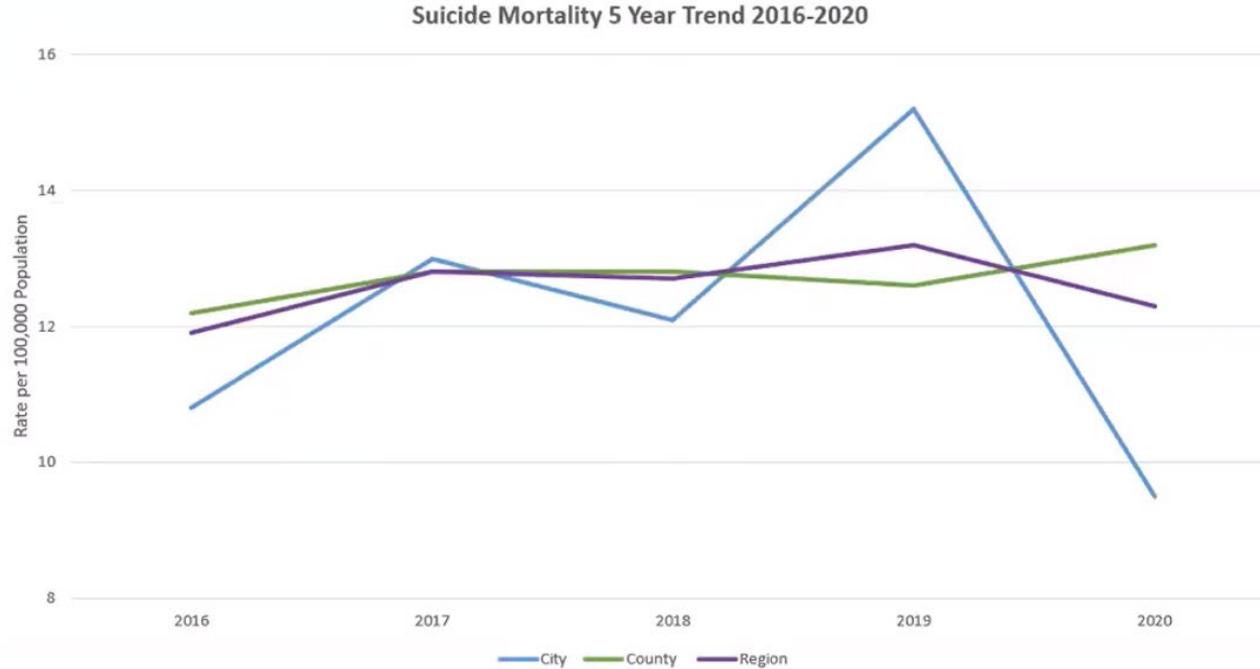
Community Profile

Homicide



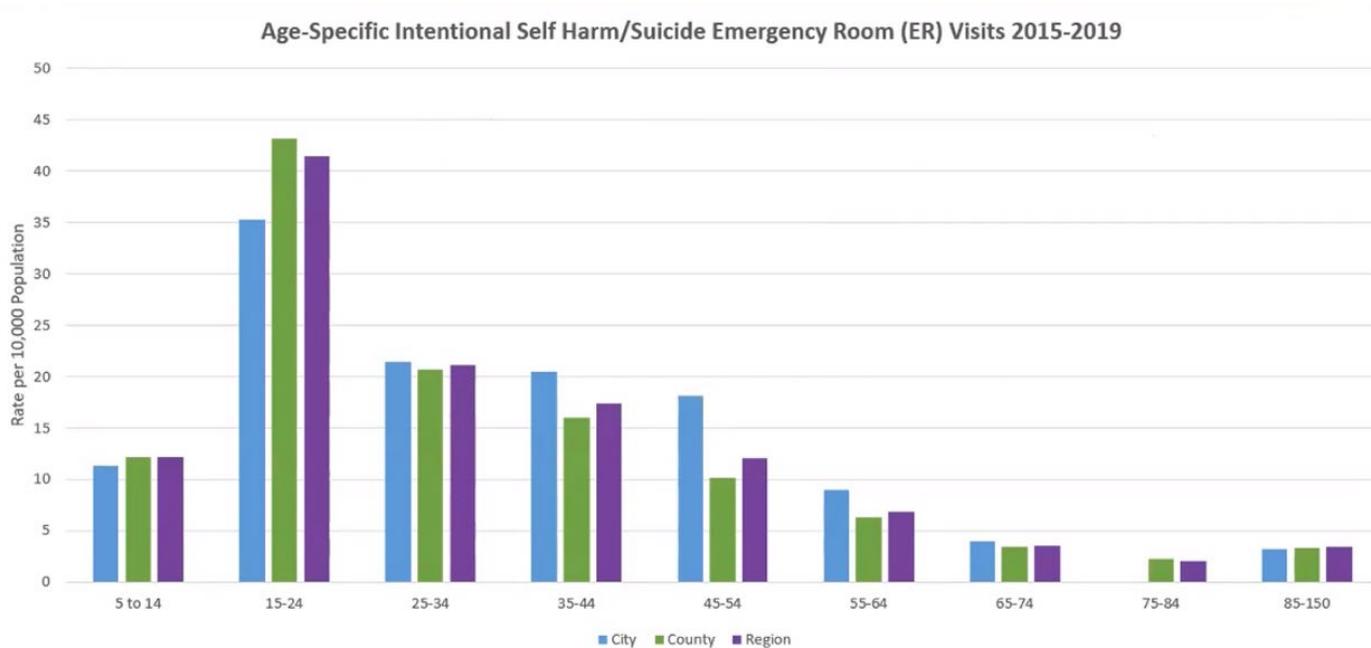
Community Profile

Suicide



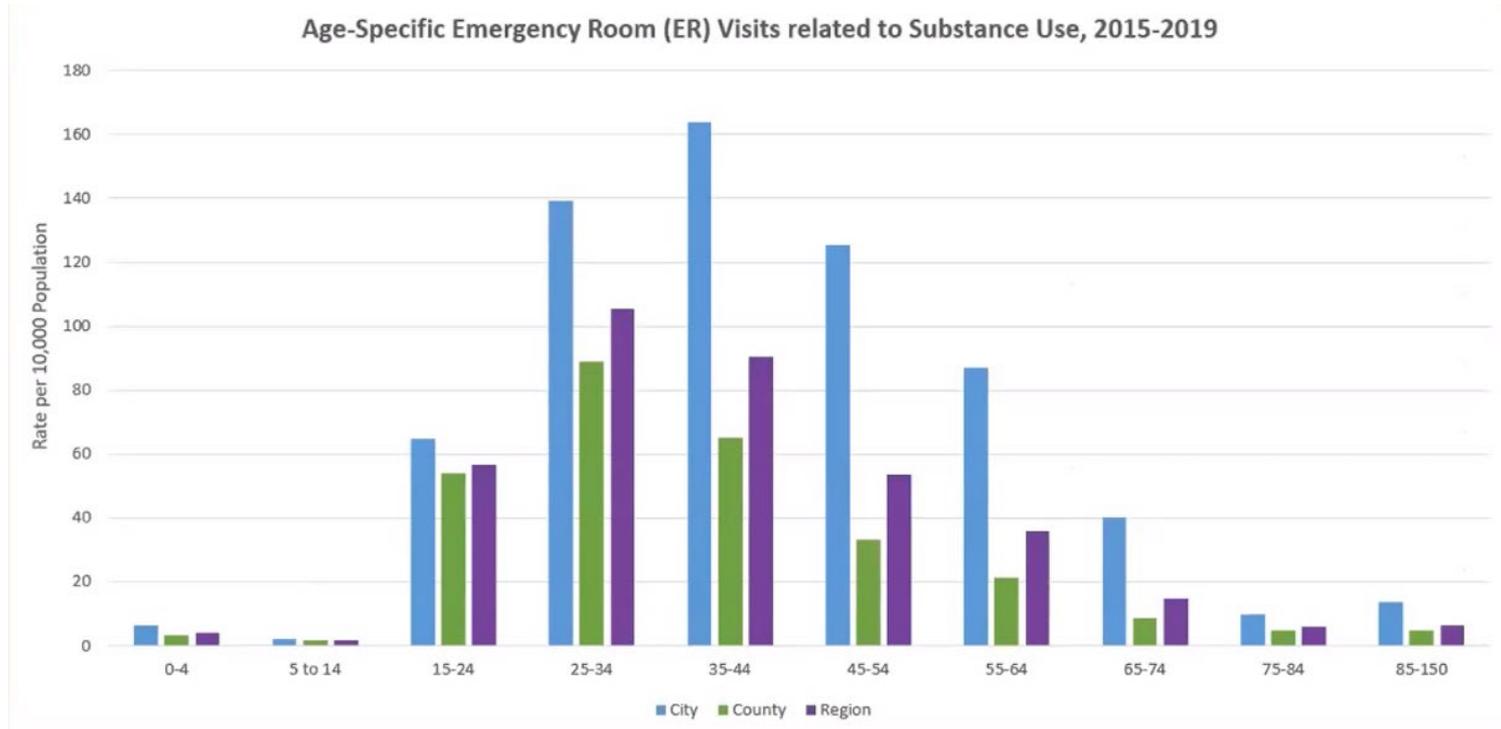
Community Profile

Intentional Self-Harm



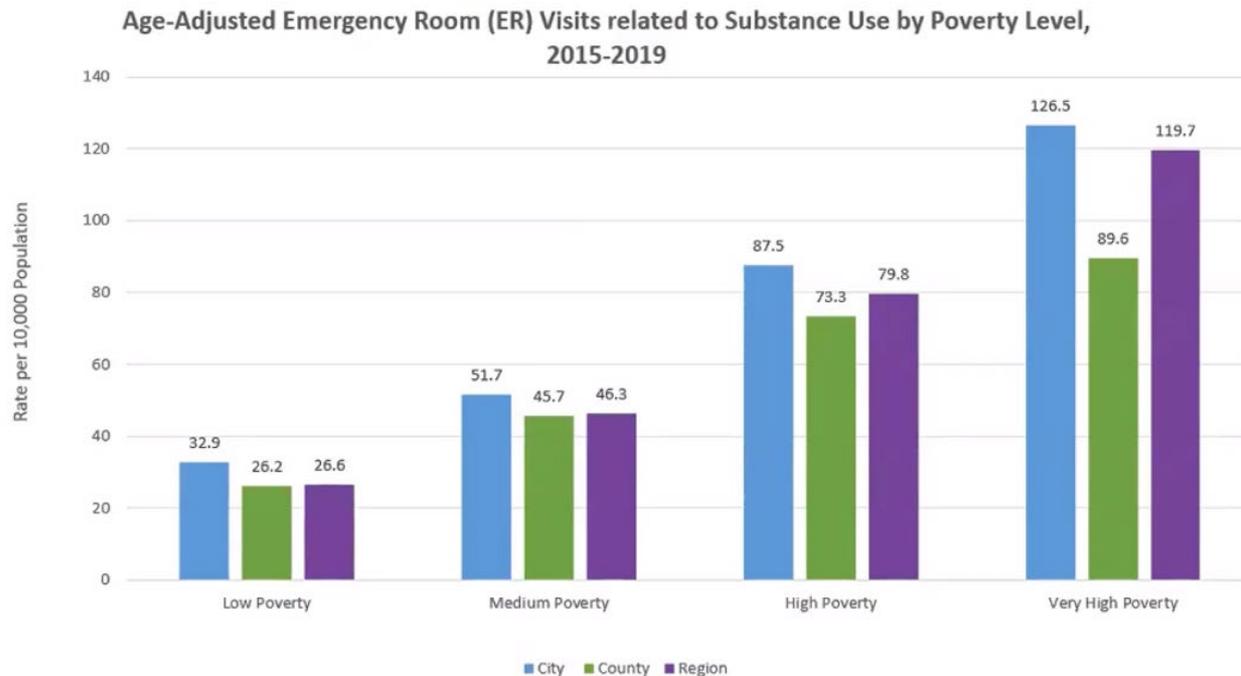
Community Profile

Substance Use



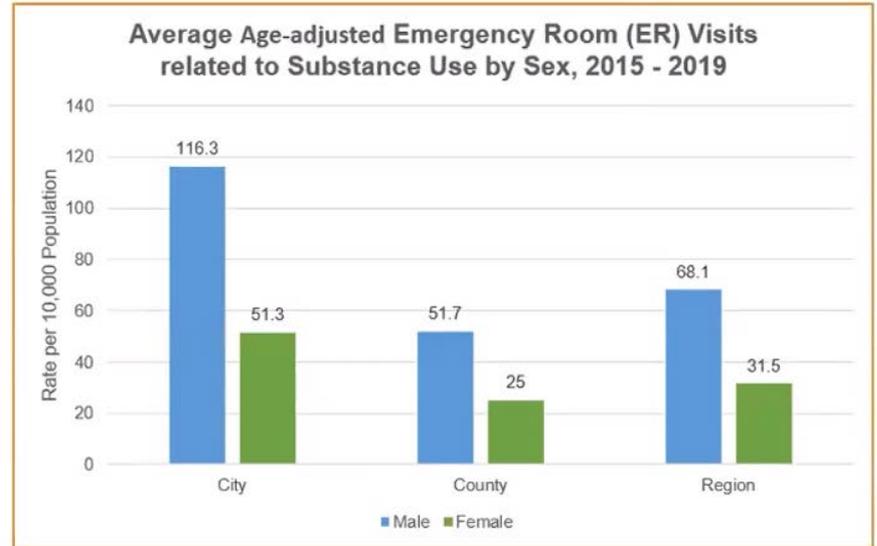
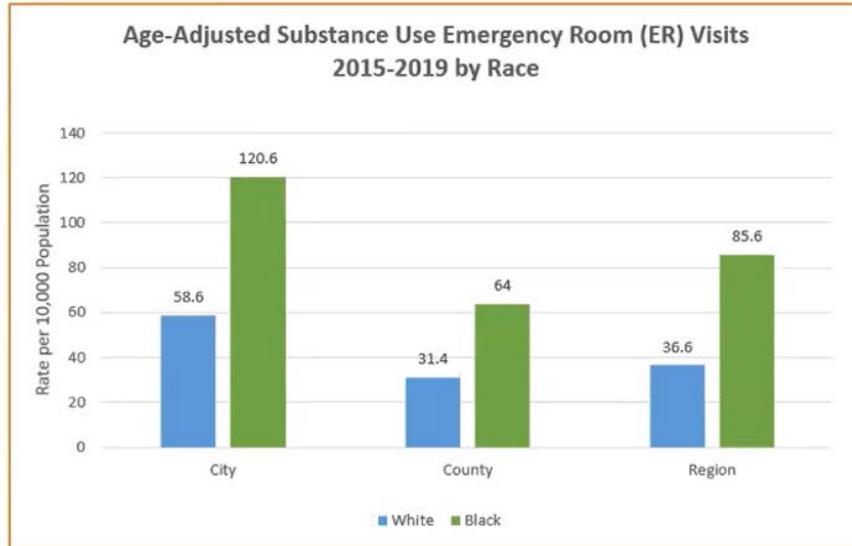
Community Profile

Substance Use (cont.)



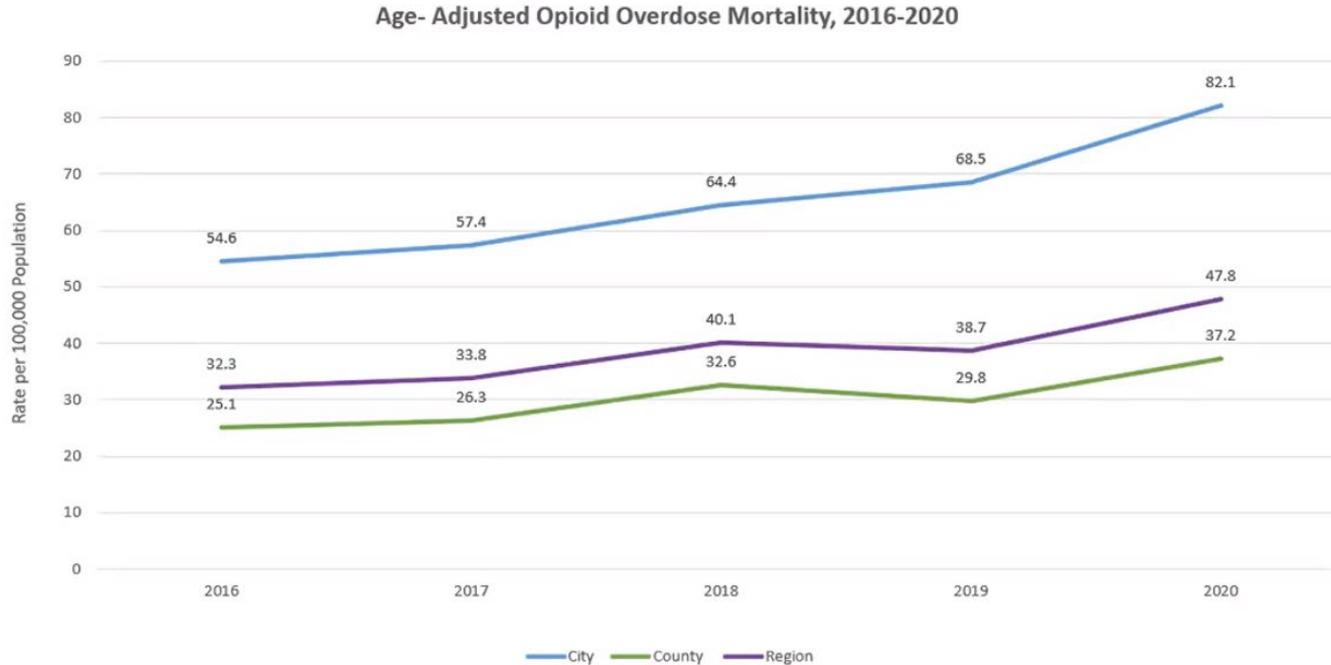
Community Profile

Substance Use (cont.)



Community Profile

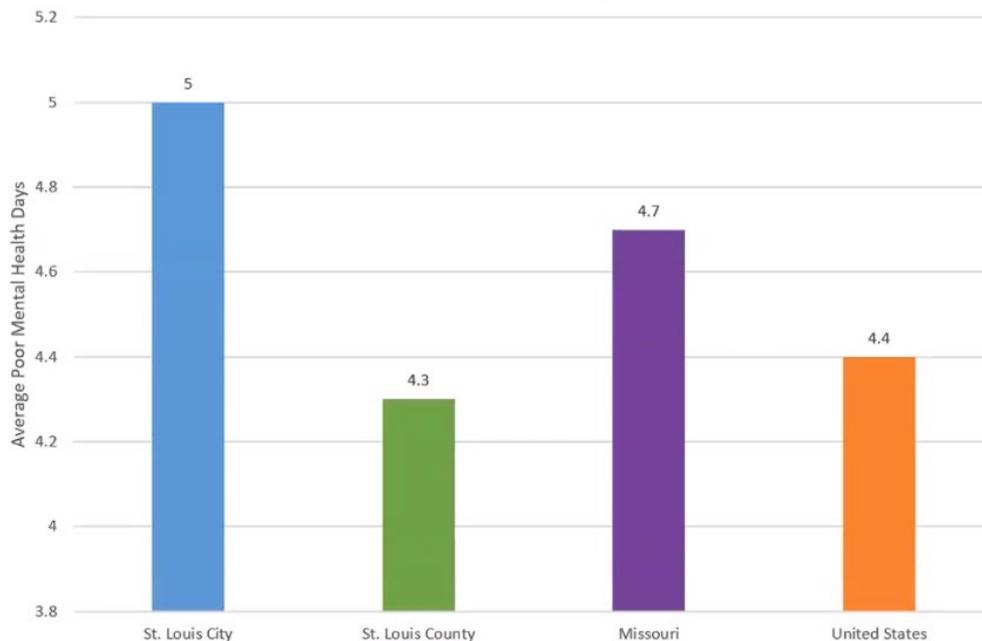
Opioid Overdose Mortality



Community Profile

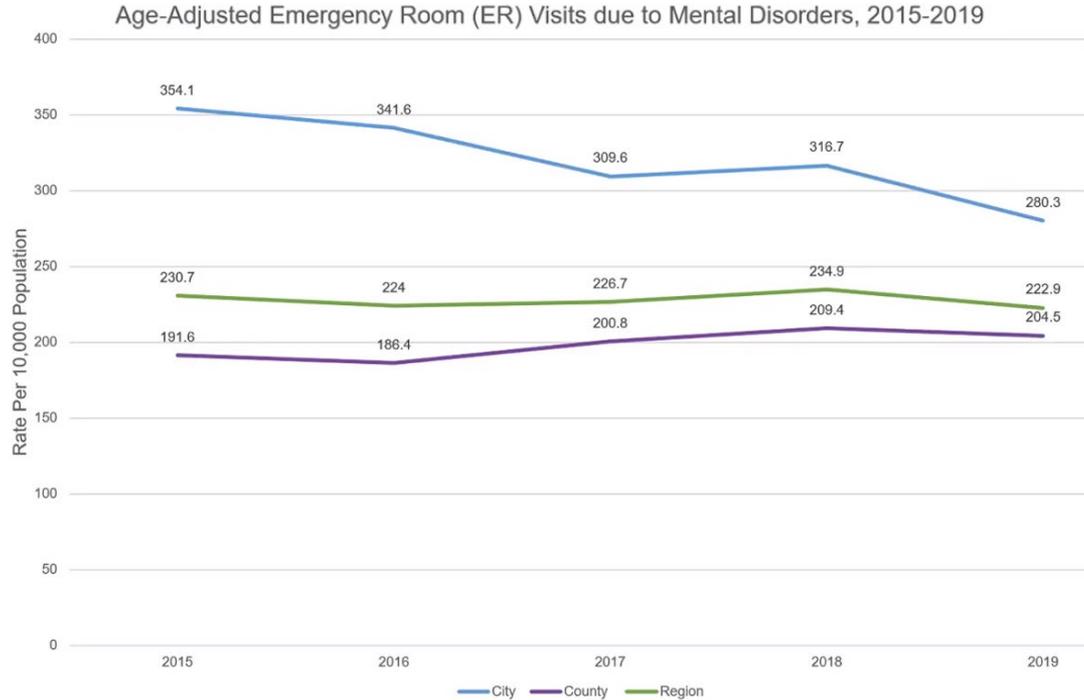
Mental Health

Self Reported Average Poor Mental Health Days per Month 2018



Community Profile

Mental Health (cont.)



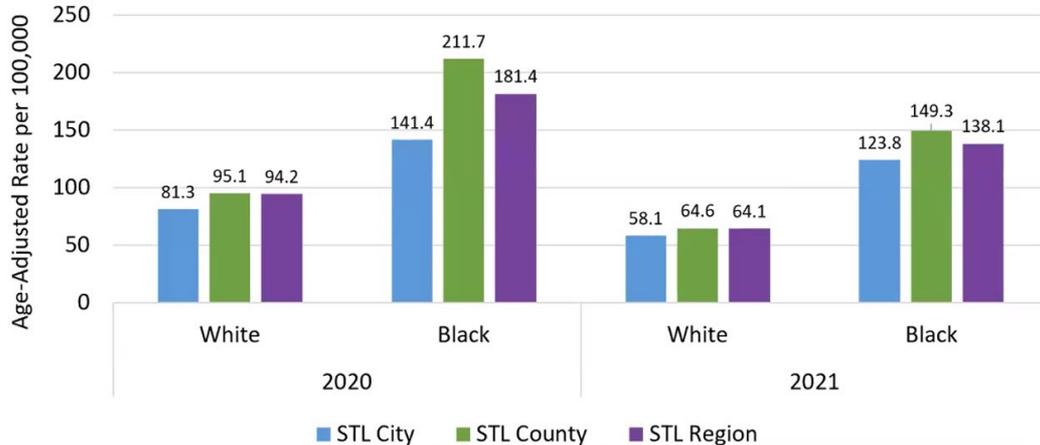
“Behavioral health is a very significant need in the area. There are not a lot of resources for that. There just aren’t enough providers available, or they have long waitlists to get in, or there are insurance issues sometimes.”

Ferguson Focus Group Participant

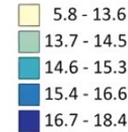
Community Profile

COVID-19

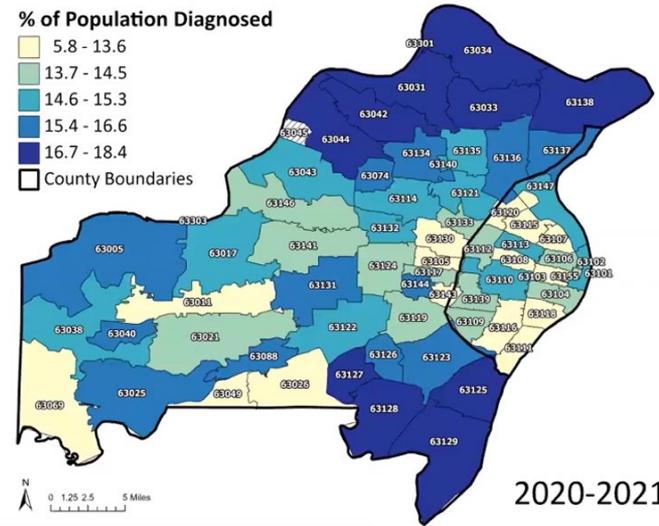
Age-Adjusted COVID-19 Mortality by Race



% of Population Diagnosed



County Boundaries

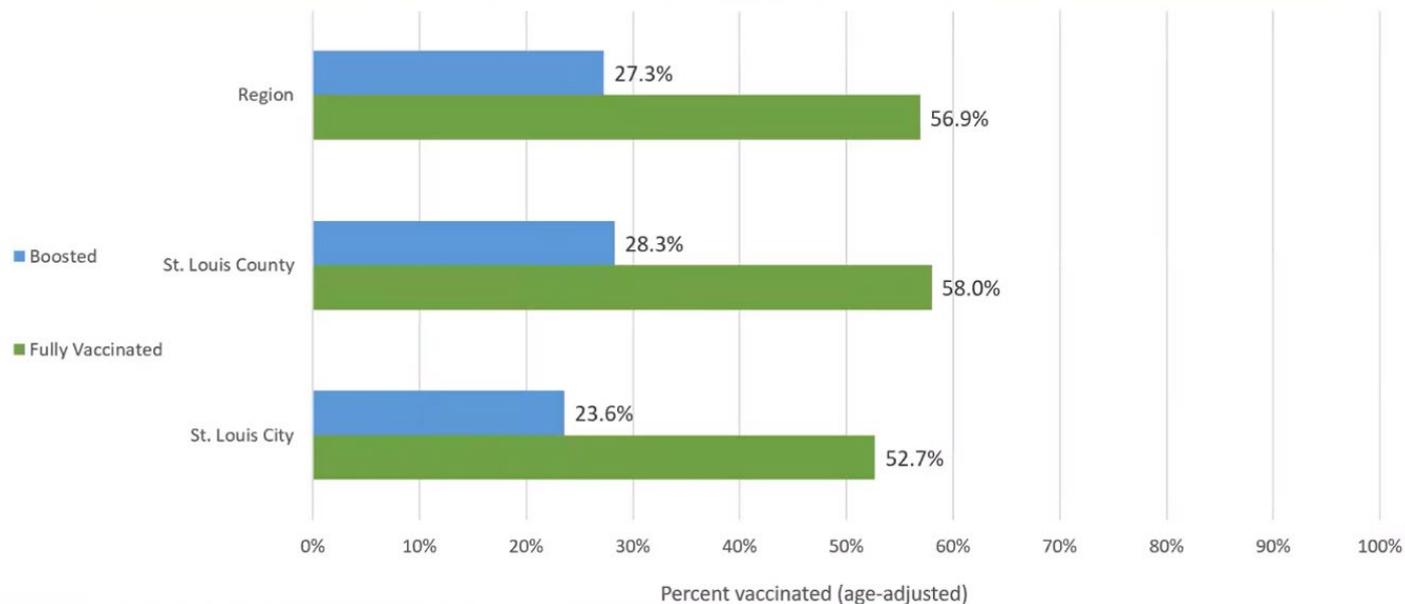


2020-2021

Community Profile

COVID-19 (cont.)

COVID-19: Vaccination Rates



Prioritization Process – Strategy Grid

		Magnitude of Need	
		High	Low
Resources	High	Maternal & Child Health, Access to Care (Transportation, Prescriptions)	
	Medium	Child Mental Health, Adult Mental Health, Substance Use	
	Low	Trauma-Informed Care, Violence, Housing	

- Access to Care*
- Access to Insurance
- Asthma
- Cancer
- COPD
- COVID-19 / Long-Haul
- Diabetes*
- Health Equity*
- Health Literacy
- Heart/Vascular Disease
- Housing
- Infectious Disease
- Financial Stability
- Maternal and Child Health*
- Mental Health*
- Prescriptions
- Seniors
- Substance Use*
- Transportation
- Violence

*current CHIP priority

Prioritization Process – Nominal Group Technique

Prioritization Criteria

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Identified Health Need						
Need 1						
Need 2						
Need 3						
Need 4						

Prioritization Process – Nominal Group Technique

Prioritization Criteria

Magnitude – the burden, scope, severity and/or urgency of the health need.

Feasibility – how complicated or multi-faceted the issue is, how much control the organization or community has over it, and/or how effective interventions are likely to be.

Mission/Strategic – how much addressing the issue aligns with the organization’s strengths, priorities, values, mission, and/or strategic plan.

Resources – whether or not existing or potential monetary, personnel, or physical resources exist to address the need, and/or whether there are existing programs or initiatives that could be built upon.

Community – the importance the community places on addressing the need or the interest the community has in addressing the need, whether or not community collaboratives or organizational efforts are in place and coordinated.

Prioritization Process – Nominal Group Technique

Example Individual Scoring Table

Prioritization Criteria

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Identified Health Need Need 1	1	4	4	4	2	15
Need 2	2	2	3	3	3	13
Need 3	3	1	2	2	4	12
Need 4	4	1	1	1	1	9

Prioritization Process Results – Nominal Group Technique

Group Total Scores

Identified Health Need	Total Score	Chosen as Priority Need



Your life is our life's work.

Community Benefit Update

FY22 YTD

Mercy Hospital St. Louis

Community Benefit Report - FY22 YTD

Community Health Improvement Services

Includes activities carried out to improve community health and services that are subsidized because they are needed in the community. Examples: education, support groups, health screenings, and immunizations.

Benefit: \$3,458,641

Total Reported
Community Benefit:
\$55,284,776

Health Professionals Education

Includes the cost of providing clinical placement for physicians, nurses and other health professionals plus the costs of the nursing anesthesia, EMS and radiology schools.

Benefit: \$3,822,522

Medicaid Subsidies

Includes the actual unpaid cost of providing care to Medicaid patients and represents the shortfall between cost of care and the payments received by the government.

Benefit: \$31,211,623

Charity Care

Includes the actual cost of providing free or discounted care to persons who cannot afford to pay and who are not eligible for public programs. Charity care does not include bad debt.

Benefit: \$16,322,238

Subsidized Health Services

Includes subsidized emergency and trauma, hospital outpatient, and behavioral health services provided to patients.

Benefit: \$0 (Entered at end of FY)

Mercy East

340b Patient Assistance Funds

FY22 March YTD

Programs Funded

- BEACN Program : \$550,166
- Loyola Academy : \$7,050
- Dispensary of Hope : \$37,500
- Ferguson Clinic: \$44,029
- Self Monitoring Blood Pressure Program: \$3,016
- Community Flu Vaccines : \$9,869
- Outpatient Infusion Pt. Asst : \$344,810
- Retail & Specialty Pharmacy Pt. Asst : \$869,245
- Mercy Clinic Pt. Drug Asst : \$398
- SURP : \$174,800
- Tabernacle Clinic : \$41,667

Total Annual Cost
\$3,765,928

FTE Commitments

- Account Coordinator (MHSL OP Infusion) : \$49,969
- OB/GYN Social Worker : \$130, 513
- Social Worker (LCSW) and CHW to work with PCPs : \$59,436
- MA Peds Medicaid : \$35,685
- FTE for Ambulatory & Specialty Pharmacy Coordinator : \$55,758
- Clinic CHW : \$31,174
- MHJ Hospice SW : \$27,653
- MHW Dietitian : \$25,358
- MHSL Dietitian : \$49,725

Community Benefit Reporting Deadlines

FY22 Q3: April 30, 2022

FY22 Q4: July 25, 2022

ALL reports must be submitted into CBISA by August 5, 2022

How do I report?

- By submitting an online form: https://mercy.co1.qualtrics.com/jfe/form/SV_aVj67207XnOCX2d
- Completing a single occurrence form*
- Completing a cumulative spreadsheet for the entire quarter*

CHIP Review & Impact

Community Health Improvement Plan (CHIP)





Access to Care

Community Health Worker Program (ED & Clinic) – FY22 Q1-Q3

- **4,567** encounters with **1,953** unique patients
 - **803** patients at Mercy Clinic – Ferguson
 - **1,158** patients through ED
- **36%** of all Self-Pay ED Patients were served by CHWs in Jan/Feb, compared to 16% in Q2 (Goal=20%)
- **659** Basic Needs Questionnaires collected in ED via pilot program (+126% from Q2 to Q3)

*From Q2 to Q3, CHW patient encounters increased by **93.2%**, and unique patients served increased by **87%** (114% in ED)*



Access to Care



Patients Served

1,953

Encounters

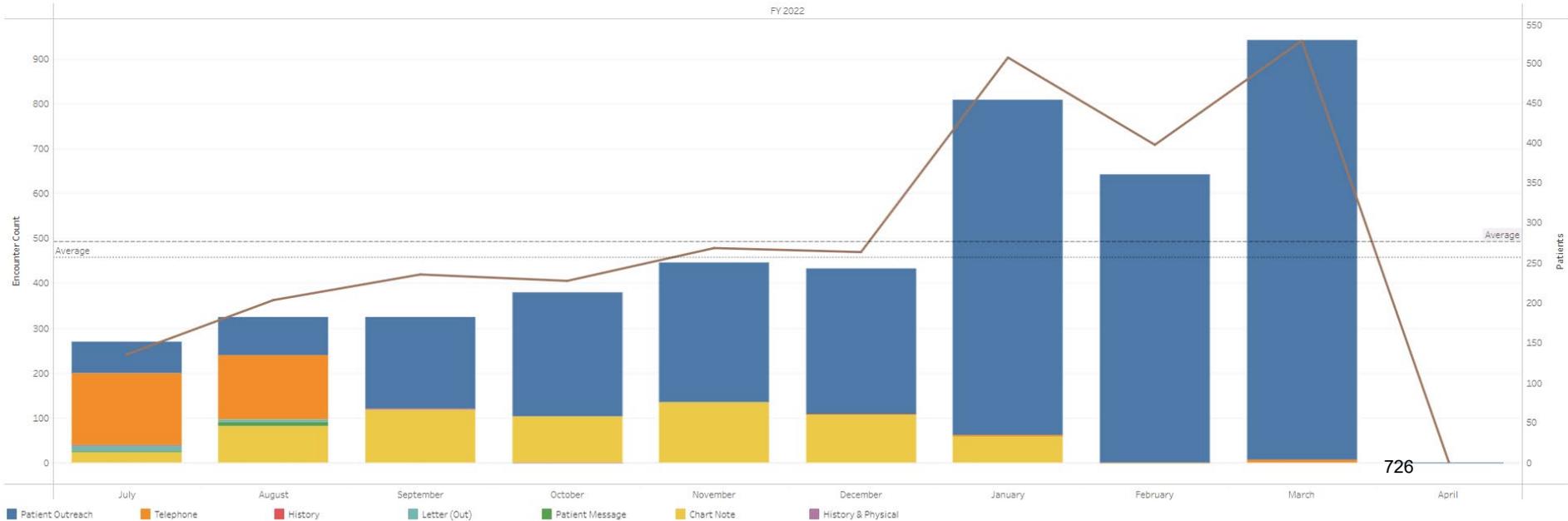
4,567

Community Health Worker Productivity

Care Model: (All) | Community: St. Louis Community | Community Health Worker: (All)

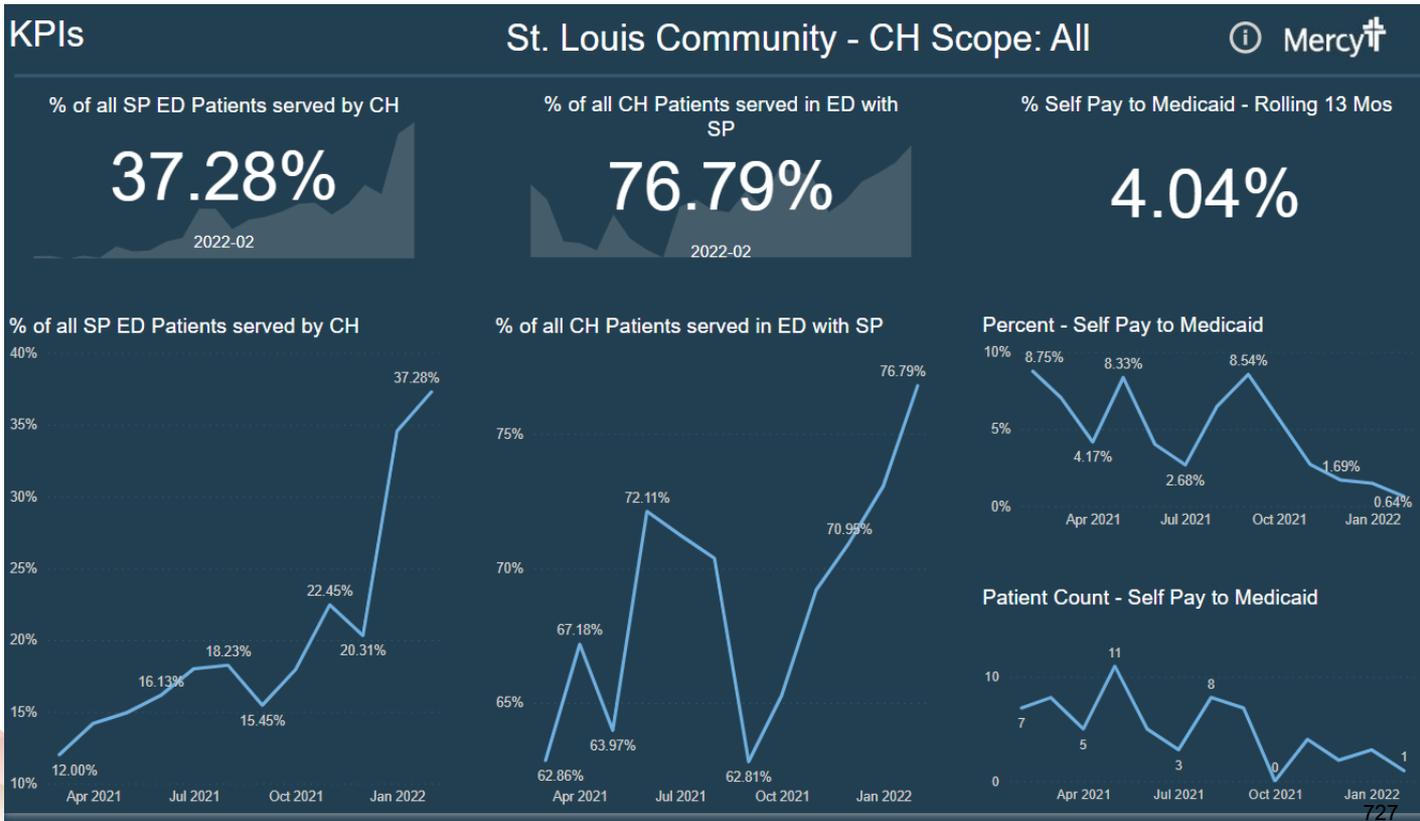
Date: 7/1/2021 to 3/31/2022

Encounter Type Trend





Access to Care





Access to Care

Community Referral Coordinator (IHN) - FY22 Jan YTD

- **1050** patient encounters with **496** patients referred to a PCP or specialist for follow-up care
- **66%** average appointment kept rate



Access to Care

50% of CRC patient encounters at Adult sites were with **Self-Pay or Uninsured** individuals

241

individuals were provided information or applications for insurance coverage

87%

of Self-pay patients, who were scheduled an appointment, had health coverage options reviewed and/or received CRC assistance in applying



Encounters by Payor Type and Site



729

*Less than 1% of patients with VA/Military Benefits



Behavioral Health

Behavioral Health Network (HCL/ERE, EPICC) – FY22 Q1-Q3

- Hospital Community Linkages (HCL) program scheduled **98** behavioral health appointments/follow-up care at community mental health centers for **140** patients during their inpatient hospitalization (79% kept rate)
- **159 adult** and **123 youth** referrals were made into the Emergency Room Enhancement (ERE) program, connecting these patients with significant behavioral health needs to treatment and support services.
 - 77% of patients referred into the ERE program became engaged in care
- **110 patients** with severe opioid use disorder (OUD) were referred into the Engaging Patients in Coordinated Care (EPICC) program, with 76% successfully connected to treatment

Other Program Updates:

Chronic Disease



- Diabetes Prevention Program largely on hold throughout the pandemic
- CHW have been trained as facilitators at Mercy Clinic Ferguson
- Mercy continues to engage in regional diabetes collaborative

Maternal and Child Health



- Awaiting final MOU approval from Nurses for Newborns for Mercy's involvement in Safe Sleep First Program
- Centering Pregnancy classes were on hold throughout the pandemic
- NICU Lactation Program (Milk Bank) and Breast Pump Donation

Community Health Needs Assessment

Prioritization Process



FY2022

Directions

- Using the table on slide 5, rate each identified health priority from 1-5 (1 being low, 5 being high), for each prioritization criteria. See slide 3 for an example, and slide 4 for definitions of the criteria.
- Calculate the total number of points accumulated for each need according to your ratings, and record the sum in the “total points” column.
- Save and email the completed document to Megan.Drissell@mercy.net by Friday, April 22, 2022.

EXAMPLE

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Need 1	1	5	4	4	3	17
Need 2	4	3	3	3	3	16
Need 3	3	1	2	2	3	11
Need 4	5	3	4	1	4	17
Need 5	2	4	2	3	3	14
Need 6	4	2	3	3	1	13

Prioritization Criteria

Magnitude – the burden, scope, severity and/or urgency of the health need.

Feasibility – how complicated or multi-faceted the issue is, how much control the organization or community has over it, and/or how effective interventions are likely to be.

Mission/Strategic – how much addressing the issue aligns with the organization’s strengths, priorities, values, mission, and/or strategic plan.

Resources – whether or not existing or potential monetary, personnel, or physical resources exist to address the need, and/or whether there are existing programs or initiatives that could be built upon.

Community – the importance the community places on addressing the need or the interest the community has in addressing the need, whether or not community collaboratives or organizational efforts are in place and coordinated.

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	2	3	5	2	2	14
Maternal & Child Health	3	4	5	5	4	21
Substance Use Disorder	5	4	5	4	5	23
Health Equity	4	1	5	2	4	16
Trauma-Informed Care	3	4	5	3	3	18
Violence	3	2	5	2	4	16
Housing	2	2	5	2	2	9
Child Mental Health	5	5	5	4	5	24
Adult Mental Health (including Maternal mental health)	5	5	5	5	4	24

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	5	4	5	4	4	22
Maternal & Child Health	5	4	5	4	4	22
Substance Use Disorder	4	4	4	3	3	18
Health Equity	4	3	4	3	3	17
Trauma-Informed Care	4	4	3	2	2	15
Violence	3	2	2	3	3	13
Housing	4	2	3	3	2	14
Child Mental Health	5	4	3	2	3	17
Adult Mental Health (including Maternal mental health)	5	4	3	3	3	18

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	5	4	5	3	5	22
Maternal & Child Health	3	3	4	3	3	16
Substance Use Disorder	3	3	4	3	3	16
Health Equity	5	4	5	3	5	22
Trauma-Informed Care	3	3	3	3	3	15
Violence	3	2	4	2	4	15
Housing	3	2	4	2	4	15
Child Mental Health	3	3	4	3	3	16
Adult Mental Health (including Maternal mental health)	3	3	4	3	3	16

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	5	4	5	3	2	19
Maternal & Child Health	4	4	5	4	3	20
Substance Use Disorder	4	3	4	4	4	19
Health Equity	4	2	5	4	3	18
Trauma-Informed Care	2	3	3	3	1	12
Violence	3	2	2	2	3	12
Housing	3	2	1	1	3	10
Child Mental Health	4	3	4	3	4	18
Adult Mental Health (including Maternal mental health)	4	3	4	3	3	17

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	5	5	5	4	4	27 23
Maternal & Child Health	4	4	5	4	4	21
Substance Use Disorder	3	4	4	3	4	18
Health Equity	5	4	5	4	5	23
Trauma-Informed Care	3	3	4	3	5	18
Violence	3	2	4	2	3	14
Housing	5	3	5	3	5	21
Child Mental Health	4	4	4	4	4	20 20
Adult Mental Health (including Maternal mental health)	4 5	4	5	3	5	22

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	5	2	5	2	5	19
Maternal & Child Health	4	4	5	3	4	20
Substance Use Disorder	5	3	5	3	5	21
Health Equity	4	3	4	2	5	18
TraumaInformed Care	4	3	4	3	4	18
Violence	4	1	4	2	3	14
Housing	5	2	3	1	3	14
Child Mental Health	5	3	5	3	5	21
Adult Mental Health (including Maternal mental health)	5	4	5	4	4	22

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	5	5	5	3	5	23
Maternal & Child Health	4	5	5	3	5	22
Substance Use Disorder	5	4	3	3	5	20
Health Equity	5	4	5	3	5	22
Trauma-Informed Care	3	3	3	2	3	14
Violence	5	1	1	1	5	13
Housing	5	1	1	1	5	13
Child Mental Health	5	5	5	4	5	24
Adult Mental Health (including Maternal mental health)	5	5	5	4	5	24

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	4	5	5	5	5	24
Maternal & Child Health	4	4	5	5	5	23
Substance Use Disorder	4	3	4	3	5	19
Health Equity	5	3	5	3	5	21
Trauma-Informed Care	5	4	5	3	4	21
Violence	5	2	3	1	5	16
Housing	5	2	3	1	5	16
Child Mental Health	4	4	4	2	4	18
Adult Mental Health (including Maternal mental health)	5	3	4	2	4	18

Prioritization Criteria

Identified Health Need

	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Access to Care (includes prescriptions & transportation)	4	3	5	4	4	20
Maternal & Child Health	4	4	5	4	3	20
Substance Use Disorder	4	3	4	3	5	19
Health Equity	5	3	5	4	5	22
Trauma-Informed Care	5	4	4	3	4	20
Violence	4	3	4	2	4	17
Housing	4	3	4	2	4	17
Child Mental Health	5	3	4	3	5	20
Adult Mental Health (including Maternal mental health)	5	4	4	3	4	20

Prioritization Process Results – Nominal Group Technique

Group Total Scores

Identified Health Need	Total Score
Access to Care (includes prescriptions and transportation)	188
Maternal & Child Health	185
Substance Use Disorder	173
Health Equity	179
Trauma-Informed Care	151
Violence	130
Housing	133
Child Mental Health	179
Adult Mental Health (including maternal mental health)	181

Prioritization Process Results – Nominal Group Technique

Rankings

Rank	Identified Health Need	Total Score	Chosen as Priority
1	Access to Care (includes prescriptions and transportation)	188	✓
2	Maternal & Child Health	185	✓
3	Adult Mental Health (including maternal mental health)	181	✓
4	Child Mental Health	179	✓
	Health Equity	179	✓
5	Substance Use Disorder	173	✓
6	Trauma-Informed Care	151	?
7	Housing	133	
8	Violence	130	

*Can be addressed jointly as Behavioral Health

Prioritization Process Results – Nominal Group Technique

Final Priorities

