Community Health Needs Assessment

Mercy Hospital South

2022-2024

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

Contents

Impact Evaluation of Previous CHNA

The 2019 Community Health Needs Assessment identified three priority health areas:

Mercy Hospital South developed and implemented a community health improvement plan which included a variety of programs and initiatives to address the needs identified in the 2019 CHNA.

Impact Evaluation of Previous CHNA

Prioritized Need #1: Access to Care

Community Health Worker (CHW) Program: CHW's have been serving at Mercy Hospital South since 2018. Our two CHW's serve as liaisons/links between health care, community and social service agencies. They screen for needs related to social determinants of health and facilitate access to services and improving the quality and cultural competence of care. They work one-on-one with at-risk patients and community members, acting as patient advocates, assisting patients applying for Medicaid and Financial Assistance and connecting patients with community resources. Our CHWs provided resources and assistance to over 3,000 patients over the last three years with over 5,900 encounters with special attention paid to assisting with enrollment into Mercy Financial Assistance and Medicaid.

Community Referral Coordinator (CRC) Program: CRC's connect patients from the Emergency Department and/or inpatient units of the hospital with a primary care home for follow-up and preventative care. The program focuses on serving underinsured and uninsured patients; however, work with all patients in need of a medical home which can be a Federally Qualified Health Center (FQHC) or a Mercy provider. The Mercy South CRC had 4,382 encounters over the past three years and scheduled appointments with an average kept rate of 76.9%

Impact Evaluation of Previous CHNA

Access to Care *(continued)*

Health Leads Program: Health Leads connects low-income patients in the clinics to the resources they need to be healthy. Staff at Mercy Clinics utilize a screening tool to identify social needs that are acting as barriers to patient's medical care. If a need is identified, patients are contacted by Health Leads staff to connect to community resources to address the need(s). Since FY 2019, 211,423 patients have been screened. An average of 7% of those screened identified as having a social need. 2,881 needs were addressed and closed.

Hancock Clinic Partnership: Mercy South financially supports the Hancock school-based Community Clinic that serves all verified residents of the 63123 and 63125 zip-code at no out-of-pocket expense to the patients. Services provided include general services, women's health, basic labs and mental health to this high-need/high-risk population. Patients from these zip codes that present at Mercy Hospital South without a PCP are connected with care at the Hancock Clinic. For the past three years, the Hancock Clinic has seen 2,831 patients and has had assisted over 200 Mercy Hospital South patients that have been directly referred to the clinic.

Impact Evaluation of Previous CHNA

Access to Care *(continued)*

Crisis Nursery Outreach Partnership: The Crisis Nursery Outreach Center at Mercy Hospital South assists area families with children birth through 12 years with crisis counseling, community referrals, home visitation, and parent education groups to prevent child abuse and neglect and promote healthy families. The program also provides community families in need with donations of food bags, diapers, cleaning supplies and other household items. In the past three years, the Crisis Nursery at Mercy Hospital South had 2,368 total encounters, assisted over 100 MHS patients and their families and helped patients, staff and community members be connected to over 3,000 basic needs items.

Impact Evaluation of Previous CHNA

Prioritized Need #2: Behavioral Health

Behavioral Health Network Partnership Programs

- *Emergency Room Enhancement (Youth and Adult ERE):* The Behavioral Health Network's ERE project facilitates an integrated 24/7 region-wide approach that targets high utilizers of emergency rooms who present with behavioral health symptoms, with the primary goal of reducing preventable hospital readmissions. Patients identified through the ERE project are connected to a peer support specialist who provide assistance with linking to community resources and inpatient and outpatient services. The program provides after-hours/weekend scheduling, as well as telephonic and mobile outreach crisis services for consumers referred to the ERE project. From 2019 to April of 2022, there were 225 referrals made into the Youth ERE program, 209 appointments scheduled with a kept rate average of 67%. For the Adult ERE program, there were 421 referrals made, 300 appointments set with an average kept rate of 70%.

Impact Evaluation of Previous CHNA

Behavioral Health *(continued)*

- *Hospital Community Linkages (HCL):* The HCL Inpatient project utilizes a designated liaison to identify and refer potential behavioral health consumers, facilitate referral and ensure discharge documentation is transferred for continuity of care. The HCL program is part of an integrated 24/7 region-wide approach that targets high utilizers of inpatient settings, with the primary goal of reducing preventable hospital readmissions. There have been 407 referrals into the program, 287 appointments made and an appointment kept rate average of 77% from 2019 to 2022.
- *Engaging Patients in Care Coordination (EPICC):* The EPICC program, in partnership with the Behavioral Health Network of Greater St. Louis (BHN) connects opioid overdose survivors treated in emergency rooms to recovery support and substance use treatment services, including Medication Assisted Treatment (MAT). Individuals must be over the age of 18 and meet diagnostic criteria for opioid dependence. Intensive referral and linkage services are provided by peer Recovery Coaches. There have been 630 referrals into the program, 563 appointments scheduled with an average appointment kept rate of 70%.

Impact Evaluation of Previous CHNA

Prioritized Need #3: Chronic Disease with a Focus on Diabetes

St. Louis County Diabetes Collaborative Program: Established as a result of the on-going St. Louis County CHNA hospital collaborative upon jointly prioritizing diabetes top health concern across the St. Louis community In the past three years, the collaborative has expanded their scope to bring together additional hospitals, community agencies and support from local health departments in order to develop regional and collaborative strategies to address diabetes.

Partners include: BJC Healthcare (including Barnes Jewish West County Hospital, St. Louis Children's Hospital, Christian Hospital and Missouri Baptist Medical Center, Mercy (including Mercy Hospital St. Louis and South), Oasis, the St. Louis County Health Department, St. Lukes (including St. Lukes and St. Lukes Des-Peres, SSM Health Care (including DePaul Hospital, St. Mary's Hospital, Cardinal Glennon Children's Hospital and St. Louis University Hospital)

Impact Evaluation of Previous CHNA

Chronic Disease with a Focus on Diabetes *(continued)*

Scope of Work and Limitations: Over the three-year cycle, the collaborative worked hard to cohesively identify goals that could be worked on across all organizations. In the first year, the team identified resources, programs and individual hospital needs that had to be considered in order to come to a consensus on how integrate referral protocols and improve the coordination of services. After setting goals and outlining next steps, COVID-19 hit the community and caused a year-long pause in our collaborative as team-members were pulled to address different community concerns. The team re-grouped in 2021 and is currently doing the work of re-assessing our resources, current programming and goals to create a new strategy for FY 23.

Executive Summary

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

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

Executive Summary *(continued)*

Six identified health needs emerged during the CHNA process. The Community Health Council of Mercy Hospital South reviewed and prioritized the needs based on several criteria. 2022 prioritized health needs are:

- Access to Care
- Behavioral Health/Substance Use
- Diabetes

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

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

Sean Hogan
President
Mercy Hospital South

Community Profile

St. Louis Region (South County)

Mercy Hospital South serves more than 630,000 residents in the St. Louis area, which covers St. Louis, southern communities and several locations in southwest Illinois. Mercy Hospital South is considered the third-largest medical center in the St. Louis metropolitan area. The majority (81%) of Mercy Hospital South's acute care patients reside in 31 zip codes, 28 in Missouri and 3 in Illinois. In Fiscal Year 2021 (July of 2020 to June of 2021), MHS had 63,181 Emergency Room visits, 359,000 outpatient visits, offered services in 57 locations and employed 2,898 co-workers.

Our needs assessment is focused on south St. Louis County, which immediately surrounds the hospital. In 2011, representatives from the St. Louis County Department of Public Health met with representatives from the St. Louis County Department of Planning and established five regions within the county to reflect how it is divided in terms of geography and social demographics. These regions were: Central, Inner North, Outer North, South, and West. Taking into account the regional distribution of medically underserved individuals, as well as the hospital's location, MHS defined its community as the south region in St. Louis County during its CHNA process.

Community Profile

Mercy Hospital South- South Region of St. Louis County

Population: 201,351

Projected 5-Year Growth: **+ 0.07%**

Race: Minorities make up 9.08% of Residents

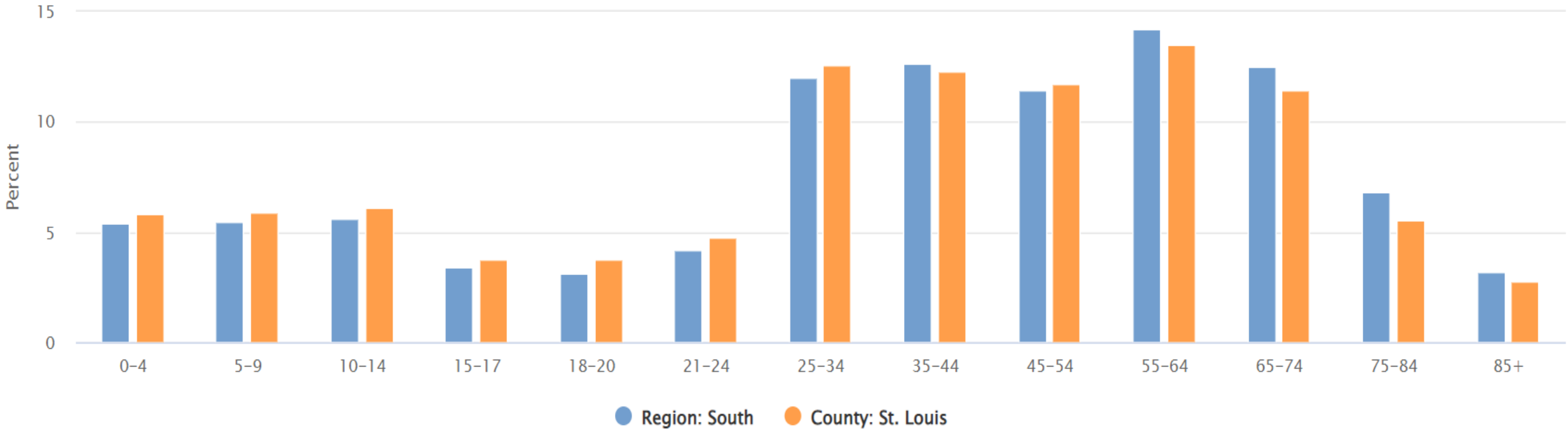
Race: 90.92% of Residents are White

Median household income is $82,337

Source: ThinkHealthStl.org, Mercy Analytics

Community Profile

Demographics: Population by Age Group



Source: ThinkHealthStl.org

Community Profile

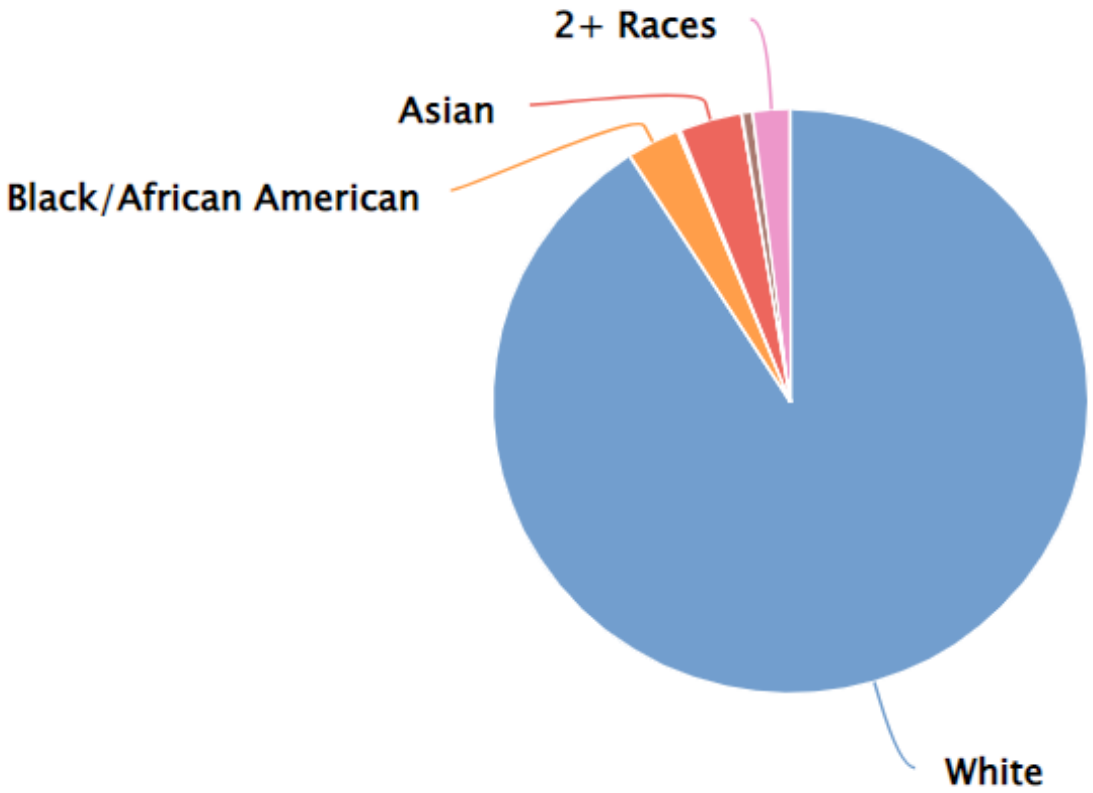
Demographics: Population by Race

Population by Race	Region: South		County: St. Louis	
	Persons	% of Population	Persons	% of Population
White	183,068	90.92%	654,301	65.91%
Black/African American	5,821	2.89%	250,755	25.26%
American Indian/Alaskan Native	333	0.17%	2,077	0.21%
Asian	6,833	3.39%	48,766	4.91%
Native Hawaiian/Pacific Islander	48	0.02%	226	0.02%
Some Other Race	1,178	0.59%	10,717	1.08%
2+ Races	4,070	2.02%	25,849	2.60%

Source: ThinkHealthStl.org

Community Profile

Demographics: Population by Race



Source: ThinkHealthStl.org

Community Profile

Average Household Income

Average Household Income by Race/Ethnicity	Region: South	County: St. Louis
	Value	Value
All	$104,424	$112,998
White	$97,489	$110,061
Black/African American	$59,255	$62,827
American Indian/Alaskan Native	$55,963	$73,020
Asian	$88,260	$120,391
Native Hawaiian/Pacific Islander	$72,000	$94,066
Some Other Race	$63,121	$64,594
2+ Races	$90,153	$86,616
Hispanic/Latino	$81,384	$98,555
Non-Hispanic/Latino	$104,884	$113,353

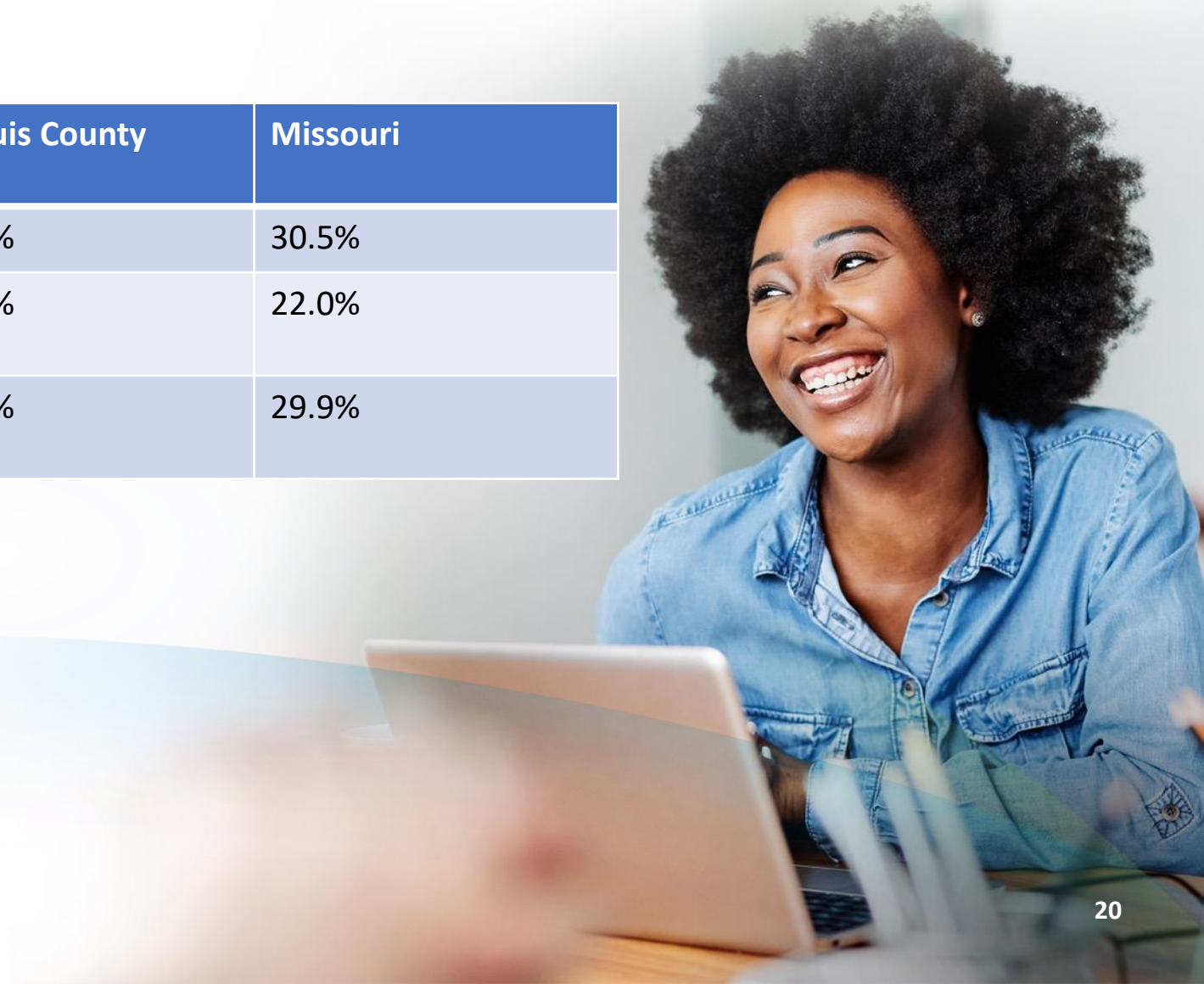
Source: ThinkHealthStl.org

Community Profile

Education

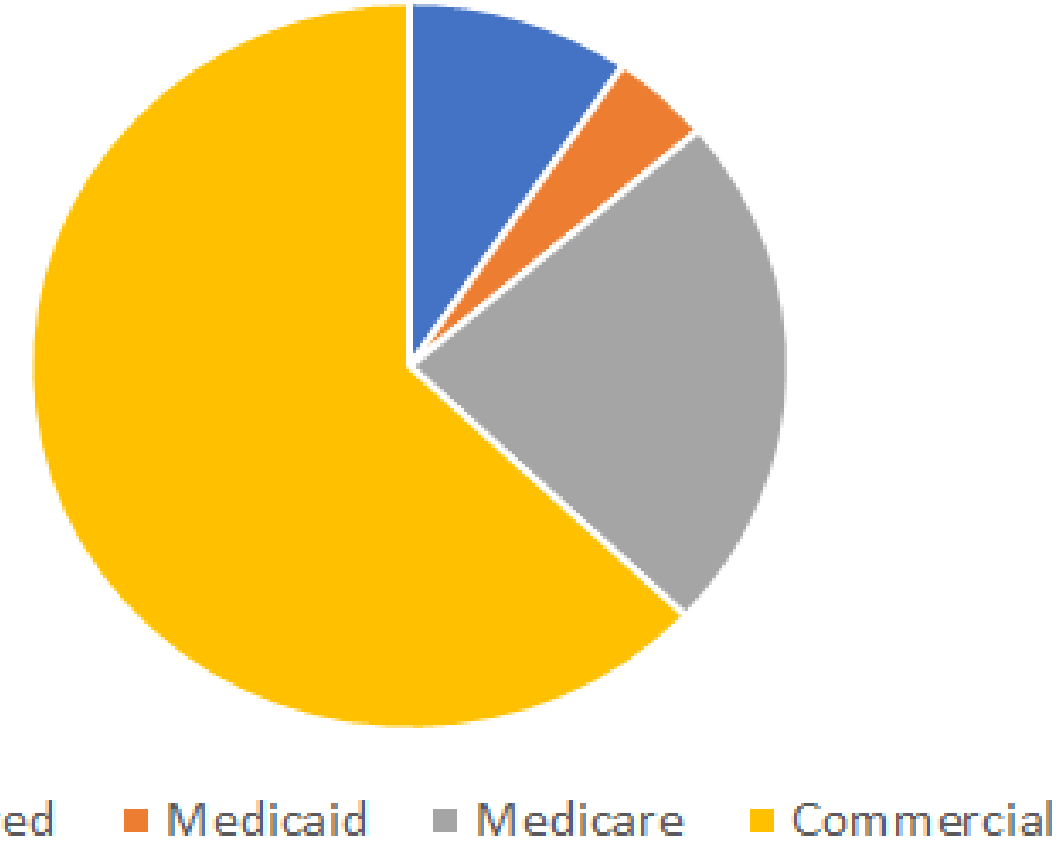
Level	South St. Louis County	St. Louis County	Missouri
High School Degree	24.93%	21.39%	30.5%
Some College, No Degree	20.97%	20.03%	22.0%
Bachelor's Degree of Greater	39.54%	50.79%	29.9%

Source: ThinkHealthStl.org, Mercy Analytics



Community Profile

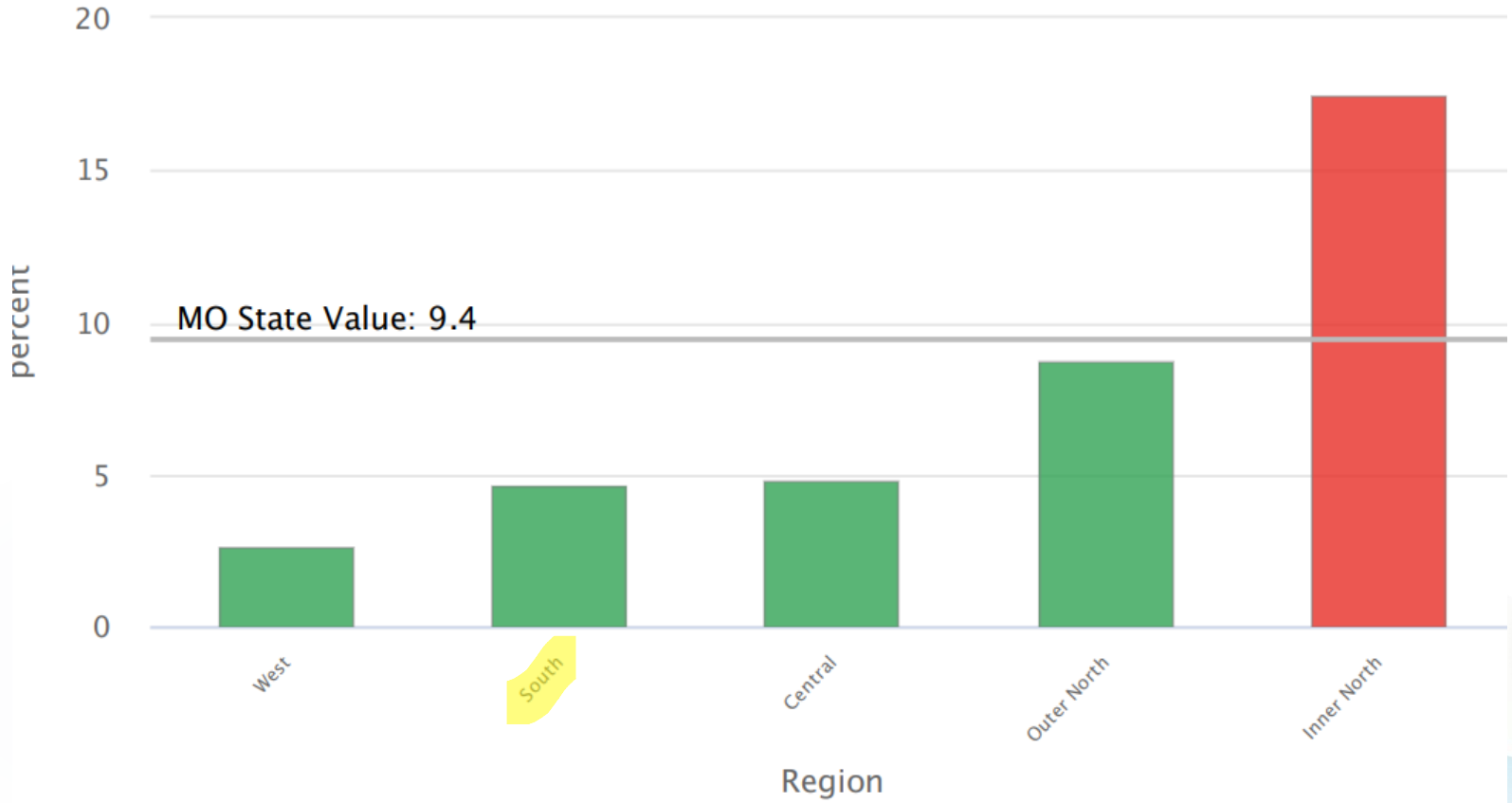
Insurance Status/Payer Mix



Source: Mercy Analytics

Community Profile

Families Living Below Poverty Level



Source: American Community Survey (2015-2019)

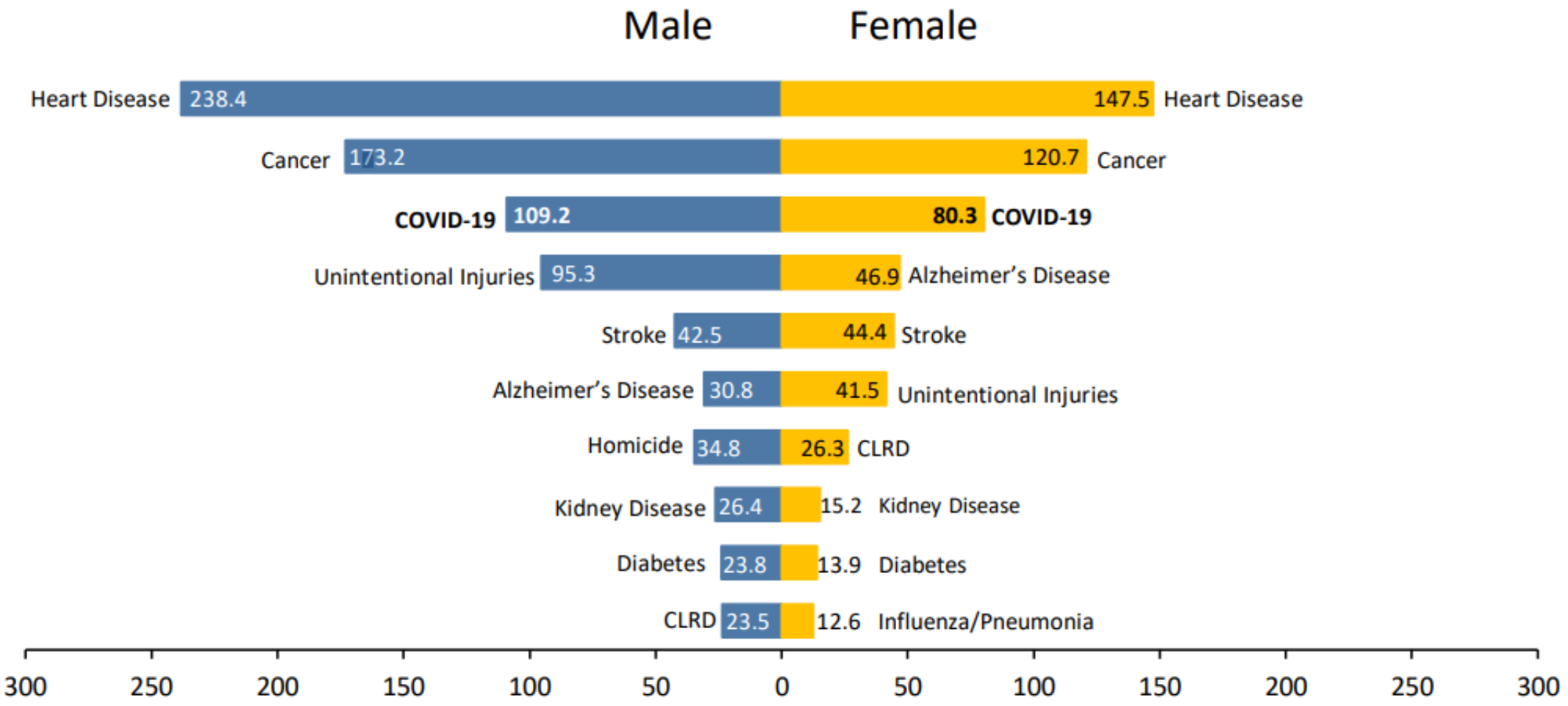
Community Profile

	St. Louis County*	State of Missouri
Primary Care Physicians	810:1	1,420:1
Dentists	1,150:1	1,670:1
Mental Health Providers	330:1	490:1
Preventable Hospital Stays per 100,000 Medicare Enrollees	4,600	4,638

**Data specific to entire St. Louis County region*

Community Profile

Leading Causes of Death - 2020



Source: St. Louis County Department of Health

Community Profile

Cancer

	VALUE	COMPARED TO:				
Adults with Cancer	8.5% (2019)	MO Counties	U.S. Counties	US Value (7.1%)	Prior Value (8.0%)	
Cervical Cancer Screening: 21-65	85.1% (2018)	MO Counties	U.S. Counties	US Value (84.7%)	HP 2030 Target (84.3%)	
Colon Cancer Screening	71.4% (2018)	MO Counties	U.S. Counties	US Value (66.4%)	HP 2020 Target (70.5%)	HP 2030 Target (74.4%)
Mammogram in Past 2 Years: 50-74	75.0% (2018)	MO Counties	U.S. Counties	US Value (74.8%)	HP 2020 Target (81.1%)	HP 2030 Target (77.1%)

Source: ThinkHealthStl.org

Community Profile

Diabetes/Healthy Lifestyle

	VALUE	COMPARED TO:			
Adults with Diabetes	9.4% (2019)	US Value (11.0%)	Prior Value (9.0%)		
	VALUE	COMPARED TO:			
Adults who are Sedentary	26.2% (2019)	US Value (26.0%)	Prior Value (21.7%)	HP 2020 Target (32.6%)	HP 2030 Target (21.2%)

Source: ThinkHealthStl.org

Community Profile

Health Care Access & Quality

	VALUE	COMPARED TO:				
Adults who have had a Routine Checkup	78.4% (2019)	MO Counties	U.S. Counties	US Value (76.6%)	Prior Value (78.7%)	
Adults without Health Insurance	12.4% (2019)	MO Counties	U.S. Counties	US Value (13.0%)	Prior Value (11.5%)	HP 2020 Target (0%)

Source: ThinkHealthStl.org

Community Profile

Heart Disease & Stroke

	VALUE	COMPARED TO:				
Adults who Experienced a Stroke	3.2% (2019)	MO Counties	U.S. Counties	US Value (3.4%)	Prior Value (3.1%)	
Adults who Experienced Coronary Heart Disease	6.4% (2019)	MO Counties	U.S. Counties	US Value (6.2%)	Prior Value (6.8%)	
Adults who Have Taken Medications for High Blood Pressure	78.5% (2019)	MO Counties	U.S. Counties	US Value (76.2%)	Prior Value (78.7%)	
Cholesterol Test History	87.1% (2019)	MO Counties	U.S. Counties	US Value (87.6%)	Prior Value (81.5%)	HP 2020 Target (82.1%)
High Cholesterol Prevalence: Adults 18+	32.3% (2019)	MO Counties	U.S. Counties	US Value (33.6%)	Prior Value (34.3%)	

Source: ThinkHealthStl.org

Community Profile

Mental Health & Substance Abuse

	VALUE	COMPARED TO:				
Adults Ever Diagnosed with Depression	21.8% (2019)	MO Counties	U.S. Counties	US Value (18.8%)		
Poor Mental Health: 14+ Days	13.6% (2019)	MO Counties	U.S. Counties	US Value (13.6%)	Prior Value (13.0%)	
	VALUE	COMPARED TO:				
Adults who Binge Drink	17.7% (2019)	MO Counties	U.S. Counties	US Value (16.7%)	Prior Value (19.6%)	HP 2020 Target (24.2%)

Source: ThinkHealthStl.org

Community Profile

Mental Health

Age-Adjusted Hospitalization for Major Depressive Disorders among Adults

	VALUE	COMPARED TO:	
County: St. Louis	37.8 Per 10,000 population (2016)	= Prior Value (35.5)	Trend
County: St. Louis City	55.6 Per 10,000 population (2016)	= Prior Value (53.2)	Trend

Age-Adjusted Hospitalization for Major Depressive Disorders among Children

	VALUE	COMPARED TO:	
County: St. Louis	31.5 Per 10,000 population (2016)	= Prior Value (27.3)	Trend
County: St. Louis City	28.4 Per 10,000 population (2016)	= Prior Value (22.3)	Trend

Age-Adjusted Hospitalization for Mental Health Disorder (Not Including Drug and Alcohol Induced) among Adults

	VALUE	COMPARED TO:	
County: St. Louis	105.1 Per 10,000 population (2016)	▽ Prior Value (114.1)	Trend

Source: ThinkHealthStl.org

Community Profile

Mental Health

Age-Adjusted Hospitalization Rate due to Pediatric Mental Health

	VALUE	COMPARED TO:
County: St. Louis	72.5 Hospitalizations per 10,000 population under 18 years (2014-2016)	St. Louis City Value (64.6)

Age-Adjusted Hospitalization Rate due to Suicide and Intentional Self-inflicted Injury

	VALUE	COMPARED TO:
County: St. Louis	52.2 Hospitalizations per 10,000 population 18+ years (2014-2016)	St. Louis City Value (98.9)

Depression: Medicare Population

	VALUE	COMPARED TO:					
County: St. Louis	21.9% (2018)	MO Counties	U.S. Counties	MO Value (21.3%)	US Value (18.4%)	Prior Value (21.7%)	Trend
County: St. Louis City	23.7% (2018)	MO Counties	U.S. Counties	MO Value (21.3%)	US Value (18.4%)	Prior Value (24.0%)	Trend

Source: ThinkHealthStl.org

Community Profile

Other

People 65+ Living Alone

29.9%
(2015-2019)


MO Counties


U.S. Counties


MO Value
(27.9%)


US Value
(26.1%)


Prior Value
(29.4%)


Trend

People 65+ Living Below Poverty Level

5.8%
(2015-2019)


MO Counties


U.S. Counties


MO Value
(8.6%)

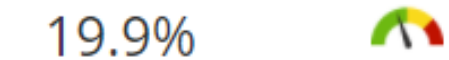

US Value
(9.3%)


Prior Value
(5.7%)


Trend

Single-Parent Households

19.9%
(2015-2019)


MO Counties


U.S. Counties


MO Value
(25.4%)


US Value
(25.5%)

Prior Value
(27.6%)


Trend

Source: ThinkHealthStl.org

Our Assessment Process

St. Louis Partnership for a Healthy Community

Mercy Hospital South'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 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 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.

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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 Mercy'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

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 Shriner's Hospital. The pandemic limited our availability to solicit feedback in-person so online surveys were key to gain input. The first survey was a community-wide survey distributed broadly throughout the St. Louis metropolitan region to reach all community members from April to June of 2021. The survey took ten minutes to complete and contained 39 questions about health challenges, access to healthcare, and social determinant 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.

Our Assessment Process

Needs Assessment Survey- Community

The community was invited to participate in the online survey through a media release with additional communication efforts done to reach specific underserved locations and neighborhoods. 277 community members responded from the South County community.

Limitations to this community survey were that an online survey might not be accessible for someone who does not have a computer or mobile device. There were efforts to put paper copies in key community settings like libraries and community centers but there still were concerns about reaching underserved populations. While health literacy was top of mind when putting the survey together, it is still impossible to eliminate this as a barrier with filling out an online survey.

In reviewing survey findings, we did find evidence of not reaching the key members of our communities that were sought after and are much needed to construct a deep understanding of community health needs. This limitation, along with the limitation of the survey only being available in the English language, is noted as a barrier in our community survey and served as an encouragement to seek out alternative forms of obtaining primary data through means such as key informant interviews and targeted, smaller focus group sessions that were held virtually.

Our Assessment Process

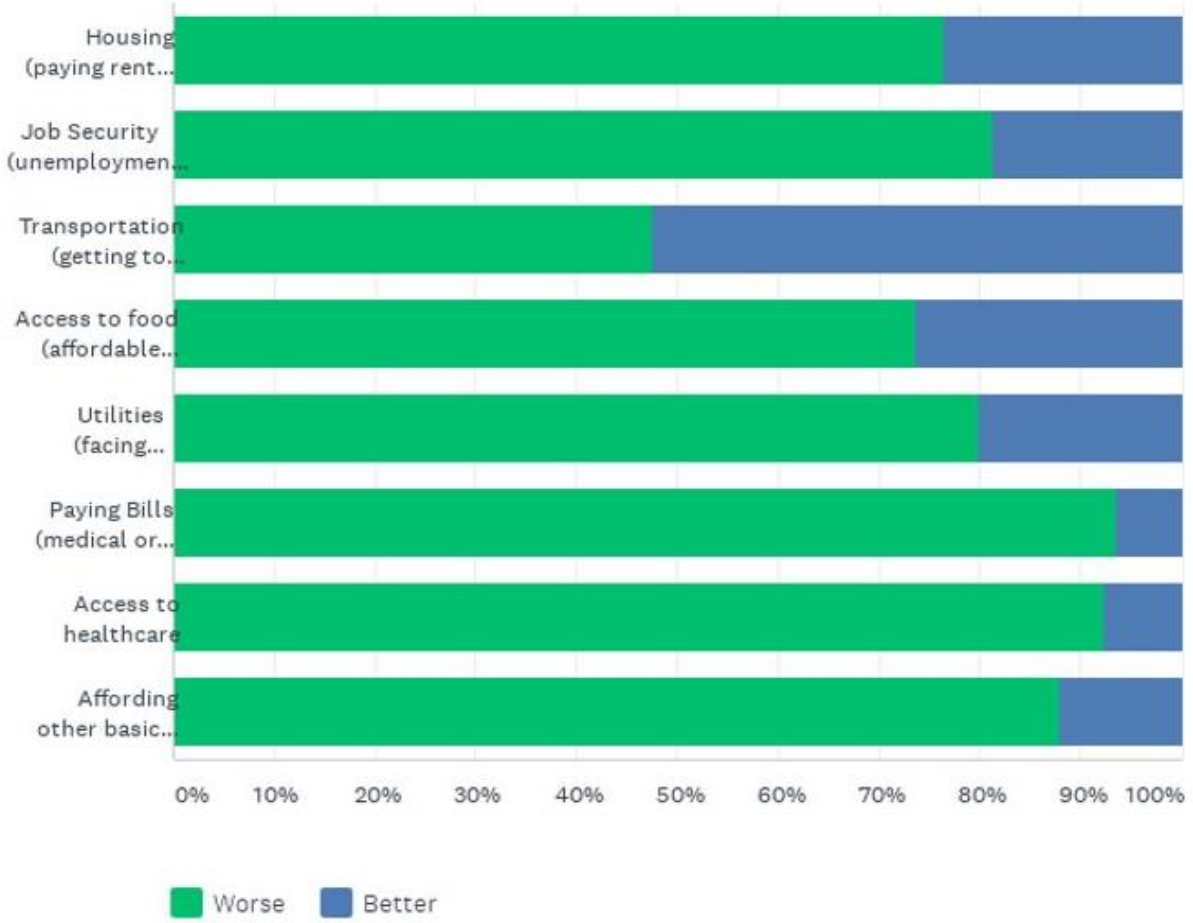
Needs Assessment Survey – Community *(continued)*

- 83.49% of people who responded to the survey were female and 15.57% of respondents were male. 93.43% of persons who responded identified as being white, 3.76% identified as being African-American or Black and 2.35% identified as being Hispanic or Latino
- In general, 15.87% said their health was excellent, as compared to 46.13% very good, 29.15% good, 8.12% fair and .74% poor
- The top five health challenges noted were overweight/obesity at 37.27%, 26.57% joint or back pain, no health challenges at 22.51%, high blood pressures at 22.51% and other at 22.14%
- 39.60% of parents indicated that the health screening, education and/or services that their child/children need access to that will keep them safe and healthy are those centered around mental health.
- Community strengths were listed as good place to raise a family at 72.85%, good schools/quality of education at 67.42%, access to community parks and other open spaces at 66.52%, opportunities to practice spiritual beliefs at 52.94% and community safety/low crime at 43.89%
- Top challenges in the community were access to affordable housing at 43.38%, racial and ethnic diversity at 40.18%, strong community leaders at 35.16% and community safety and crime at 31.96%

Our Assessment Process

Needs Assessment Survey – Community *(continued)*

Impact of the COVID-19 Pandemic



Our Assessment Process

Needs Assessment Survey - Stakeholder

For the stakeholder survey, the sponsoring hospitals also conducted an online survey in the summer of 2021, but the focus of this survey shifted to public health experts, leaders and those with a special interest in the health needs of the metropolitan St. Louis area. There were 9 South County representatives that participated, and that list included school officials, EMS and Fire, County Health officials and Health Department representatives and Behavioral Health partners. Stakeholders were asked 16 questions about the health needs of their communities and were given a list of health needs and asked to rank them on a scale of little to significant concern. Participants were also asked to weigh in on the potential of community partnerships, barriers to healthcare in their respective communities and what types of social factors and needs 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 in an in-person, focus group type setting. While participation numbers for the online survey were acceptable, focus groups are typically preferred for our collaborative because they tend to encourage good discussion and provide rich qualitative data that aids in a clear understanding of community needs.

Our Assessment Process

Stakeholder Survey *(continued)*

- Drug abuse, alcohol abuse and diabetes were listed as the health needs that cause the highest level of concern
- Health barriers most concerning were the inability to pay co-pays/deductibles and lack of mental health services nearby
- The populations noted to be most at risk of poor health outcomes were the low-income population and those suffering from substance abuse
- Social factors historically having the greatest impact on health were listed as exposure to drug use and abuse, eldercare services and safe and affordable housing
- Stakeholders conveyed that the greatest impact that COVID-19 had on the health of the community was increased feelings of loneliness/isolation and increased symptoms of depression, stress and anxiety
- Social issues captured that are the most concern for the future are substance abuse and mental health concerns and an increase in anxiety and depression in youth
- 63123 and 63125 were the zip codes listed that are especially vulnerable and at-risk

From Our Stakeholder Assessment:

This is a quote from question #12 in our stakeholder assessment that asks if there are new/additional health or social issues that are a concern for the future. ***"Depression, anxiety and substance abuse are a real concern among our entire population, as is income inequality and a need for a liveable wage"***

South County Stakeholder Survey Participant

Our Assessment Process

Focus Group: Meacham Park

Mercy Hospital South (MHS) partnered with Mercy Hospital St. Louis (MHSL) to conduct a stakeholder focus group with members of Meacham Park, a neighborhood located in Kirkwood. 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 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, 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 Our Focus Group:

"...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 Focus Group Participant

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:

- Centers for Disease Control and Prevention Overweight & Obesity Statistics, 2020. https://www.cdc.gov/obesity/data/prevalence-maps.html#overall.
- Centers for Disease Control and Prevention United States Diabetes Surveillance System, 2019. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html
- County Health Rankings, 2021. https://www.countyhealthrankings.org/
- Healthy People 2030, 2022. https://health.gov/healthypeople
- Johns Hopkins University Coronavirus Resource Center, 2021. https://coronavirus.jhu.edu/us-map
- Missouri Department of Health & Senior Services Data & Statistics https://health.mo.gov/data/

Our Assessment Process

Resources *(continued)*

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

- SparkMap – Center for Applied Research and Engagement Systems (CARES), University of Missouri, 2018-2020. https://sparkmap.org/report/
- St. Louis Partnership for a Healthy Community – Think Health St. Louis https://www.thinkhealthstl.org/indicators
- U.S. Census Bureau American Community Survey, 2019. https://www.census.gov/programs-surveys/acs/data.html
- U.S. Census Bureau, 2020 Census Results. https://www.census.gov/

Prioritized Needs

Prioritizing Identified Health Needs

Six identified health needs emerged during the community health needs assessment process of analyzing primary and secondary data. Needs were identified as they repeatedly ranked high on the community and stakeholder survey and as discussed in the focus group session. The identified needs that ranked high in the data collection were Access to Care, Transportation, Behavioral Health, COVID-19, Substance Abuse and Obesity/Diabetes.

The Community Health Council at Mercy Hospital South met in April of 2022 to prioritize the six health needs after reviewing the data collected from the community health needs assessment process. Special consideration was taken when narrowing down the health needs that arose during the assessment process. The Council considered the resources available to MHS and community partners, Mercy's overall strategic plan and the ability to make an impact in the community.

Prioritized Needs

Prioritizing Identified Health Needs *(continued)*

A nominal group technique was used to rank the six final health priority health needs. Each member of the Community Health Council ranked the needs according to five criteria: 1) Magnitude of Need, 2) Feasibility to Change, 3) Alignment with Mission/Strategic Goals, 4) Resources Available, and 5) Importance to Community. Scores were totaled for all participants. Results of the nominal group technique are included in the table below:

Identified Health Need	Total Score	Chosen as Priority Need
Access to Care	183	Yes
Transportation	146	No*
Behavioral Health	186	Yes
COVID-19	125	No
Substance Abuse	168	Yes
Diabetes	147	Yes

**Transporation will be addressed under the Access to Care need*

Prioritized Needs

Prioritized Needs

Access to Care

Many people across St. Louis County do not get the health care services they need. A focus on Access to Care will help to improve health by helping people get the high-quality care in a timely manner. About 1 in 10 people in the United States do not have health insurance and many of those same people are without a primary care provider. 8.7% of South St. Louis County residents are uninsured and the number is rising. 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. This can often lead to utilizing the local Emergency Department for routine, non-emergent health care needs.

Many social need barriers can also have a tremendous impact on access to care. These barriers include the high cost of care, lack of insurance coverage, transportation barriers, lack of access to needed medications, etc. These barriers can result in further exacerbation of chronic health conditions and can reduce quality of life and even lead to premature death. Mercy Hospital South chose to continue our focus on Access to Care as we are committed to increasing the work around addressing social needs for vulnerable persons and continuing to strengthen connections to resources and services that impact overall health.

Prioritized Needs

Behavioral Health/Substance Use

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Estimates suggest that only half of all people with mental disorders get the treatment they need. More than 20 million people in the United States have a substance use disorder, and most of them don't get the treatment they need. Substance use disorders are linked to many health problems and can lead to overdose and death. Deaths from opioid use disorder have increased dramatically in recent years.

We have seen evidence that COVID-19 has had on the members of our community in terms of behavioral health and substance abuse. Our efforts will continue to grow over the next several years and we work on implementing more virtual behavioral health services across our ministry and seek to eliminate barriers to care that result in the hardship of establishing treatment for behavioral health and substance use disorders.

Prioritized Needs

Diabetes

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death in the US and the ninth leading cause of death in St. Louis County. Many people in the United States have prediabetes, but many don't know they have it. People with prediabetes are at higher risk for type 2 diabetes, heart disease, and stroke. Programs that help people lose weight, eat healthier, and get more physical activity can reduce the risk of prediabetes.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

Mercy Hospital South has been part of the St. Louis Diabetes Collaborative, a joint effort between area hospitals and hospital systems, that has a goal to reduce the diabetes burden in the St. Louis region. Mercy will also continue to explore other initiatives for our community members that will seek to address diabetes and obesity.

Needs Not Addressed

In any case of prioritization, there will be some areas of need that are identified that are not chosen as a priority. Because Mercy Hospital South has limited resources, not every community need will be addressed. Throughout the CHNA process, the following needs arouse as a community concern. However, they will not be directly addressed at this time due to the need already be addressed by another initiative or organization or due to a limitation of resources.

- COVID-19
- Transportation

While these needs listed will not be specifically addressed as an actual identified priority, they will most likely be impacted indirectly through the work of our other identified priorities.

Next Steps

After carefully reviewing the data and mapping existing resources, Mercy Hospital South is developing an implementation plan with evidence-based strategies. The plan will be submitted to a committee of appointed members from Mercy Hospital South for their approval. The final version of the CHNA and Implementation Plan will be available to the public on the Mercy website: www.mercy.net/communitybenefits

Appendices

Appendix A: St. Louis Region Community Health Assessment & Community Health Improvement Plan
Appendix B: St. Louis Collaborative: Community Survey – South County Results
Appendix C: St. Louis Collaborative: Stakeholder Survey
Appendix D: Meacham Park Focus Group Summary
Appendix E: Community Health Council Prioritization

Appendices are available as a separate, supplemental pdf document to this Community Health Needs Assessment report.

Mercy

Your life is our life's work.

Appendix A

St. Louis Region Community Health Assessment & Community Health Improvement Plan

St. Louis Partnership for a Healthy Community

Saint Louis Region Community Health Assessment & Community Health Improvement Plan

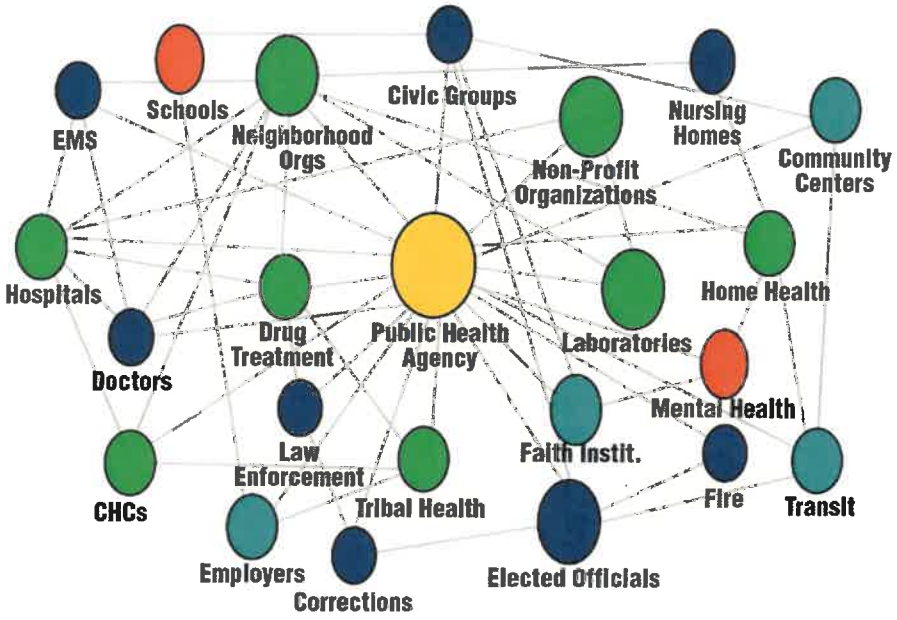
August 2018

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)



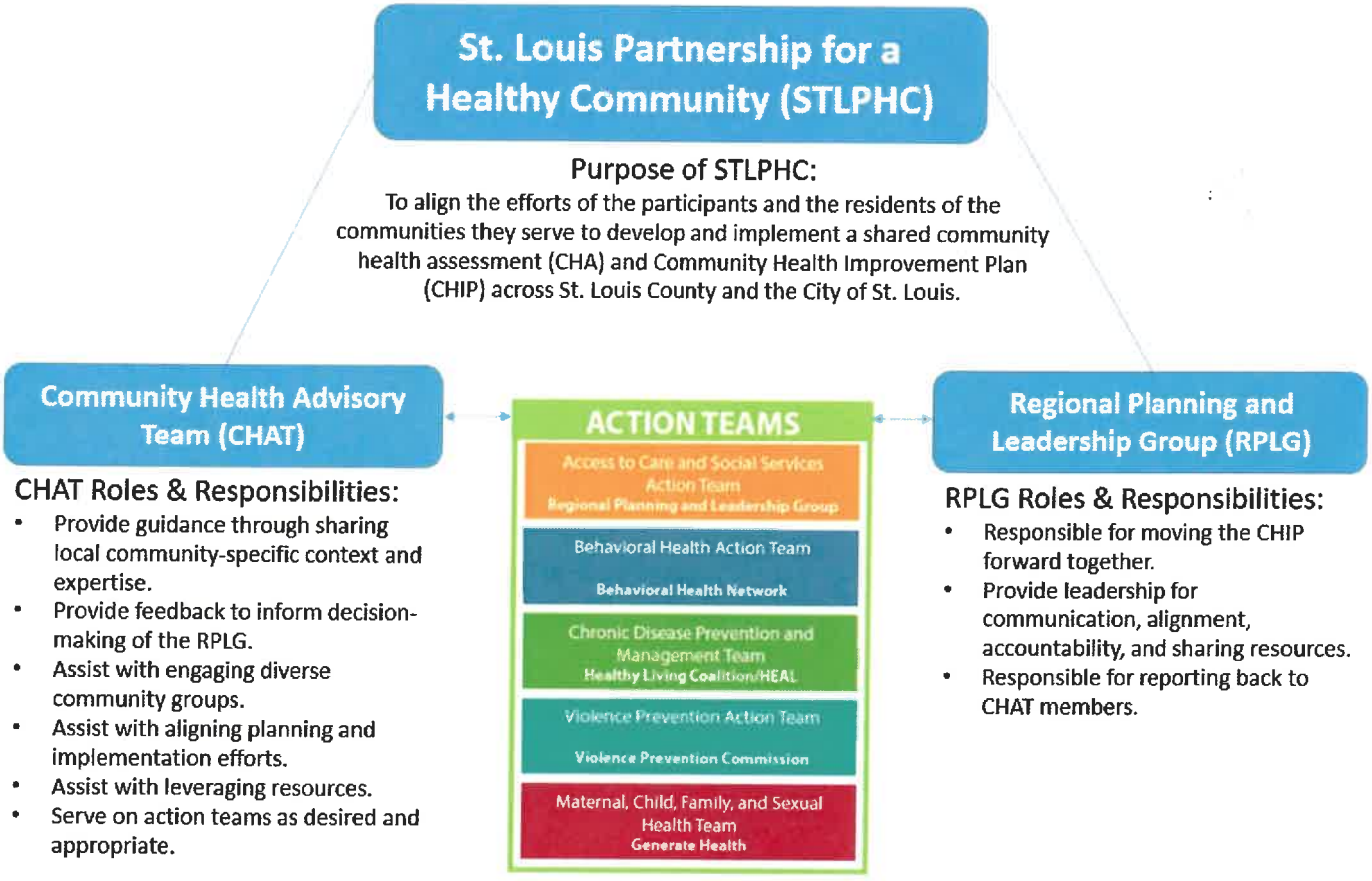
The membership of STLPHC is intended to represent the wide range of entities that impact health- it includes both the City of St. Louis Department of Health and the St. Louis County Department of Public Health, area hospital systems, government agencies/departments, coordinated care organizations, community-based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

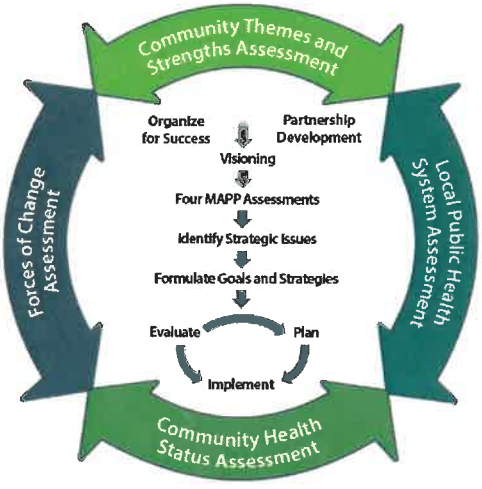
Commitment to Addressing Health Disparities

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.

Figure 3: MAPP Model (NACCHO)



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 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)

• 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	• 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

Key Findings

Social determinants of health and equity[3]

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.

Mortality[4]

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 tool[5] 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 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	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	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	Public transit/infrastructure Parks and access to green space Place-making efforts Community gardening International housing standards that city adopted in code
HEALTH CARE	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	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	Legal counsel team Citizen Service Bureau (City of St. Louis) Recreation centers (YMCA) STLcondoms.com Music therapy program Philanthropic resources and United Way
WORKFORCE	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	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:

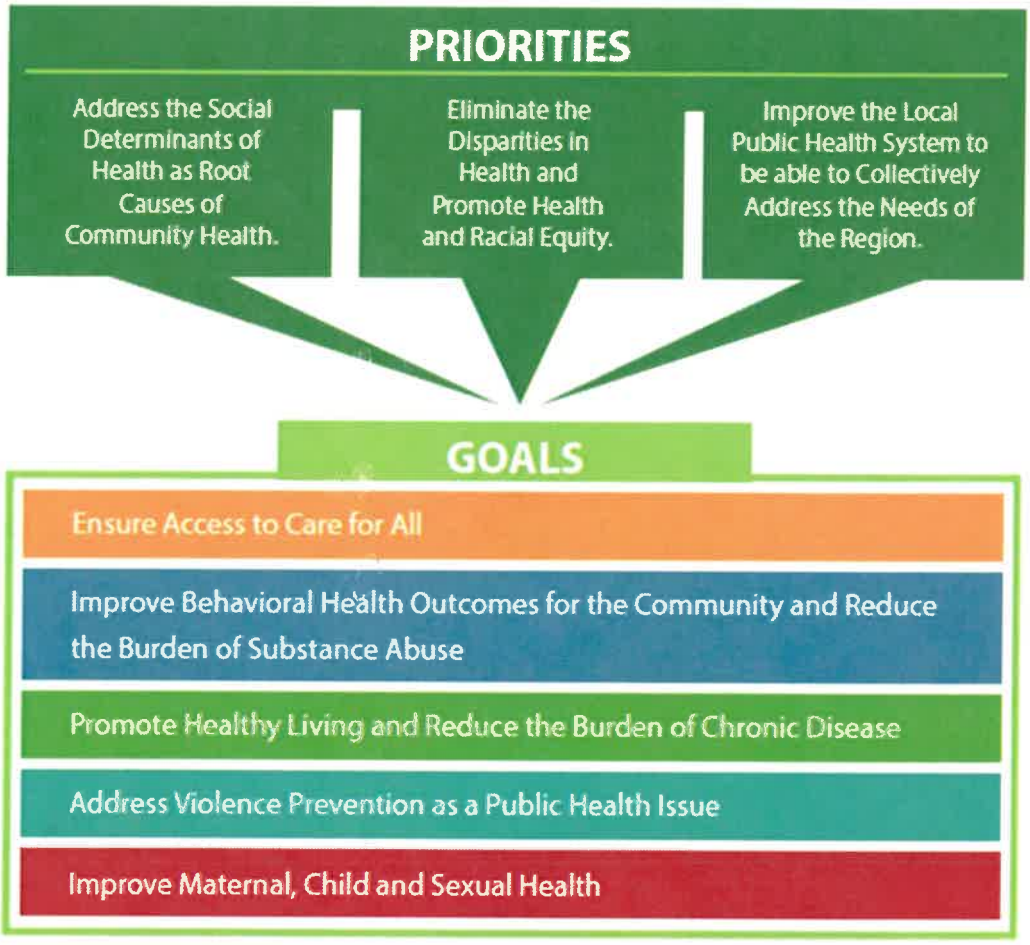
- A strategic issue will surface in at least **3 of the 4 assessments as a need**.
- Focusing on this issue will help achieve our **vision.**
- The **consequences** of not addressing this issue are severe.
- This issue requires a **multi-sector, multi-faceted** approach.
- This issue is a **root cause 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/.

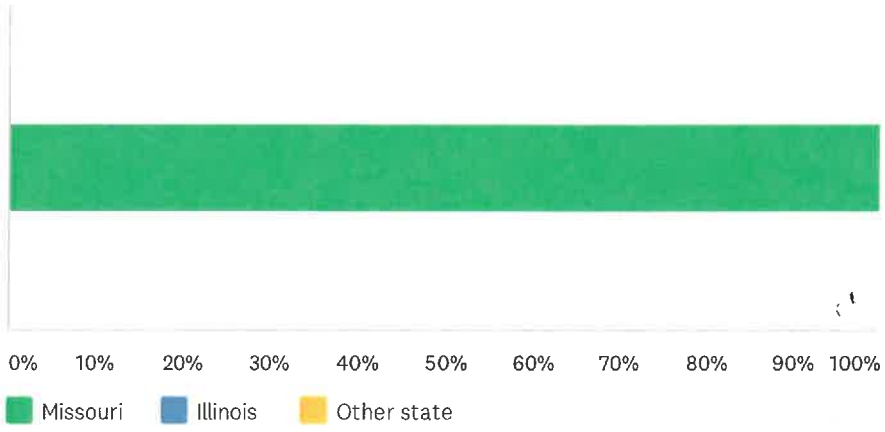
Appendix B

St. Louis Collaborative Community Survey

South County Results

Q1 In what state do you reside?

Answered: 277 Skipped: 1



ANSWER CHOICES	RESPONSES	
Missouri (1)	100.00%	277
Illinois (2)	0.00%	0
Other state (3)	0.00%	0
TOTAL		277

BASIC STATISTICS

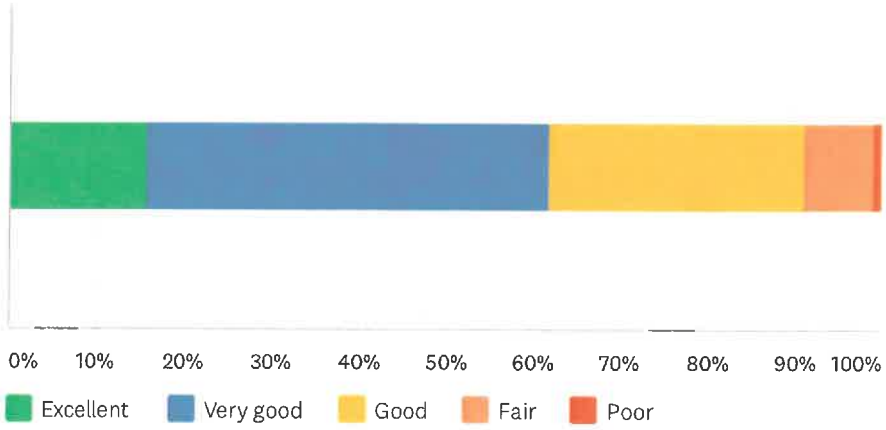
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	1.00	1.00	1.00	0.00

Q2 What is the zip code of your primary residence?

Answered: 278 Skipped: 0

Q3 In general, would you say your health is:

Answered: 271 Skipped: 7



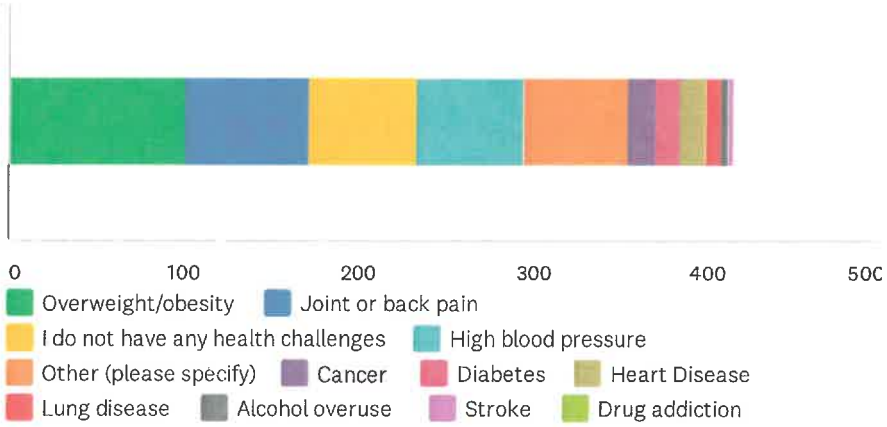
ANSWER CHOICES	RESPONSES	
Excellent (1)	15.87%	43
Very good (2)	46.13%	125
Good (3)	29.15%	79
Fair (4)	8.12%	22
Poor (5)	0.74%	2
TOTAL		271

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	2.00	2.32	0.86

Q4 Please select the main health challenge/s you face. (Check all that apply)

Answered: 271 Skipped: 7



ANSWER CHOICES	RESPONSES	
Overweight/obesity (4)	37.27%	101
Joint or back pain (9)	26.57%	72
I do not have any health challenges (1)	22.51%	61
High blood pressure (6)	22.51%	61
Other (please specify) (12)	22.14%	60
Cancer (2)	5.90%	16
Diabetes (3)	5.54%	15
Heart Disease (8)	5.54%	15
Lung disease (5)	3.32%	9
Alcohol overuse (11)	1.48%	4
Stroke (7)	1.11%	3
Drug addiction (10)	0.00%	0

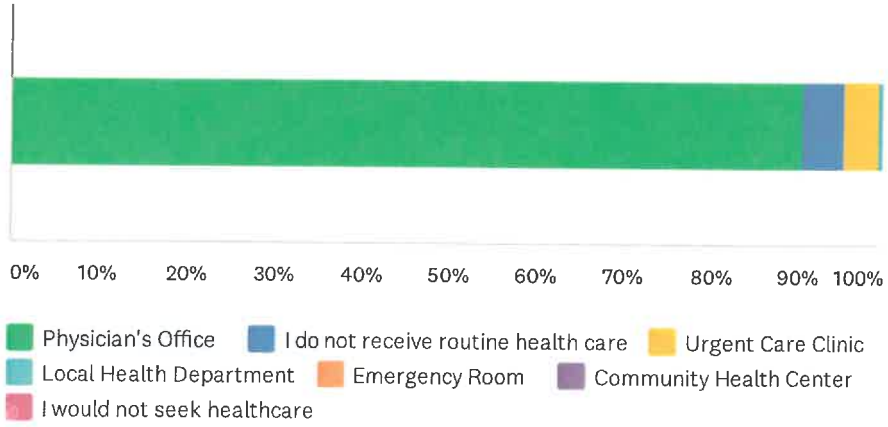
Total Respondents: 271

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	13.00	6.00	7.04	3.42

Q5 Where do you most often go for routine healthcare

Answered: 271 Skipped: 7



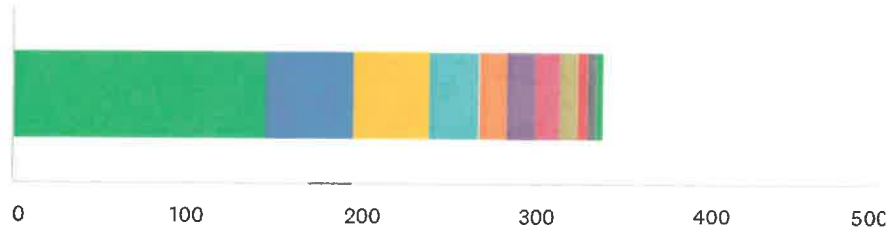
ANSWER CHOICES	RESPONSES	
Physician's Office (1)	90.77%	246
I do not receive routine health care (6)	4.80%	13
Urgent Care Clinic (4)	4.06%	11
Local Health Department (2)	0.37%	1
Emergency Room (3)	0.00%	0
Community Health Center (5)	0.00%	0
I would not seek healthcare (7)	0.00%	0
TOTAL		271

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.37	1.20

Q6 What barriers prevent you and/or your family from accessing healthcare? (Check all that apply)

Answered: 262 Skipped: 16



ANSWER CHOICES	RESPONSES	
I/my family have no barriers preventing us from accessing health care. (1)	55.73%	146
Scheduling problems (9)	19.08%	50
Costs/Co-pays (7)	16.41%	43
Difficulty finding doctors (3)	11.07%	29
My health insurance is not accepted (10)	6.11%	16
Other (please specify) (12)	6.11%	16
Fear (e.g. of doctors/health systems/not ready to face or discuss health issues) (5)	5.34%	14
No health insurance/unable to pay (6)	3.82%	10
Transportation/mobility issues (8)	2.29%	6
Don't feel welcome (11)	1.91%	5
Lack of nearby health centers/services/providers (4)	1.53%	4
Cultural/religious beliefs (2)	0.00%	0

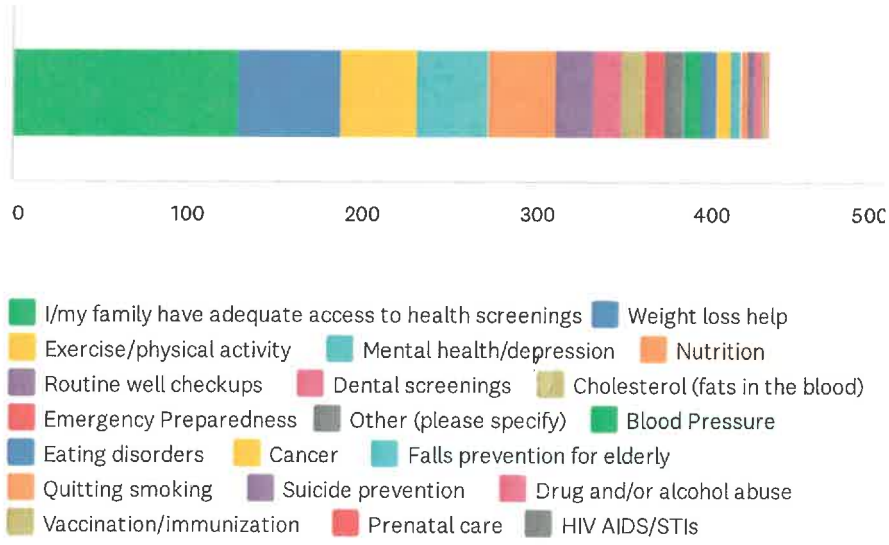
Total Respondents: 262

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
3.00	13.00	7.00	7.54	2.80

Q7 Please select the health screenings and/or services for which you need better access. (Check all that apply)

Answered: 248 Skipped: 30



ANSWER CHOICES	RESPONSES	
I/my family have adequate access to health screenings (1)	52.42%	130
Weight loss help (13)	23.79%	59
Exercise/physical activity (7)	17.34%	43
Mental health/depression (15)	16.53%	41
Nutrition (9)	15.32%	38
Routine well checkups (18)	8.87%	22
Dental screenings (5)	6.45%	16
Cholesterol (fats in the blood) (4)	5.24%	13
Emergency Preparedness (6)	4.84%	12
Other (please specify) (20)	4.84%	12
Blood Pressure (2)	4.03%	10
Eating disorders (19)	3.63%	9
Cancer (3)	3.23%	8
Falls prevention for elderly (8)	2.42%	6
Quitting smoking (11)	1.61%	4
Suicide prevention (12)	1.61%	4
Drug and/or alcohol abuse (16)	1.61%	4
Vaccination/immunization (14)	1.21%	3
Prenatal care (10)	0.40%	1
HIV AIDS/STIs (17)	0.00%	0

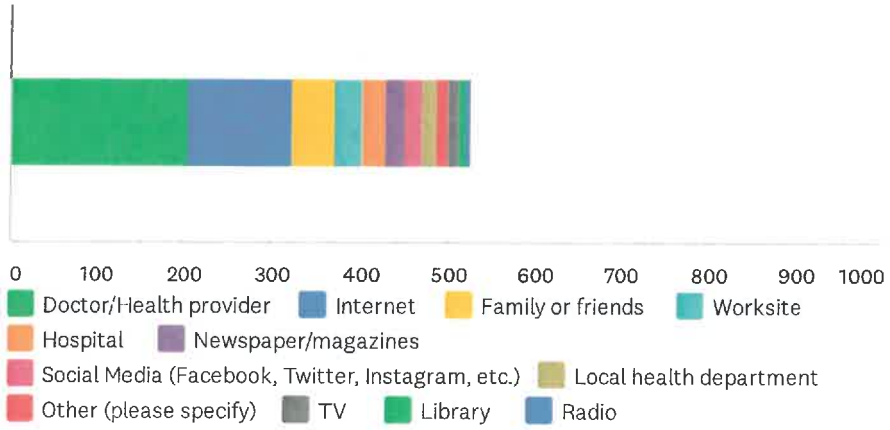
Total Respondents: 248

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	21.00	12.00	10.98	4.99

Q8 Where do you get most of your health information? (Choose top 3)

Answered: 249 Skipped: 29



ANSWER CHOICES	RESPONSES	
Doctor/Health provider (1)	81.93%	204
Internet (6)	48.19%	120
Family or friends (3)	19.28%	48
Worksite (11)	12.45%	31
Hospital (5)	10.44%	26
Newspaper/magazines (8)	8.84%	22
Social Media (Facebook, Twitter, Instagram, etc.) (2)	8.43%	21
Local health department (4)	6.43%	16
Other (please specify) (12)	6.02%	15
TV (10)	4.42%	11
Library (7)	3.21%	8
Radio (9)	2.81%	7

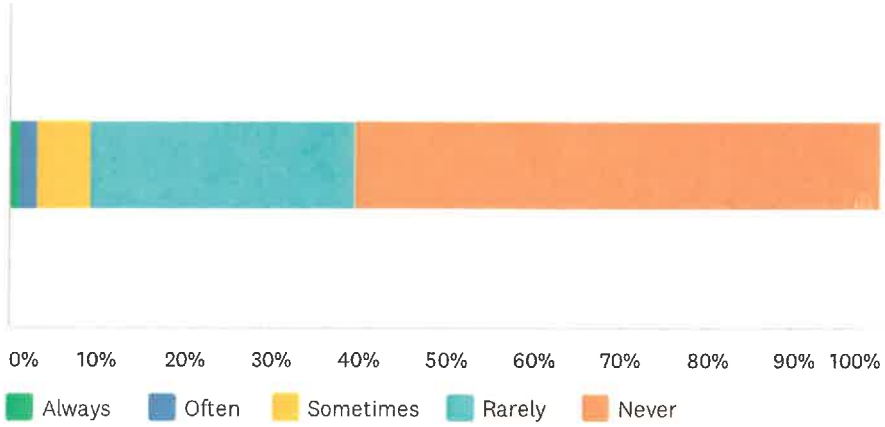
Total Respondents: 249

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	12.00	3.00	4.22	3.35

Q9 How often do you need to have someone help you understand instructions, pamphlets or other written materials from your doctor or pharmacy?

Answered: 249 Skipped: 29



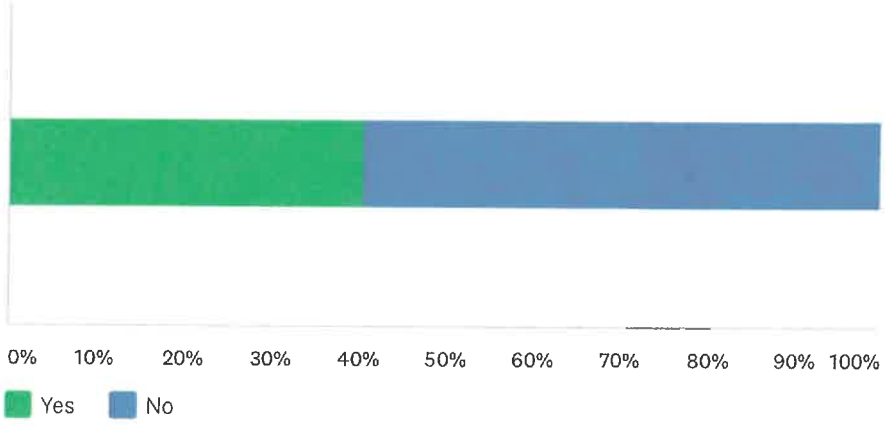
ANSWER CHOICES	RESPONSES	
Always (1)	1.20%	3
Often (2)	2.01%	5
Sometimes (3)	6.02%	15
Rarely (4)	30.52%	76
Never (5)	60.24%	150
TOTAL		249

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	5.00	4.47	0.80

Q10 Do you have children for whose health you are responsible?

Answered: 249 Skipped: 29



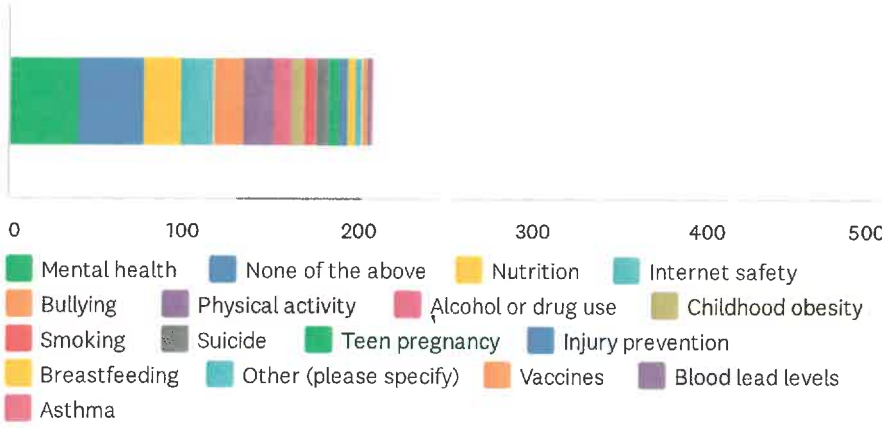
ANSWER CHOICES	RESPONSES	
Yes (1)	40.56%	101
No (2)	59.44%	148
TOTAL		249

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.59	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: 101 Skipped: 177



ANSWER CHOICES	RESPONSES	
Mental health (14)	39.60%	40
None of the above (1)	37.62%	38
Nutrition (4)	20.79%	21
Internet safety (9)	18.81%	19
Bullying (15)	17.82%	18
Physical activity (3)	16.83%	17
Alcohol or drug use (5)	9.90%	10
Childhood obesity (2)	6.93%	7
Smoking (8)	6.93%	7
Suicide (13)	6.93%	7
Teen pregnancy (7)	5.94%	6
Injury prevention (12)	4.95%	5
Breastfeeding (6)	3.96%	4
Other (please specify) (17)	3.96%	4
Vaccines (16)	2.97%	3
Blood lead levels (10)	1.98%	2
Asthma (11)	0.99%	1

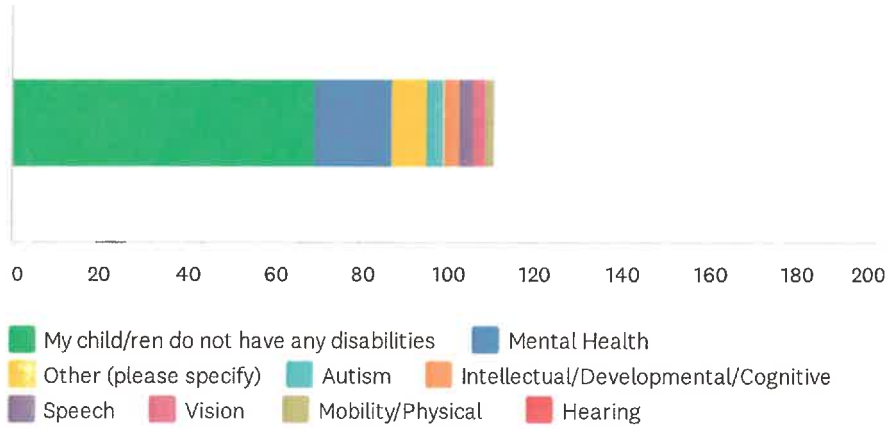
Total Respondents: 101

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	18.00	9.00	9.50	4.80

Q12 Please indicate any disabilities that apply to your children. (Check all that apply)

Answered: 96 Skipped: 182



ANSWER CHOICES	RESPONSES	
My child/ren do not have any disabilities (1)	71.88%	69
Mental Health (5)	18.75%	18
Other (please specify) (9)	8.33%	8
Autism (2)	4.17%	4
Intellectual/Developmental/Cognitive (4)	4.17%	4
Speech (7)	3.13%	3
Vision (8)	3.13%	3
Mobility/Physical (6)	2.08%	2
Hearing (3)	0.00%	0

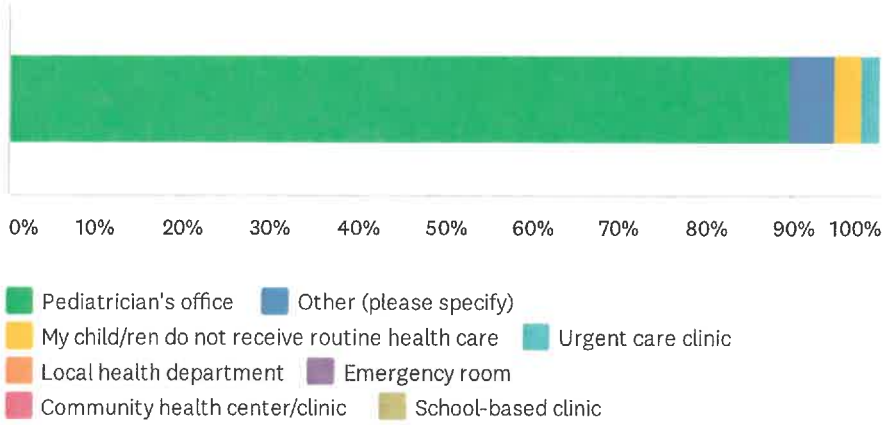
Total Respondents: 96

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	10.00	5.00	5.98	2.40

Q13 Where do you take your child/ren under age 18 for routine health care most often?

Answered: 98 Skipped: 180



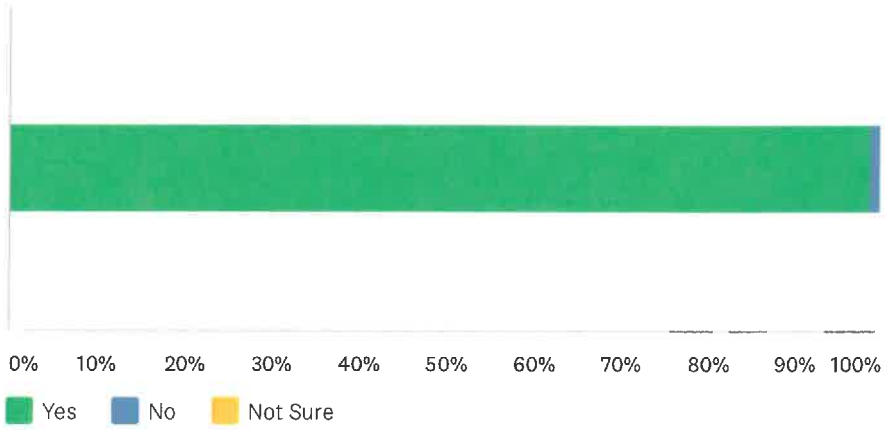
ANSWER CHOICES	RESPONSES	
Pediatrician's office (2)	89.80%	88
Other (please specify) (8)	5.10%	5
My child/ren do not receive routine health care (1)	3.06%	3
Urgent care clinic (5)	2.04%	2
Local health department (3)	0.00%	0
Emergency room (4)	0.00%	0
Community health center/clinic (6)	0.00%	0
School-based clinic (7)	0.00%	0
TOTAL		98

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	9.00	2.00	2.43	1.61

Q14 Do your children have health insurance?

Answered: 100 Skipped: 178



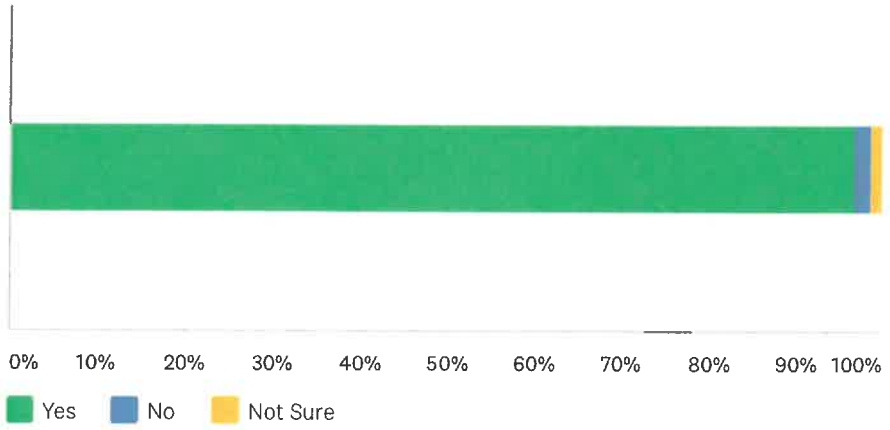
ANSWER CHOICES	RESPONSES	
Yes (1)	99.00%	99
No (2)	1.00%	1
Not Sure (3)	0.00%	0
TOTAL		100

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.01	0.10

Q15 Do your children have dental insurance?

Answered: 100 Skipped: 178



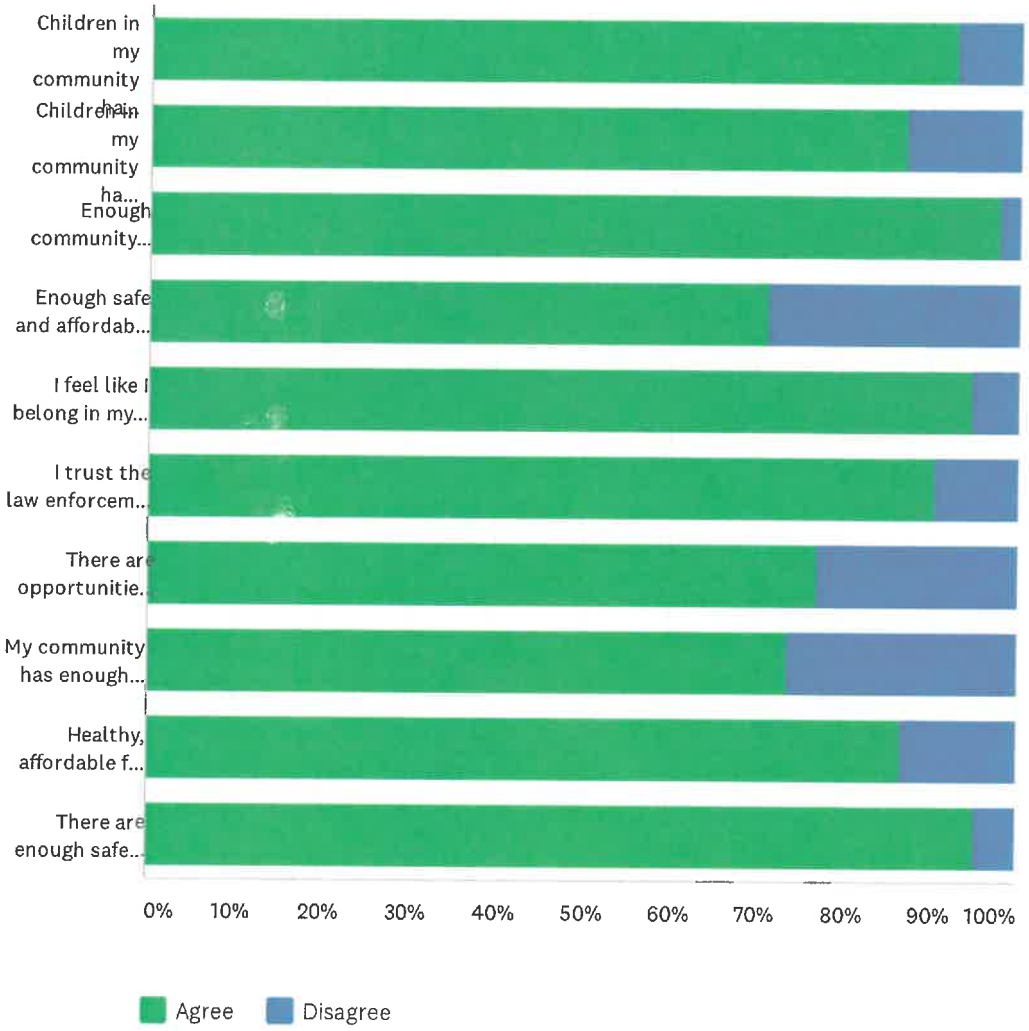
ANSWER CHOICES	RESPONSES	
Yes (1)	97.00%	97
No (2)	2.00%	2
Not Sure (3)	1.00%	1
TOTAL		100

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	3.00	1.00	1.04	0.24

Q16 Please choose the best response to reflect your opinion

Answered: 236 Skipped: 42



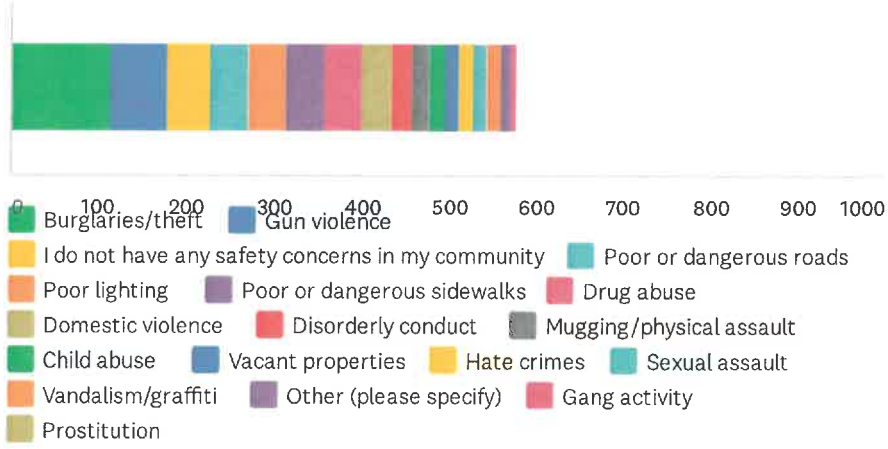
	AGREE	DISAGREE	TOTAL	WEIGHTED AVERAGE
Children in my community have access to high quality education	92.86% 195	7.14% 15	210	1.07
Children in my community have enough safe places to play	87.13% 176	12.87% 26	202	1.13
Enough community gatherings: parks, places of worship, community events	97.74% 216	2.26% 5	221	1.02
Enough safe and affordable houses and apartments in my community	71.35% 132	28.65% 53	185	1.29
I feel like I belong in my community	94.87% 185	5.13% 10	195	1.05
I trust the law enforcement officials in my community	90.55% 182	9.45% 19	201	1.09
There are opportunities for my voice to be heard about community decisions	77.14% 135	22.86% 40	175	1.23
My community has enough good-paying jobs	73.65% 123	26.35% 44	167	1.26
Healthy, affordable food is easily accessible in my community	86.96% 180	13.04% 27	207	1.13
There are enough safe places to be physically active in my community	95.28% 202	4.72% 10	212	1.05

BASIC STATISTICS

	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Children in my community have access to high quality education	1.00	5.00	2.00	1.88	0.87
Children in my community have enough safe places to play	1.00	5.00	2.00	2.07	0.97
Enough community gatherings: parks, places of worship, community events	1.00	5.00	2.00	1.65	0.71
Enough safe and affordable houses and apartments in my community	1.00	5.00	2.00	2.50	1.13
I feel like I belong in my community	1.00	4.00	2.00	1.99	0.78
I trust the law enforcement officials in my community	1.00	5.00	2.00	1.97	0.93
There are opportunities for my voice to be heard about community decisions	1.00	5.00	2.00	2.46	0.98
My community has enough good-paying jobs	1.00	5.00	2.00	2.56	0.98
Healthy, affordable food is easily accessible in my community	1.00	5.00	2.00	2.11	0.92
There are enough safe places to be physically active in my community	1.00	4.00	2.00	1.87	0.75

Q17 What types of safety concerns do you have in your community? (Check all that apply)

Answered: 232 Skipped: 46



ANSWER CHOICES	RESPONSES	
Burglaries/theft (3)	49.57%	115
Gun violence (2)	28.02%	65
I do not have any safety concerns in my community (1)	20.69%	48
Poor or dangerous roads (8)	19.40%	45
Poor lighting (7)	18.53%	43
Poor or dangerous sidewalks (9)	18.53%	43
Drug abuse (10)	18.53%	43
Domestic violence (5)	14.66%	34
Disorderly conduct (6)	10.34%	24
Mugging/physical assault (13)	8.62%	20
Child abuse (4)	7.76%	18
Vacant properties (17)	7.33%	17
Hate crimes (12)	6.90%	16
Sexual assault (15)	6.90%	16
Vandalism/graffiti (16)	6.47%	15
Other (please specify) (18)	5.60%	13
Gang activity (11)	2.16%	5
Prostitution (14)	0.43%	1

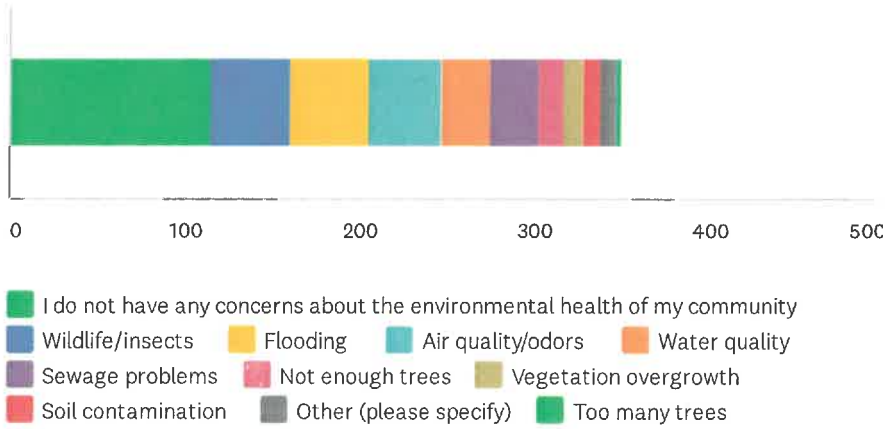
Total Respondents: 232

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	19.00	7.00	7.27	4.63

Q18 What concerns do you have about the environmental health of your community? (Check all that apply)

Answered: 231 Skipped: 47



ANSWER CHOICES	RESPONSES	
I do not have any concerns about the environmental health of my community (1)	49.35%	114
Wildlife/insects (10)	20.35%	47
Flooding (9)	19.48%	45
Air quality/odors (3)	18.18%	42
Water quality (2)	12.12%	28
Sewage problems (6)	11.69%	27
Not enough trees (4)	6.06%	14
Vegetation overgrowth (8)	4.76%	11
Soil contamination (7)	4.33%	10
Other (please specify) (11)	3.90%	9
Too many trees (5)	1.30%	3

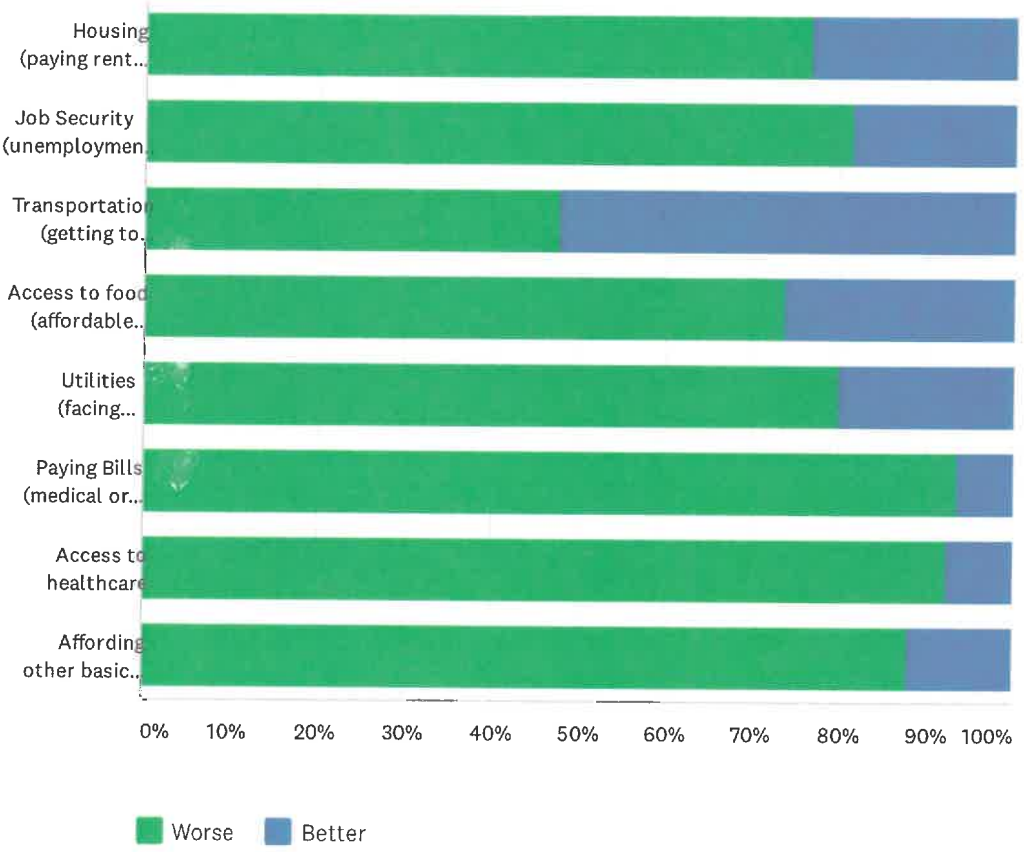
Total Respondents: 231

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	12.00	7.00	6.59	3.15

Q19 How has the COVID-19 (coronavirus) pandemic impacted the following for you/your household?

Answered: 228 Skipped: 50



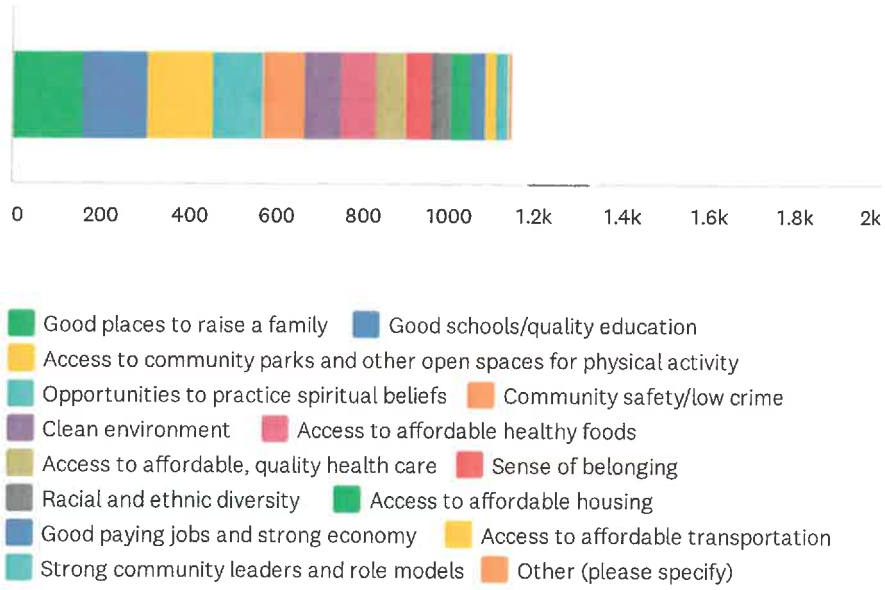
	WORSE	BETTER	TOTAL
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	76.47% 13	23.53% 4	17
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	81.36% 48	18.64% 11	59
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	47.62% 10	52.38% 11	21
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	73.68% 14	26.32% 5	19
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	80.00% 12	20.00% 3	15
Paying Bills (medical or other)	93.55% 29	6.45% 2	31
Access to healthcare	92.31% 36	7.69% 3	39
Affording other basic needs (not mentioned above)	88.00% 22	12.00% 3	25

BASIC STATISTICS

	MINIMUM	MAXIMUM	MEDIAN	MEAN	STANDARD DEVIATION
Housing (paying rent, facing eviction, foreclosure, maintenance, etc.)	1.00	3.00	2.00	1.96	0.27
Job Security (unemployment, got fired, laid off, less work to do than before, less income, etc.)	1.00	3.00	2.00	1.84	0.48
Transportation (getting to places you need to go, riding public transit, driving a car, etc.)	1.00	3.00	2.00	2.00	0.30
Access to food (affordable groceries, getting SNAP benefits, feeding family/loved ones, etc.)	1.00	3.00	2.00	1.96	0.29
Utilities (facing electric, gas or water shutoffs or difficulty paying them)	1.00	3.00	2.00	1.96	0.25
Paying Bills (medical or other)	1.00	3.00	2.00	1.88	0.35
Access to healthcare	1.00	3.00	2.00	1.86	0.39
Affording other basic needs (not mentioned above)	1.00	3.00	2.00	1.92	0.32

Q20 What do you think are the top STRENGTHS of your community right now?

Answered: 221 Skipped: 57



ANSWER CHOICES	RESPONSES	
Good places to raise a family (9)	72.85%	161
Good schools/quality education (10)	67.42%	149
Access to community parks and other open spaces for physical activity (5)	66.52%	147
Opportunities to practice spiritual beliefs (11)	52.94%	117
Community safety/low crime (7)	43.89%	97
Clean environment (6)	37.56%	83
Access to affordable healthy foods (2)	36.65%	81
Access to affordable, quality health care (1)	31.22%	69
Sense of belonging (13)	27.15%	60
Racial and ethnic diversity (12)	20.36%	45
Access to affordable housing (3)	19.91%	44
Good paying jobs and strong economy (8)	15.38%	34
Access to affordable transportation (4)	12.22%	27
Strong community leaders and role models (14)	11.76%	26
Other (please specify) (15)	3.17%	7

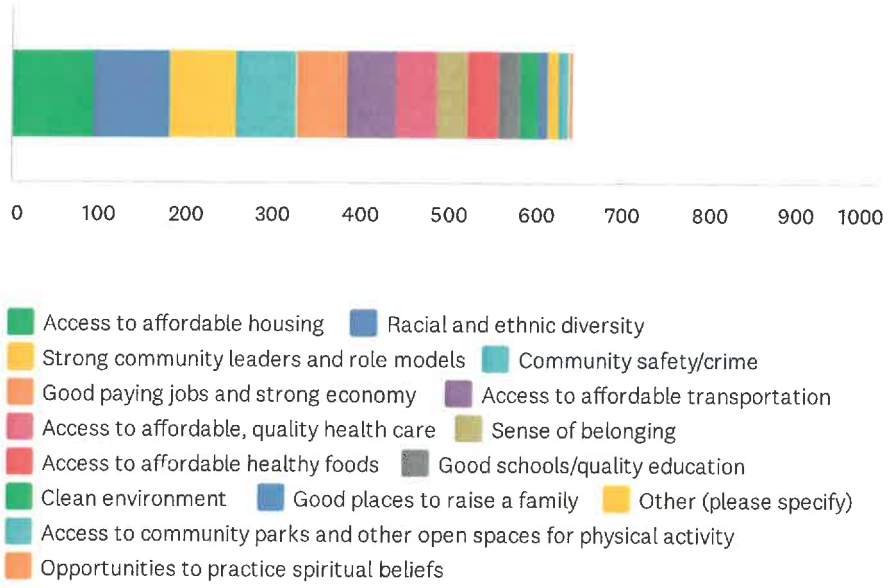
Total Respondents: 221

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	8.00	7.56	3.58

Q21 What do you think are the top CHALLENGES of your community right now?

Answered: 219 Skipped: 59



ANSWER CHOICES	RESPONSES	
Access to affordable housing (3)	43.38%	95
Racial and ethnic diversity (12)	40.18%	88
Strong community leaders and role models (14)	35.16%	77
Community safety/crime (7)	31.96%	70
Good paying jobs and strong economy (8)	26.48%	58
Access to affordable transportation (4)	25.57%	56
Access to affordable, quality health care (1)	20.55%	45
Sense of belonging (13)	16.44%	36
Access to affordable healthy foods (2)	15.98%	35
Good schools/quality education (10)	10.96%	24
Clean environment (6)	9.59%	21
Good places to raise a family (9)	5.48%	12
Other (please specify) (15)	5.48%	12
Access to community parks and other open spaces for physical activity (5)	5.02%	11
Opportunities to practice spiritual beliefs (11)	2.28%	5

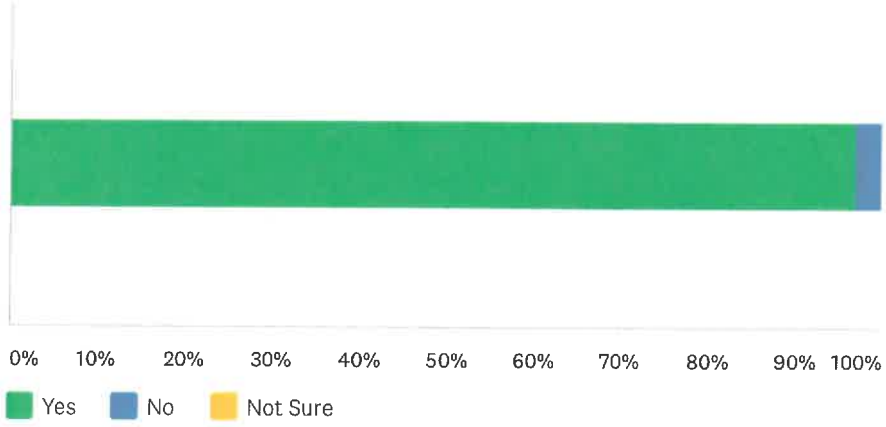
Total Respondents: 219

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	15.00	7.00	7.67	4.44

Q22 Do you currently have health insurance?

Answered: 215 Skipped: 63



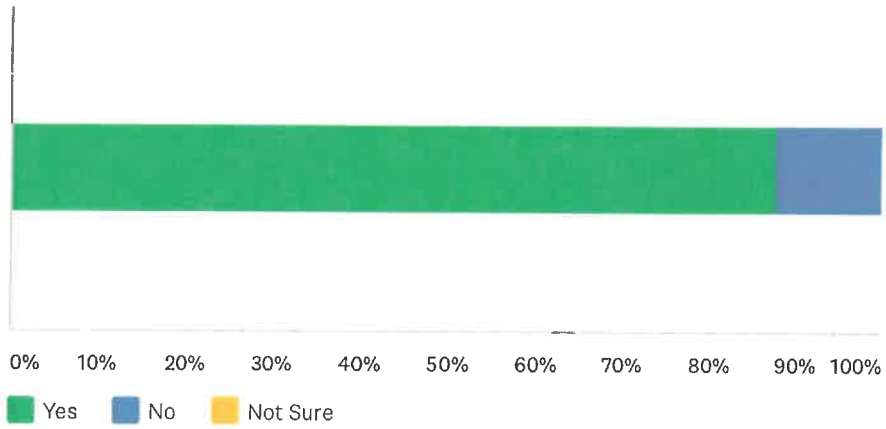
ANSWER CHOICES	RESPONSES	
Yes (1)	97.21%	209
No (2)	2.79%	6
Not Sure (3)	0.00%	0
TOTAL		215

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.03	0.16

Q23 Do you currently have dental insurance?

Answered: 215 Skipped: 63



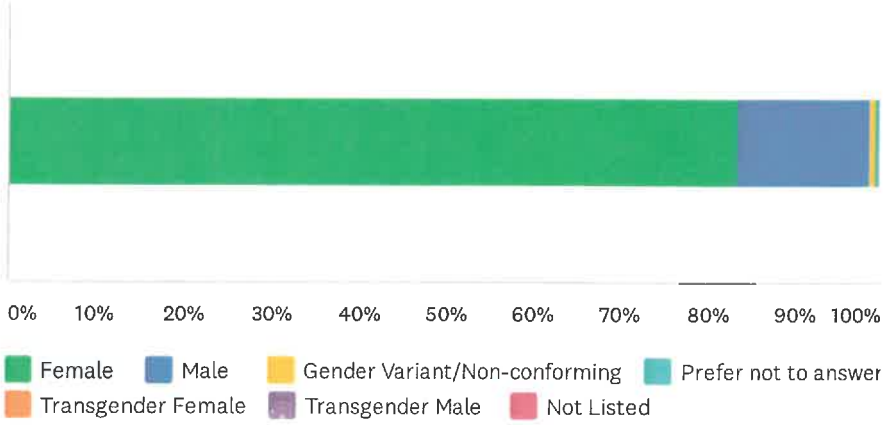
ANSWER CHOICES	RESPONSES	
Yes (1)	87.91%	189
No (2)	12.09%	26
Not Sure (3)	0.00%	0
TOTAL		215

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	1.00	1.12	0.33

Q24 With which gender identity do you most identify?

Answered: 212 Skipped: 66



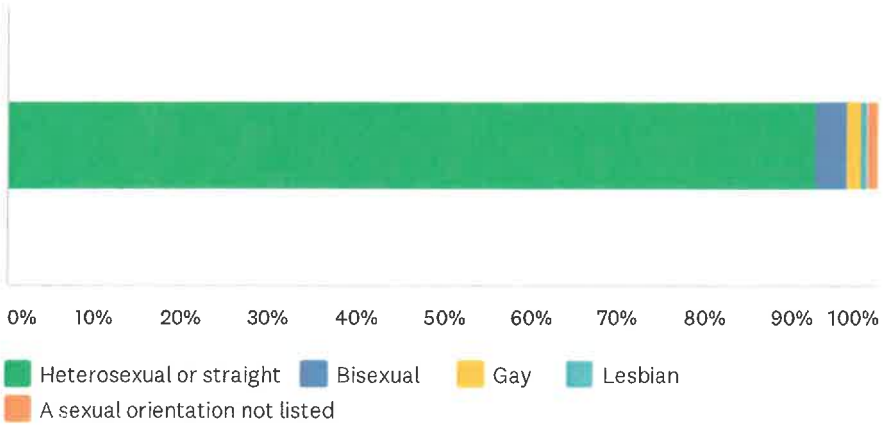
ANSWER CHOICES	RESPONSES	
Female (1)	83.49%	177
Male (2)	15.57%	33
Gender Variant/Non-conforming (5)	0.47%	1
Prefer not to answer (6)	0.47%	1
Transgender Female (3)	0.00%	0
Transgender Male (4)	0.00%	0
Not Listed (7)	0.00%	0
TOTAL		212

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.20	0.56

Q25 What is your sexual orientation?

Answered: 211 Skipped: 67



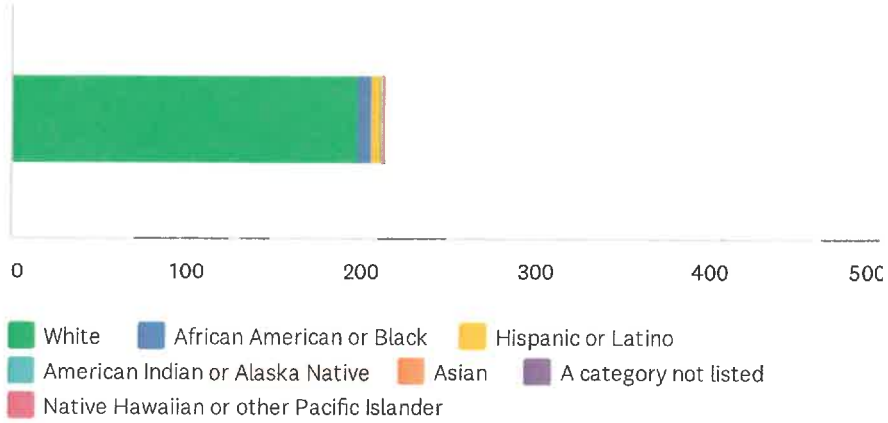
ANSWER CHOICES	RESPONSES	
Heterosexual or straight (1)	92.89%	196
Bisexual (4)	3.79%	8
Gay (2)	1.42%	3
Lesbian (3)	0.95%	2
A sexual orientation not listed (5)	0.95%	2
TOTAL		211

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	1.00	1.18	0.71

Q26 With which race/ethnicity do you identify? You may check more than one.

Answered: 213 Skipped: 65



ANSWER CHOICES	RESPONSES	
White (6)	93.43%	199
African American or Black (1)	3.76%	8
Hispanic or Latino (4)	2.35%	5
American Indian or Alaska Native (2)	0.47%	1
Asian (3)	0.47%	1
A category not listed (7)	0.47%	1
Native Hawaiian or other Pacific Islander (5)	0.00%	0

Total Respondents: 213

BASIC STATISTICS

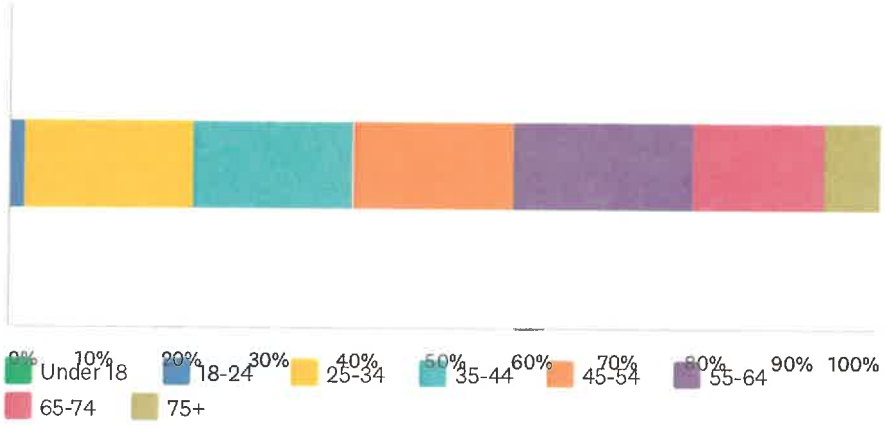
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	6.00	5.74	1.04

Q27 What languages do you speak at home?

Answered: 204 Skipped: 74

Q28 What is your age group?

Answered: 212 Skipped: 66



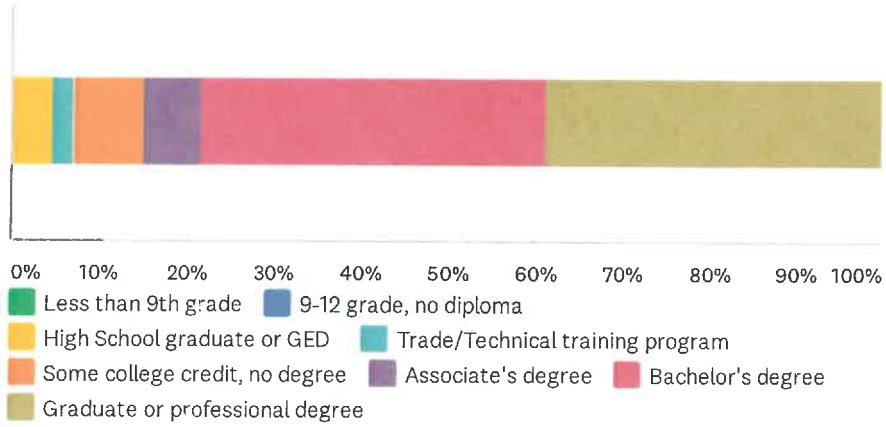
ANSWER CHOICES	RESPONSES	
Under 18 (1)	0.00%	0
18-24 (2)	1.89%	4
25-34 (3)	19.34%	41
35-44 (4)	18.40%	39
45-54 (5)	18.40%	39
55-64 (6)	20.75%	44
65-74 (7)	15.09%	32
75+ (8)	6.13%	13
TOTAL		212

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	8.00	5.00	5.07	1.58

Q29 What is the highest grade or year of school you completed?

Answered: 212 Skipped: 66



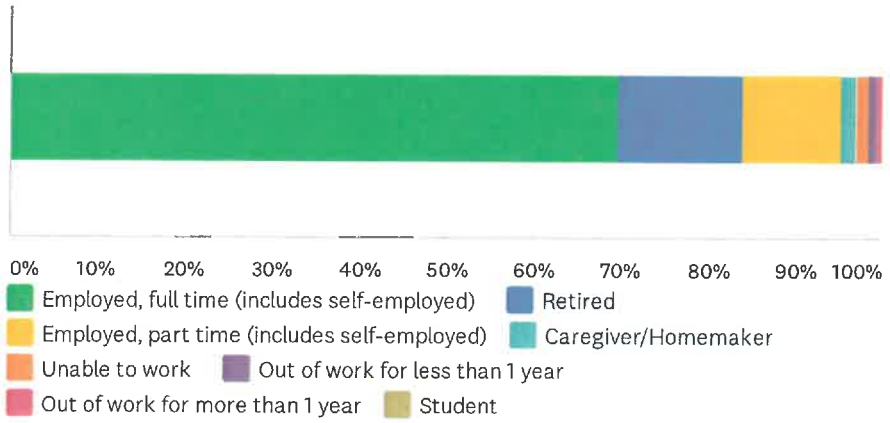
ANSWER CHOICES	RESPONSES	
Less than 9th grade (1)	0.00%	0
9-12 grade, no diploma (2)	0.00%	0
High School graduate or GED (3)	4.72%	10
Trade/Technical training program (4)	2.36%	5
Some college credit, no degree (5)	8.02%	17
Associate's degree (6)	6.60%	14
Bachelor's degree (7)	39.62%	84
Graduate or professional degree (8)	38.68%	82
TOTAL		212

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
3.00	8.00	7.00	6.90	1.32

Q30 What is your employment status

Answered: 213 Skipped: 65



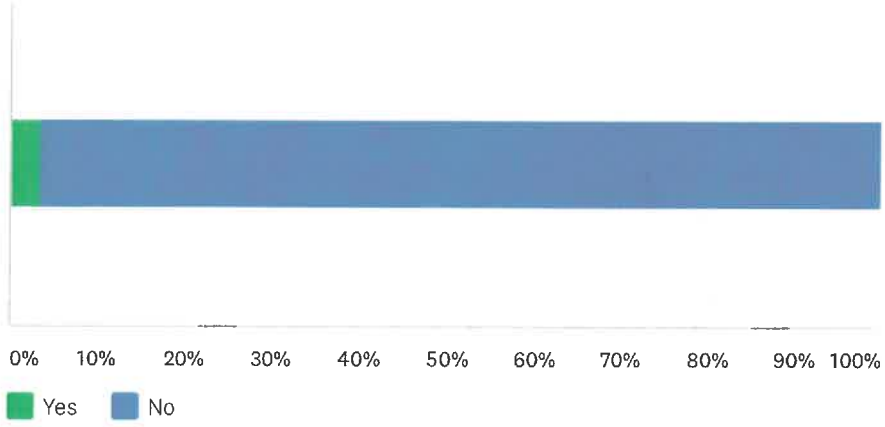
ANSWER CHOICES	RESPONSES	
Employed, full time (includes self-employed) (1)	69.95%	149
Retired (7)	14.08%	30
Employed, part time (includes self-employed) (2)	11.27%	24
Caregiver/Homemaker (5)	1.88%	4
Unable to work (8)	1.41%	3
Out of work for less than 1 year (4)	0.94%	2
Out of work for more than 1 year (3)	0.47%	1
Student (6)	0.00%	0
TOTAL		213

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	8.00	1.00	2.17	2.22

Q31 Are you a Veteran?

Answered: 206 Skipped: 72



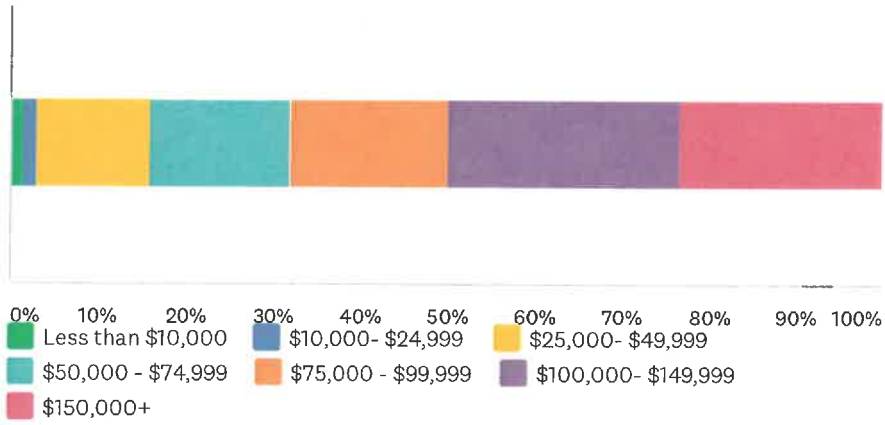
ANSWER CHOICES	RESPONSES	
Yes (1)	3.40%	7
No (2)	96.60%	199
TOTAL		206

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.97	0.18

Q32 Which of these describes your household income last year?

Answered: 201 Skipped: 77



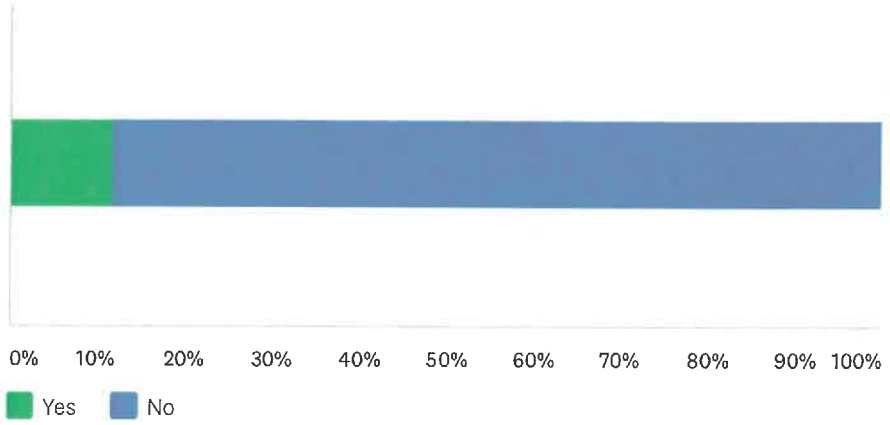
ANSWER CHOICES	RESPONSES	
Less than $10,000 (1)	1.49%	3
$10,000- $24,999 (2)	1.49%	3
$25,000- $49,999 (3)	12.94%	26
$50,000 - $74,999 (4)	15.92%	32
$75,000 - $99,999 (5)	18.41%	37
$100,000- $149,999 (6)	26.37%	53
$150,000+ (7)	23.38%	47
TOTAL		201

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	5.00	5.21	1.48

Q33 Do you consider yourself to be a person with a disability?

Answered: 211 Skipped: 67



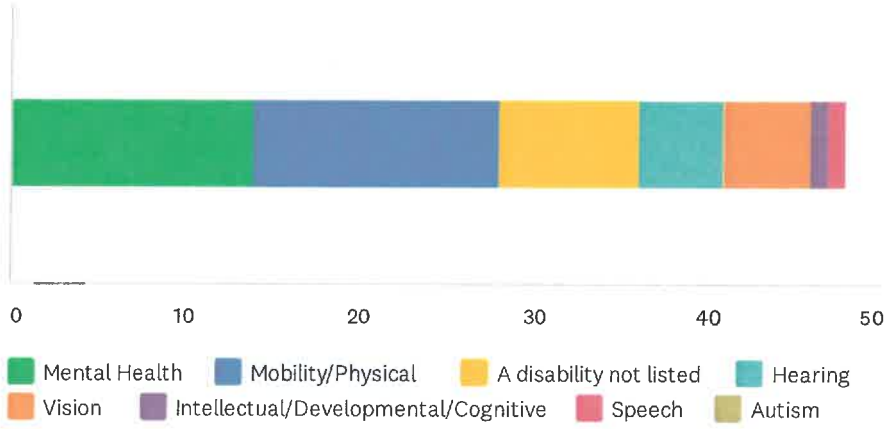
ANSWER CHOICES	RESPONSES	
Yes (1)	11.85%	25
No (2)	88.15%	186
TOTAL		211

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	2.00	2.00	1.88	0.32

Q34 Please select the type of disabilities that apply to you

Answered: 40 Skipped: 238



ANSWER CHOICES	RESPONSES	
Mental Health (4)	35.00%	14
Mobility/Physical (5)	35.00%	14
A disability not listed (8)	20.00%	8
Hearing (2)	12.50%	5
Vision (7)	12.50%	5
Intellectual/Developmental/Cognitive (3)	2.50%	1
Speech (6)	2.50%	1
Autism (1)	0.00%	0

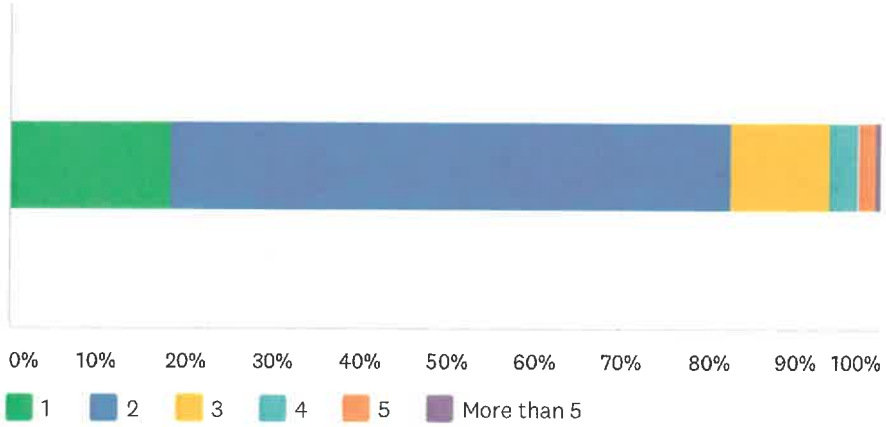
Total Respondents: 40

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
2.00	8.00	5.00	5.08	1.80

Q35 How many adults (age 18+) live in your household (including yourself)?

Answered: 208 Skipped: 70



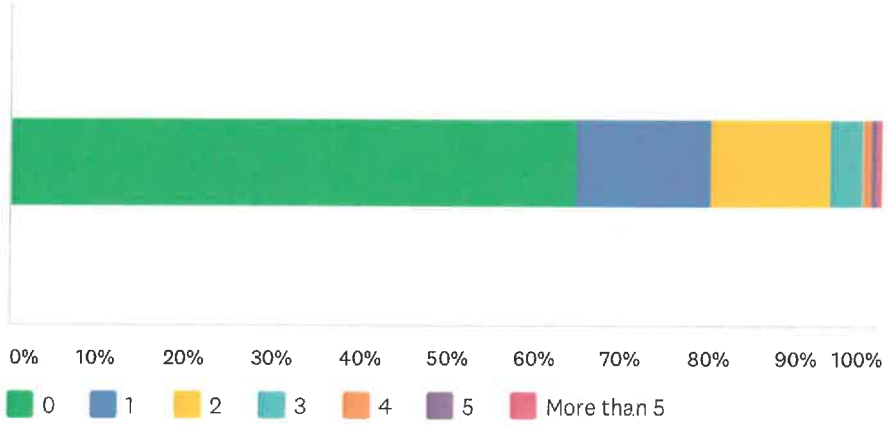
ANSWER CHOICES	RESPONSES	
1 (1)	18.27%	38
2 (2)	64.42%	134
3 (3)	11.54%	24
4 (4)	3.37%	7
5 (5)	1.92%	4
More than 5 (6)	0.48%	1
TOTAL		208

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	2.00	2.08	0.82

Q36 How many children under age 18 live in your household?

Answered: 206 Skipped: 72



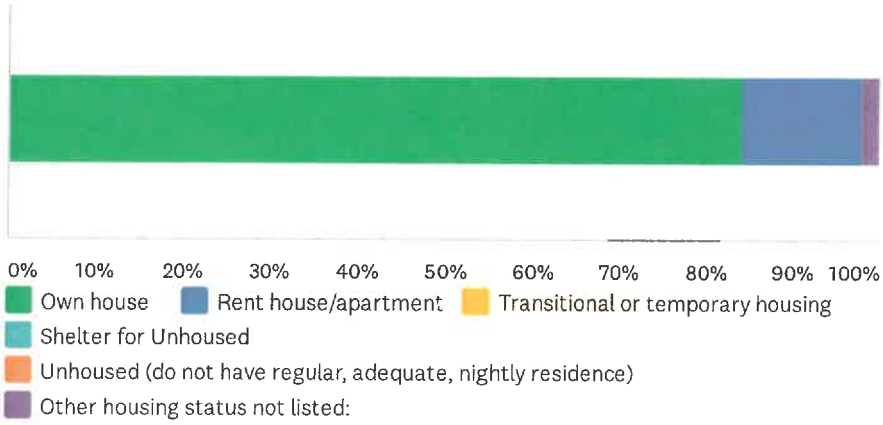
ANSWER CHOICES	RESPONSES	
0 (1)	65.05%	134
1 (2)	15.53%	32
2 (3)	13.59%	28
3 (4)	3.88%	8
4 (5)	0.97%	2
5 (6)	0.49%	1
More than 5 (7)	0.49%	1
TOTAL		206

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	7.00	1.00	1.64	1.05

Q37 Please indicate your housing status

Answered: 211 Skipped: 67



ANSWER CHOICES	RESPONSES	
Own house (1)	84.36%	178
Rent house/apartment (2)	13.74%	29
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)	1.90%	4
TOTAL		211

BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	1.00	1.23	0.75

Q38 If you were able to implement one, single solution to improve your health, what would it be? (No more than 100 characters)

Answered: 162 Skipped: 116

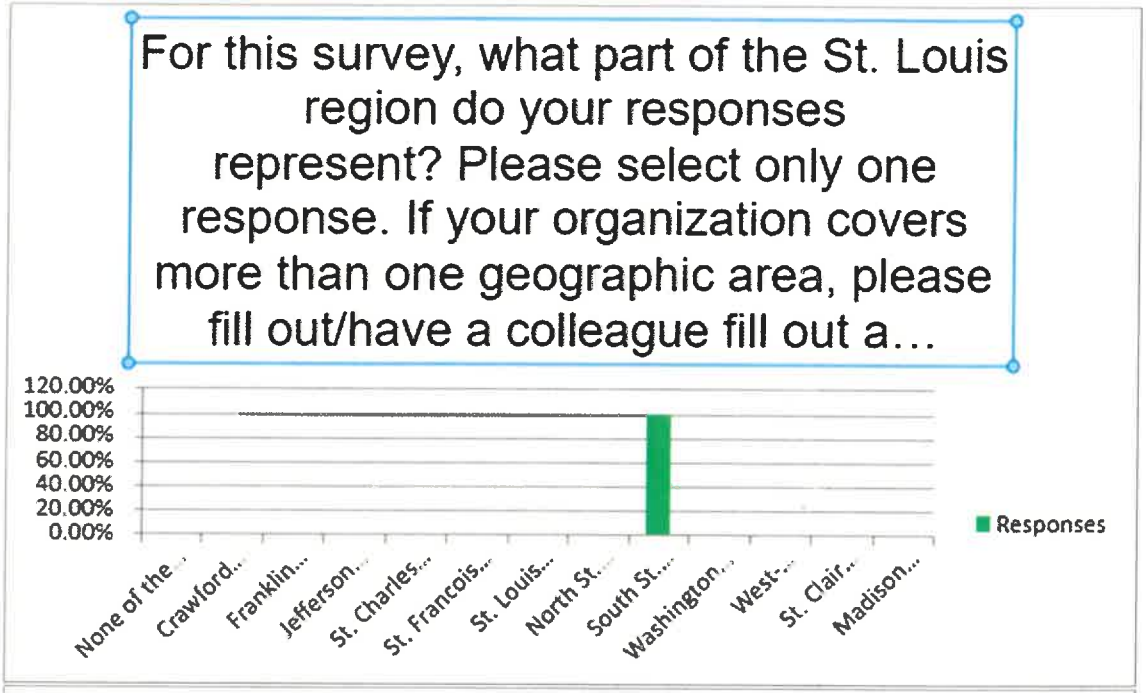
Q39 If you were able to implement one, single solution to improve the health of your community, what would it be? (No more than 100 characters)

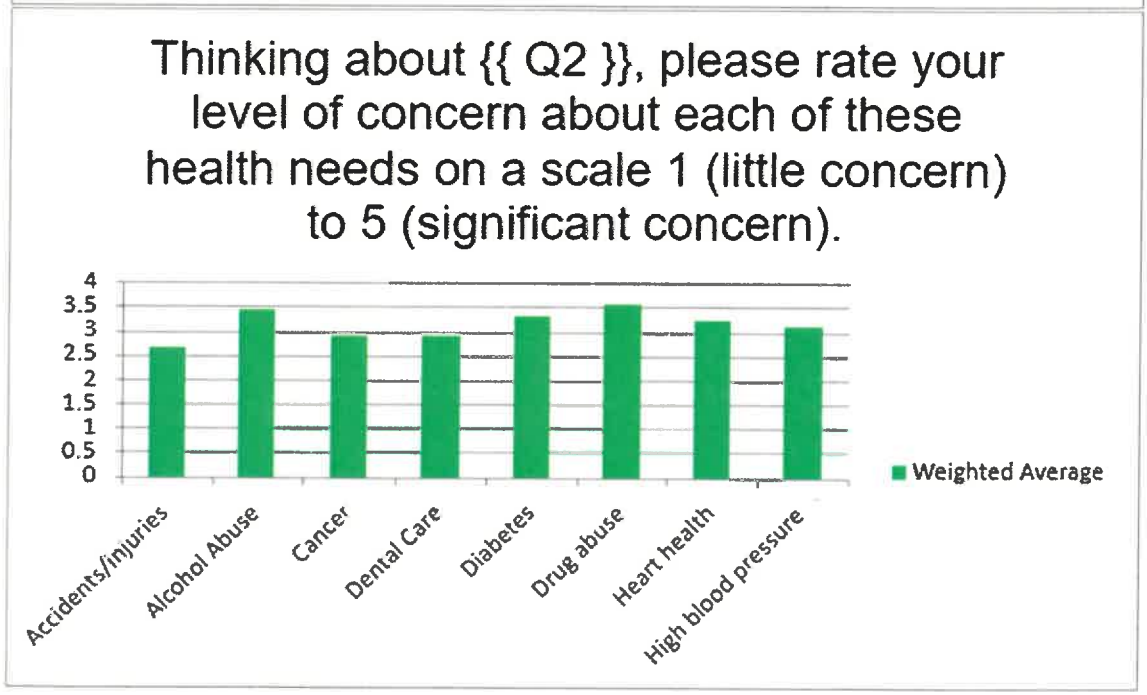
Answered: 151 Skipped: 127

Appendix C

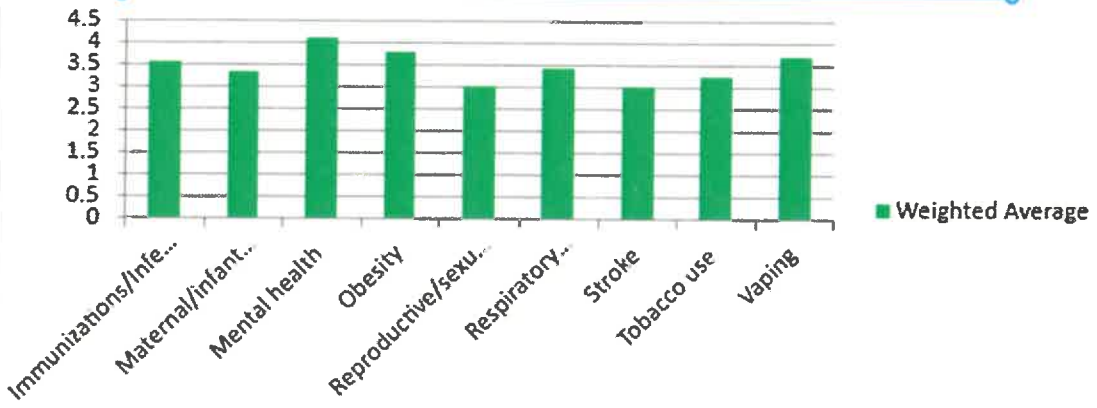
St. Louis Collaborative: Stakeholder Survey

CHNA Stakeholder Responses - South

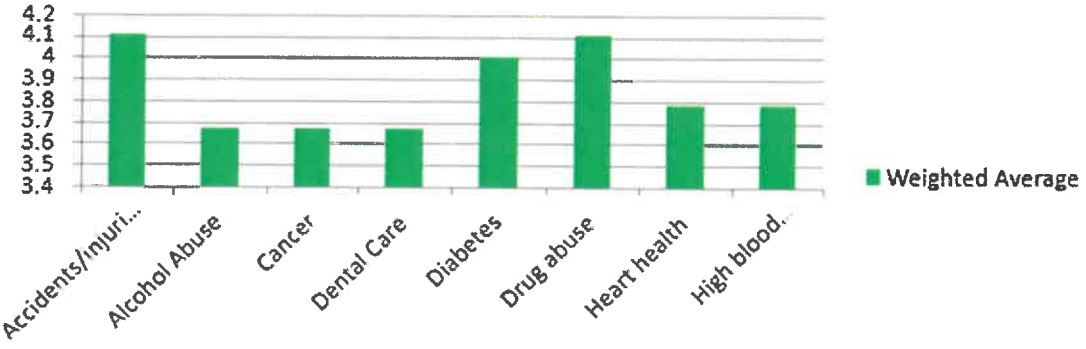




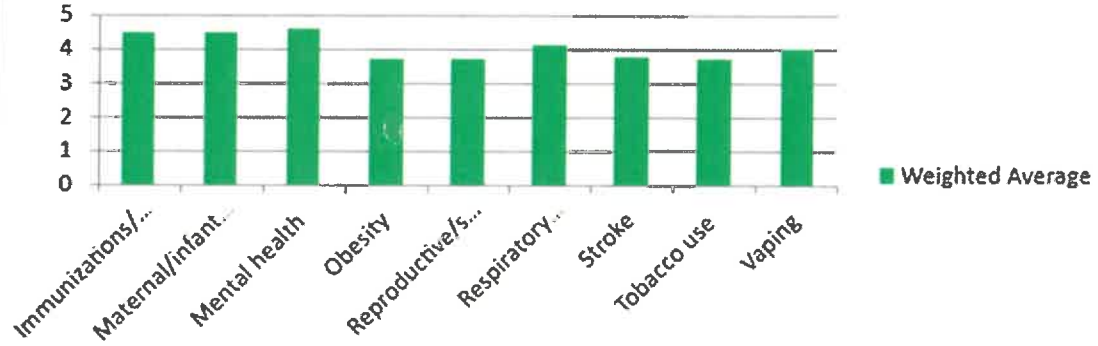
Thinking about {{ Q2 }}, please rate your level of concern about each of these health needs on a scale 1 (little concern) to 5 (significant concern).



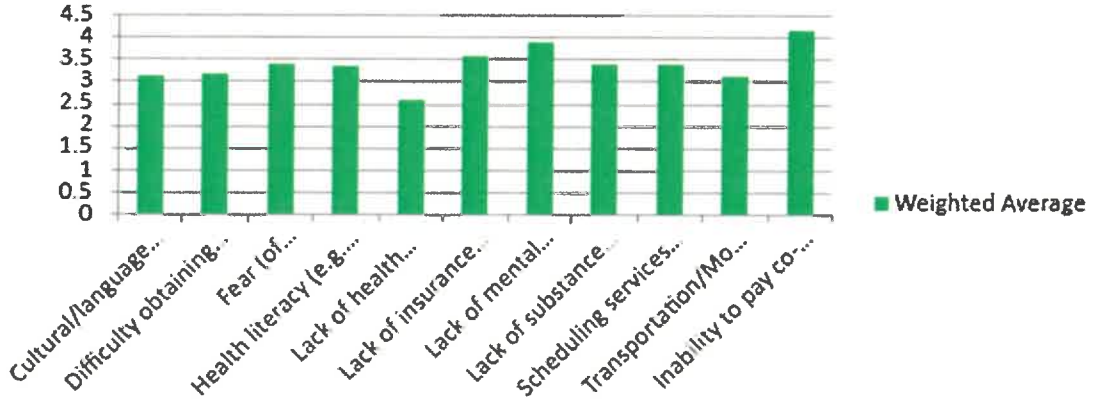
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



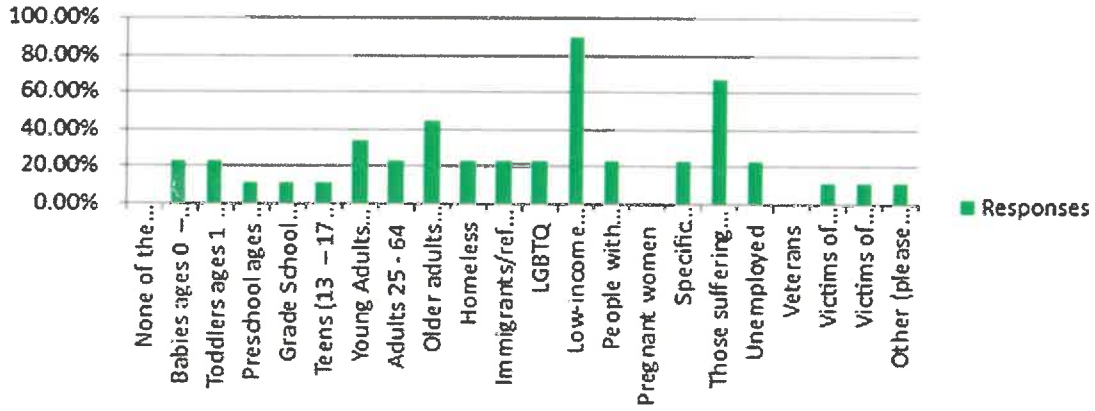
How would you rate the potential of community partners in {{ Q2 }} to work together to address each of these health needs? Please rate each on a scale 1 (little potential) – 5 (significant potential).



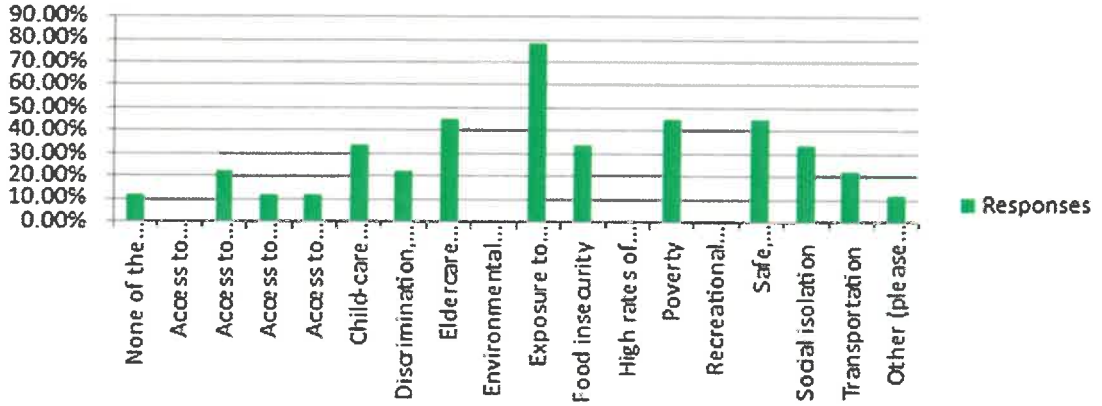
How impactful are each of the following barriers in {{ Q2 }} to accessing health care? Rate each on a scale of 1 (little impact) – 5 (significant impact).

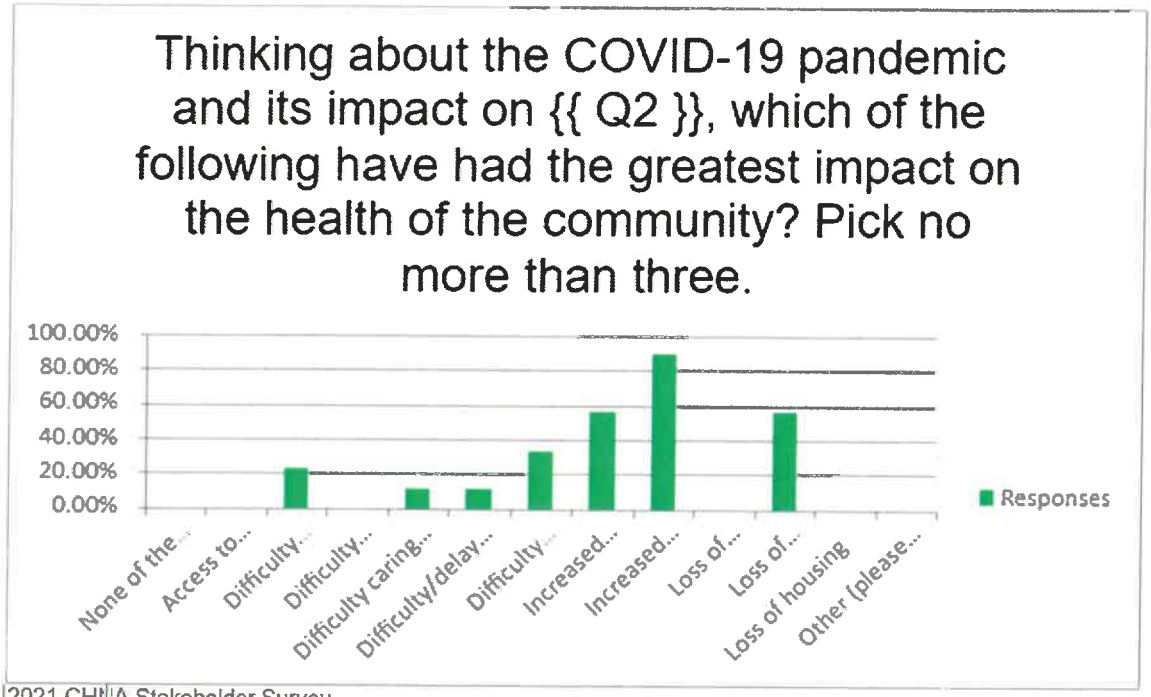


Among those you serve in {{ Q2 }}, which of the following populations are most at risk for poor health outcomes? Pick no more than five.



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.





2021 CHNA Stakeholder Survey

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?

Answered 6
Skipped 4

Respondents	Response Date	Responses	Tags
1	Aug 24 2021	Depression, anxiety and substance use among all populations. Income inequality, need for livable wage.	
2	Jul 13 2021	Mental Health issues; specifically depression and anxiety after being in quarantine.	
3	Jul 02 2021	Not sure	
4	Jun 18 2021	Housing	
5	Jun 14 2021	Increase in anxiety and depression in children/youth and a lack of mental healthcare professionals.	
6	Jun 09 2021	Substance use and mental health concerns	

2021 CHNA Stakeholder Survey

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.

Answered 6
Skipped 4

Respondents	Response Date	Responses	Tags
1	Aug 24 2021	Lack of mental health and substance use services. Lack of jobs that provide a live-able wage. Poverty and low income creates barrier to services, housing and resources.	
2	Jul 13 2021	Access to computers and devices for children to do classwork remotely, food insecurity, mental health services	
3	Jul 02 2021	Not sure	
4	Jun 18 2021	N/A	
5	Jun 14 2021	It was the general lack of preparedness by the healthcare community and public health for the pandemic. However, it has provided an opportunity for a system-level change.	
6	Jun 09 2021	Awareness and availability of resources that address behavioral health issues	

2021 CHNA Stakeholder Survey

How can community stakeholders in {{ Q2 }} work together to use their collective strengths to improve the health of the community?

Answered 6
Skipped 4

Respondents	Response Date	Responses	Tags
1	Aug 24 2021	Align with existing initiatives and promote operational practices that maximize existing resources and introduce efficiency. Cultivate a climate of trust, transparency, coordination, partnership, and inclusivity with stakeholders.	
2	Jul 13 2021	Maybe offer pop up clinics that are free to local residents. I think there would be no reason then for anyone to go without care	
3	Jul 02 2021	Additional Partnerships of all providers	
4	Jun 18 2021	N/A	
5	Jun 14 2021	Clear and consistent and "grass roots" messaging on COVID-19 vaccine safety. Advocating for more mental health professionals, especially for kids/youth. Coming together to move forward for better system-level preparedness for emerging threats and diseases.	
6	Jun 09 2021	Raise awareness of resources and increase access	

2021 CHNA Stakeholder Survey

Within the {{ Q2 }}, which communities, neighborhoods or ZIP codes are especially vulnerable or at risk?

Answered	**6**
Skipped	**4**

Respondents	Response Dat	Responses	Tags
1	Aug 24 2021	63123 and 63125	
2	Jul 13 2021 0	63125. 63123	
3	Jul 02 2021 0	Not sure in South County	
4	Jun 26 2021	63125	
5	Jun 18 2021 (	63125	
6	Jun 14 2021 (	63123, 63126, 63128, 63129, 63125	

Appendix D

Meacham Park Focus Group Summary

Focus Group Summary

Meacham Park Community

Conducted March 28, 2022
Webex

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Invitee & Participant List

Community Stakeholders invited:

- Harriet Patton, MPNIA
- Bum Kim, MPNIA
- Jeffrey Blair, MPNIA
- Romona Miller, Kirkwood High School
- Cari French, YMCA
- Gary Baldridge, Kirkwood Police
- Kirkwood Fire Department
- Tasha Fondren, YWCA Head Start Educare Center
- Bishop Ike Motley, ACTION Christian Center
- Pastor Darren Smotherson, First Baptist Church of Meacham Park
- Community Government:
  - Maggie Duwe, Kirkwood City Council
  - Mark Zimmer, Kirkwood City Council
  - Wallace Ward, Kirkwood City Council
  - Kara Wurtz, Kirkwood City Council
  - Liz Gibbons, Kirkwood City Council
  - Bob Sears, Kirkwood City Council
  - Kirkwood Mayor – Tim Griffin
- Community Members: Members of MPNIA

Attendees:

- Facilitator: Megan Drissell, Director of Community Health and Access, Mercy Hospital St. Louis
- Scribe: Laura Bub, Director of Community Health and Access, Mercy Hospital South
- Harriet Patton, President of Meacham Park Neighborhood Association (MNIA)
- Wallace Ward, Kirkwood City Council
- Gary Baldridge, Community Service Officer, Kirkwood Police, Direct Liaison to MP Community

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2

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?

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3

Overall Themes

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4

Q1: Defining a Healthy Community

- Robust resources – availability of resources that benefit the community
- Platforms for the community to voice their needs and concerns – visibility and representation
- Collaboration and teamwork
- Preventative healthcare (supportive resources and education)
- Neighborhood connectivity - Meacham Park as a neighborhood within a larger community, connectivity within and beyond
- Diversity:
  - Age / multigenerational
  - Gender
  - Ethnicity
  - Education
  - Socioeconomic status

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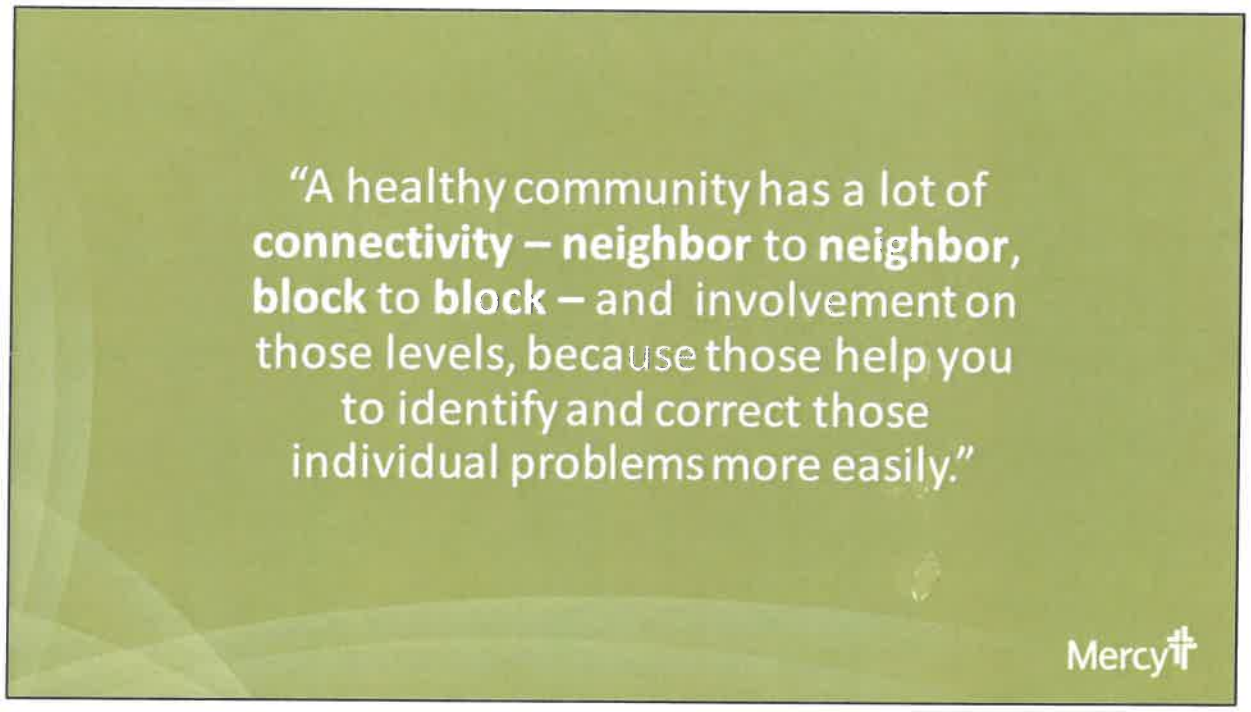
"A healthy community has a lot of **connectivity – neighbor** to **neighbor**, **block** to **block** – and involvement on those levels, because those help you to identify and correct those individual problems more easily."
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Q2: Community Strengths

- Faith community – multiple churches open within the neighborhood
- Relationship with the YWCA
- Strong relationship with the Kirkwood School District (recently moved administrative offices to the old Turner School)
- Representation and communication:
  - Voices are heard when issues arise
  - Issues with Police Department have been addressed (community members can anonymously report policing concerns)
- Meacham Park Memorial Playground
- TIFF money led to upgraded street lighting, the park, updated infrastructure to make Meacham Park a safer place to live
- Hotdogs at the Park with Officer Gary Baldridge
- Neighborhood in transition– comes with pros and cons

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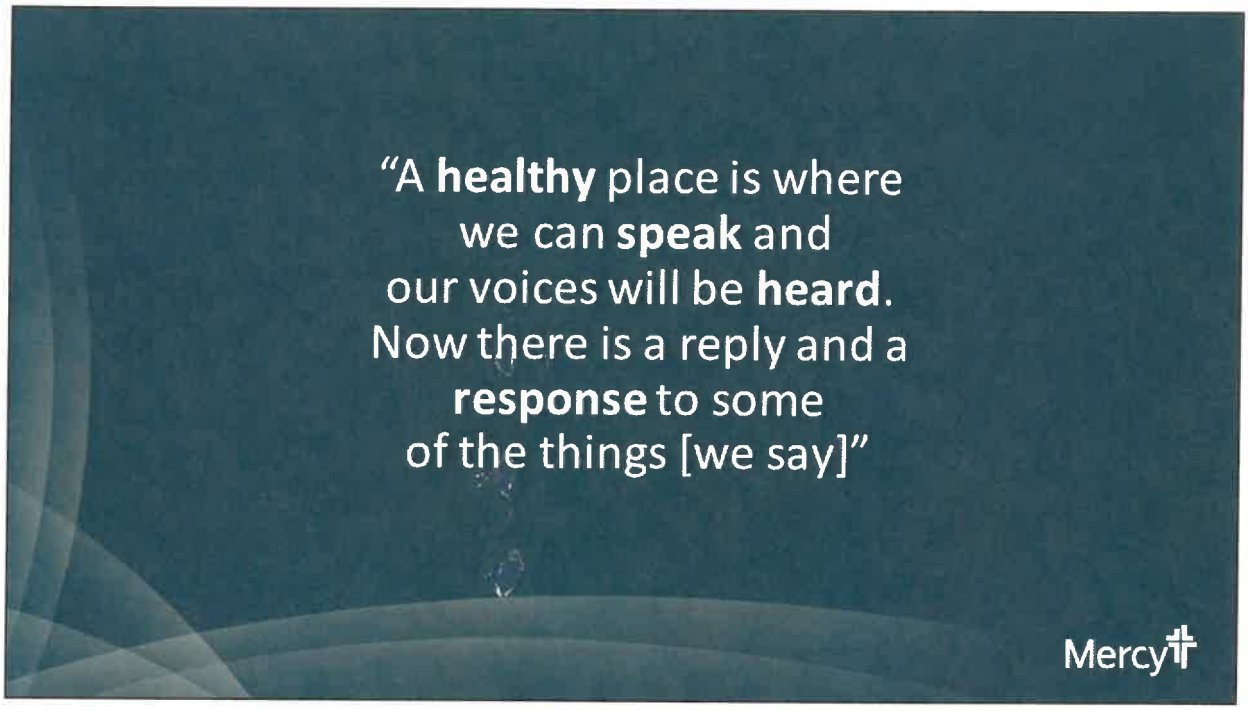
"A **healthy** place is where
we can **speak** and
our voices will be **heard**.
Now there is a reply and a
response to some
of the things [we say]"
Mercy

Q3: Community Challenges

- Violence & Safety:
  - Small group of residents (2-5%) causing majority of crime
- Lack of Access to Healthcare:
  - Lack of Health insurance
  - Do not seek care for health issues (need preventative care)
  - Need more door-to-door, 1:1 care like Sisters used to provide
- Distrust/Not sharing:
  - Community members do always seek assistance when they need it. Let chronic conditions go on too long without help.
- Neighborhood in Transition:
  - Long-standing residents are getting older or moving on
  - More people moving out means more people moving in and there is a loss of connectivity (can lead to crime)
- Opioid epidemic
- Disconnect of neighborhood from larger community ("self-segregation")
  - Community members may not utilize what is available and accessible to them
- Could benefit from more precise data on community needs

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9

"..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**."

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Q4: Most Urgent Issues

- Access and Navigation
  - Adequate Housing – lots of empty lots/houses
  - Adequate Social Services
  - Adequate Health Care coverage
- Recreation
- Need more young families in the neighborhood
- Crime
  - Juveniles with guns, evidence of guns with casings, etc. on road
  - Residents will not assist with providing info on who committed crimes, want to handle themselves.
  - Potential for innocent bystanders to be hurt

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"I believe that the biggest issue right now is **crime**.
The criminal element in there we spoke of before.
It's a **small group** [who commits these crimes]
but also a **small neighborhood**.
And so it has had a really **significant impact**
on the **perception** of those who don't live there,
so we need to figure that out."

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Q5: Healthcare Access

- Access to clinics like JFK Clinic difficult due to lack of transportation
- Uninsurance
  - No concrete data on uninsurance rate in the community, but there are community members who report having no insurance and no access
- Used to have Meacham Park clinic and that provided health and dental services
- Need 1:1 advocates, door-to-door care

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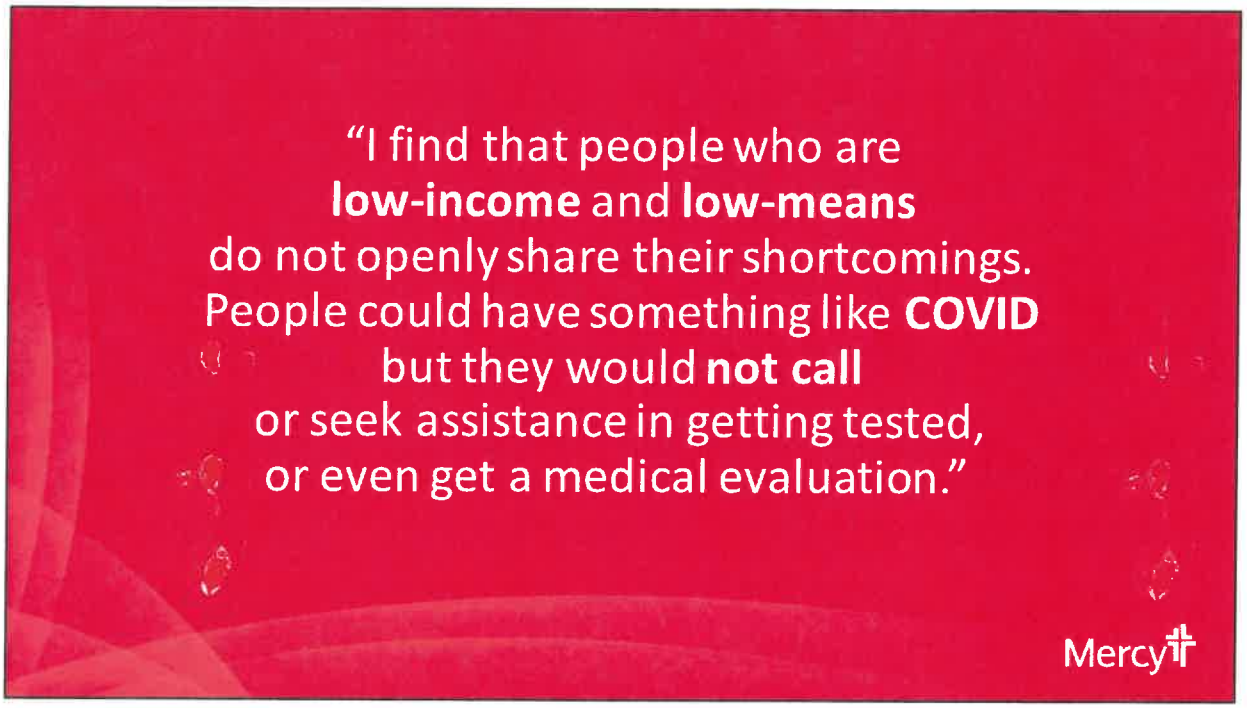
"I find that people who are
low-income and low-means
do not openly share their shortcomings.
People could have something like COVID
but they would not call
or seek assistance in getting tested,
or even get a medical evaluation."
Mercy

Q6: Barriers & Equity

- Lack of Healthcare Insurance
  - People do not have health insurance and have medical conditions that have not been evaluated or treated
- Transportation
  - Many people are without vehicles and do not have transportation to JFK or other healthcare clinics
- Communication/Expressing Need
  - Many people do share their needs or medical conditions with others and do not seek help
- Data-driven response to neighborhood needs may help optimize how resources are distributed within the community
- Tendency towards self-segregation within the neighborhood

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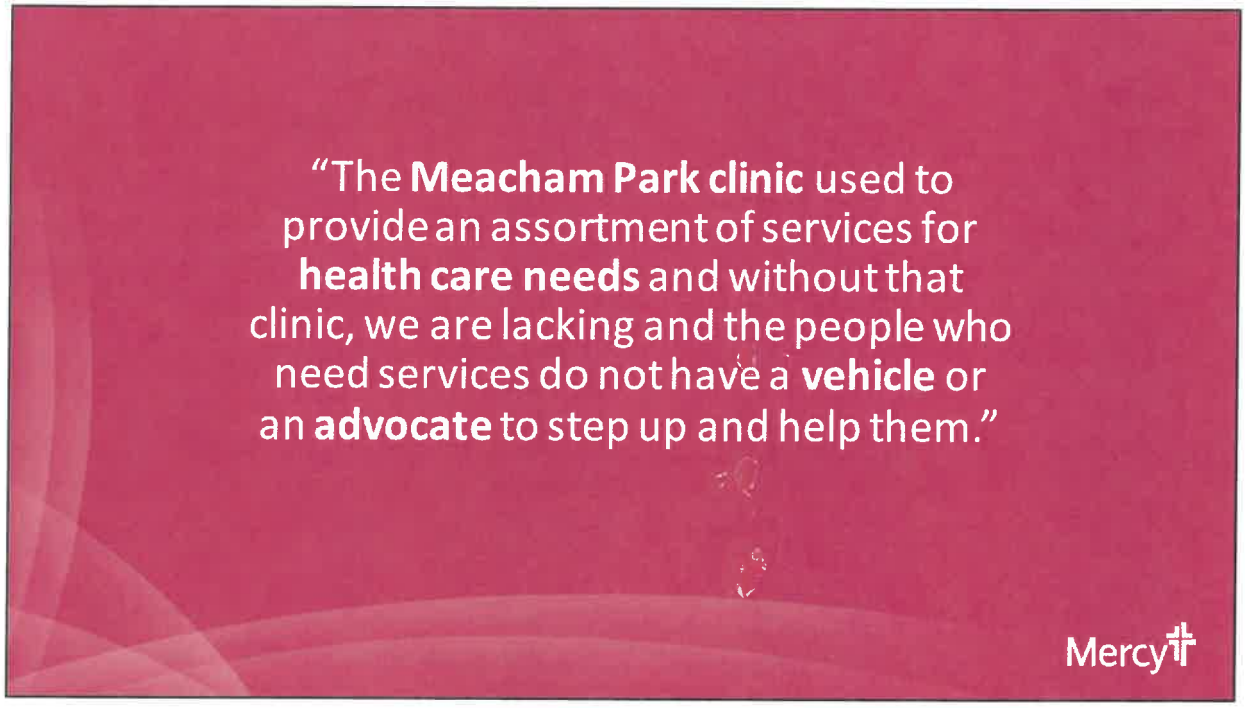
"The **Meacham Park clinic** used to provide an assortment of services for **health care needs** and without that clinic, we are lacking and the people who need services do not have a **vehicle** or an **advocate** to step up and help them."
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Appendix E

Mercy Hospital South

Community Health Council Prioritization Exercise

Community Health Council- Prioritization Exercise

Mercy Hospital South

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FY2022

April 25, 2022

Agenda

- Prayer & Reflection
- Community Health Needs Assessment Discussion
  - CHNA Timeline, Prioritization, & Updates

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CHNA Timeline

April 2021

- ✓ Discuss CHNA timeline at both system level and at ministry level.

May 2021

- ✓ Finalize timelines
- ✓ Set short term process goals for strategic planning
- ✓ Begin discussions on stakeholder & community engagement and an information gathering plan.
- ✓ Begin identifying secondary data sources

June 2021-July 2021

- ✓ Conduct community & stakeholder surveys
- ✓ Priority -focus group training with Mercy team.

August 2021-Oct 2021

- ✓ Conduct focus groups and identify priorities
- ✓ Summarize and report out results of focus groups regarding priority setting and the community.

Jan 2022-Feb. 2022

- ✓ Begin drafting CHNA shell for agencies and finalize for internal presentations

March 2022-May 2022

- Submit required information to internal departments for inclusion in the final CHNA and plan.

June 2022

- Final CHNA process and plans documents produced

***CHIP Due in Fall of 2022 (Mercy)**

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Impact Evaluation of Previous CHNA

The 2019 Community Health Needs Assessment identified three priority health areas:

Mercy Hospital South developed and implemented a community health improvement plan which included a variety of programs and initiatives to address the needs identified in the 2019 CHNA.

Community Health Improvement Plan (CHIP)

- Prioritized Needs Refresher

Access to Care

- CHW, CRC, Hancock Clinic, Health Leads, & Crisis Nursery

Mental Health/Substance Use

- BHN & Assessing gaps

Chronic Disease: Focus on Diabetes

- Diabetes Collaborative

Mercy

Community Profile

Mercy Hospital South- South Region of St. Louis County

Population: 201,351

Projected 5-Year Growth: + 0.07%

Race: Minorities make up 9.08% of residents

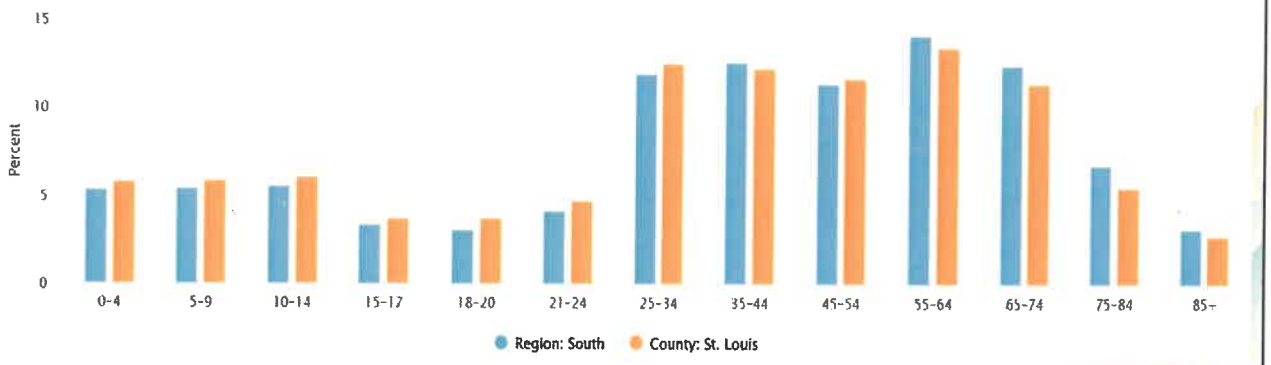
Race: 90.92% of Residents are white

Median household income is $82,337

Source: ThinkHealthStl.org, Mercy Analytics

Community Profile

Demographics: Population by Age Group



Source: ThinkHealthStl.org

Community Profile

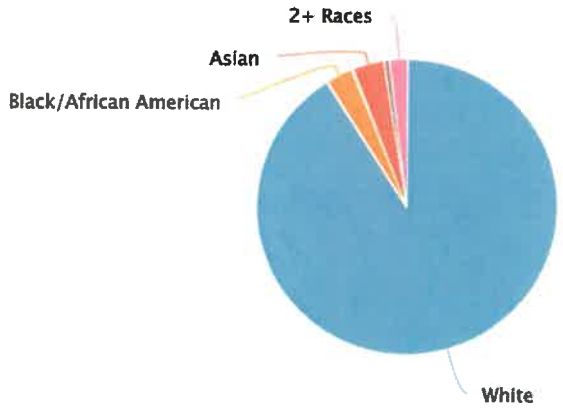
Demographics: Population by Race

Population by Race	Region: South		County: St. Louis	
	Persons	% of Population	Persons	% of Population
White	183,068	90.92%	654,301	65.91%
Black/African American	5,821	2.89%	250,755	25.26%
American Indian/Alaskan Native	333	0.17%	2,077	0.21%
Asian	6,833	3.39%	48,766	4.91%
Native Hawaiian/Pacific Islander	48	0.02%	226	0.02%
Some Other Race	1,178	0.59%	10,717	1.08%
2+ Races	4,070	2.02%	25,849	2.60%

Source: ThinkHealthStl.org

Community Profile

Demographics: Population by Race



Source: *ThinkHealthStl.org*

Community Profile

Average Household Income

Average Household Income by Race/Ethnicity	Region: South	County: St. Louis
	Value	Value
All	$104,424	$112,998
White	$97,489	$110,061
Black/African American	$59,255	$62,827
American Indian/Alaskan Native	$55,963	$73,020
Asian	$88,260	$120,391
Native Hawaiian/Pacific Islander	$72,000	$94,066
Some Other Race	$63,121	$64,594
2+ Races	$90,153	$86,616
Hispanic/Latino	$81,384	$98,555
Non-Hispanic/Latino	$104,884	$113,353

Source: ThinkHealthStl.org

Community Profile

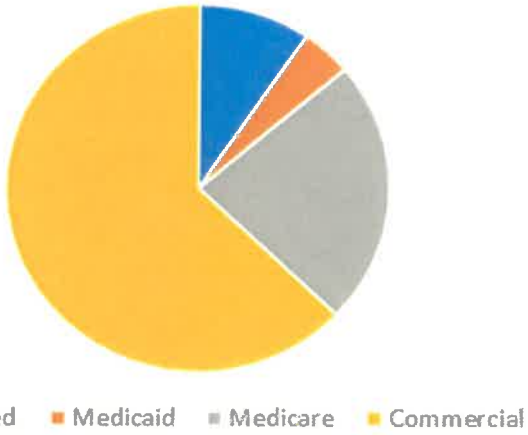
Education

Level	South St. Louis County	St. Louis County	Missouri
High School Degree	24.93%	21.39%	30.5%
Some College, No Degree	20.97%	20.03%	22.0%
Bachelor's Degree of Greater	39.54%	50.79%	29.9%

Source: ThinkHealthStl.org, Mercy Analytics

Community Profile

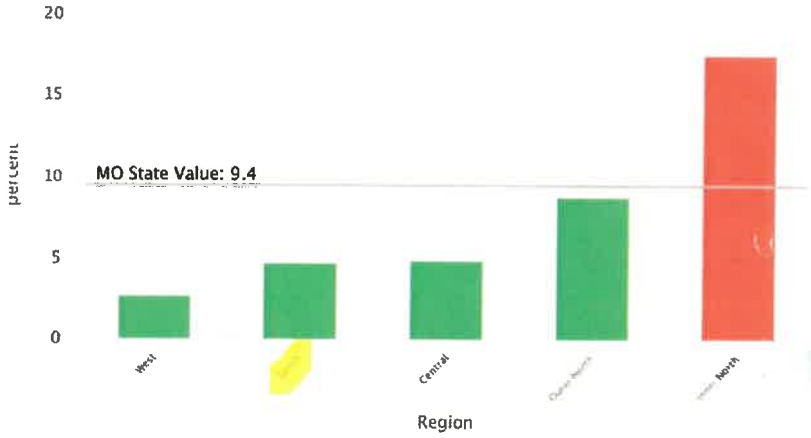
Insurance Status/Payer Mix



Source: Mercy Analytics

Community Profile

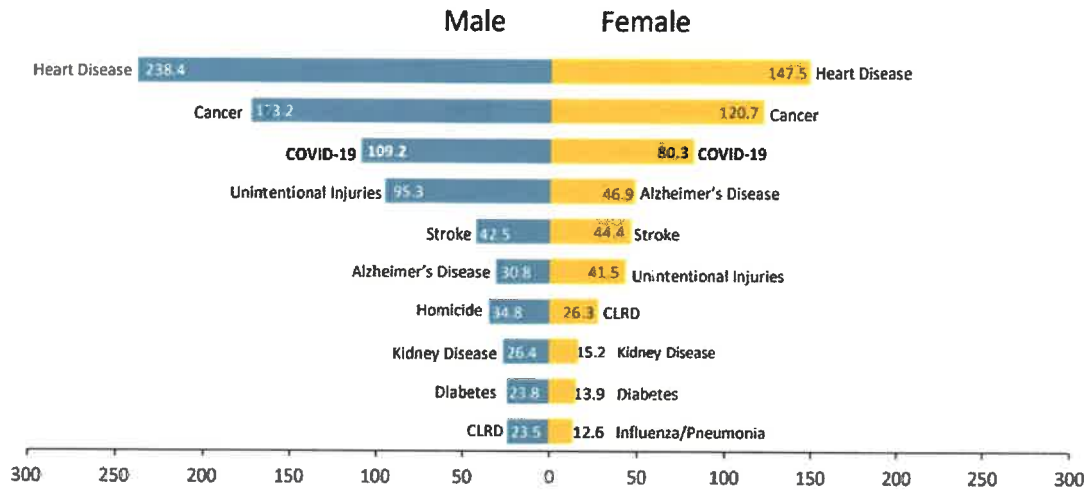
Families Living Below Poverty Level



Source: American Community Survey (2015-2019)

Community Profile

Leading Causes of Death - 2020



MercyHT Source: St. Louis County Department of Health

Community Health Needs Assessment

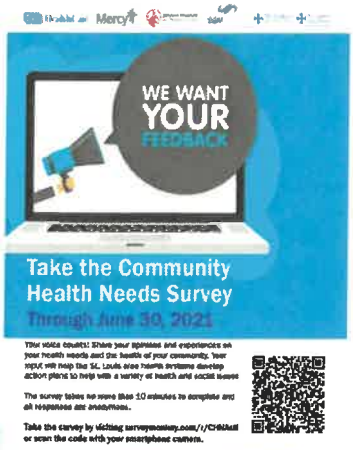
14

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 Shriner's Hospital. The pandemic limited our availability to solicit feedback in-person so online surveys were key to gain input. The first survey was a community-wide survey distributed broadly throughout the St. Louis metropolitan region to reach all community members from April to June of 2021. The survey took ten minutes to complete and contained 39 questions about health challenges, access to healthcare, and social determinant 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.



Our Assessment Process

Needs Assessment Survey – Community *(continued)*

- 83.49% of people who responded to the survey were female and 15.57% of respondents were male. 93.43% of persons who responded identified as being white, 3.76% identified as being African-American or Black and 2.35% identified as being Hispanic or Latino
- In general, 15.87% said their health was excellent, as compared to 46.13% very good, 29.15% good, 8.12% fair and .74% poor
- The top five health challenges noted were overweight/obesity at 37.27%, 26.57% joint or back pain, no health challenges at 22.51%, high blood pressures at 22.51% and other at 22.14%
- 39.60% of parents indicated that the health screening, education and/or services that their child/children need to access to keep them safe and healthy are those centered around mental health.
- Community strengths were listed as good place to raise a family at 72.85%, good schools/quality of education at 67.42%, access to community parks and other open spaces at 66.52%, opportunities to practice spiritual beliefs at 52.94% and community safety/low crime at 43.89%
- Top challenges in the community were access to affordable housing at 43.38%, racial and ethnic diversity at 40.18%, strong community leaders at 35.16% and community safety and crime at 31.96%

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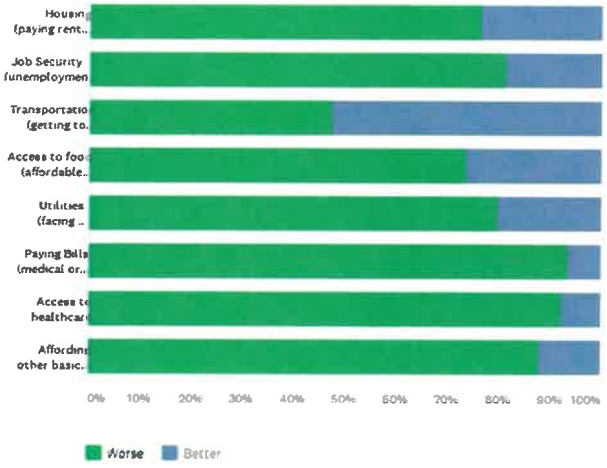
Our Assessment Process

Needs Assessment Survey – Community *(continued)*

Impact of the COVID-19 Pandemic



Mercy

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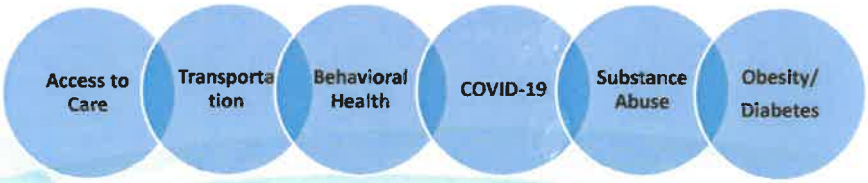
Our Assessment Process

Stakeholder Survey *(continued)*

- Drug abuse, alcohol abuse and diabetes were listed as the health needs that cause the highest level of concern
- Health barriers most concerning were the inability to pay co-pays/deductibles and lack of mental health services nearby
- The populations noted to be most at risk of poor health outcomes were the low-income population and those suffering from substance abuse
- Social factors historically having the greatest impact on health were listed as exposure to drug use and abuse, eldercare services and safe and affordable housing
- Stakeholders conveyed that the greatest impact that COVID-19 had on the health of the community was increased feelings of loneliness/isolation and increased symptoms of depression, stress and anxiety
- Social issues captured that are the most concern for the future are substance abuse and mental health concerns and an increase in anxiety and depression in youth
- 63123 and 63125 were the zip codes listed that are especially vulnerable and at-risk

Identified Needs

- Criteria for choosing as an identified need
  - Priority health need in 2019
  - Health disparity in public health data for South County vs. Missouri or U.S.
  - Ranked highly as a need by survey respondents
- Six identified community needs



Access to Care

- 2019 prioritized need
- Active programs will be continuing
  - Community Health Worker
  - Hancock Clinic
  - Health Leads
  - Community Referral Coordinator
  - Crisis Nursery
- Data supports the need
  - Ranked highly as need in surveys & focus groups
  - Access issues span all health needs

Behavioral Health

- 2019 prioritized need
- Program changes
  - Mercy initiating virtual behavioral health initiatives in 2022 based at Mercy Virtual Care Center
- Data supports the need
  - Low numbers of mental health care providers
  - Ranked highly as need in survey
  - Both adults and children in need
  - COVID-19 exasperated behavioral health needs

Substance Use

- 2019 prioritized need
- Program changes
  - Mercy initiating virtual behavioral health initiatives in 2022 based at Mercy Virtual Care Center
- Data supports the need
  - Low numbers of mental health care providers
  - Ranked highly as need in surveys & focus group

COVID-19 Impact

- New need
- Current programs
  - COVID testing
  - COVID vaccine outreach
- Data supports the need
  - Very large community and hospital impact
  - Ranked as a need by survey respondents (immunizations was listed in stakeholder survey)

Other High Ranked Needs

- Transportation
  - Working on requirements for securing a Ministry wide transportation vendor to provide rides to our patients
- Obesity/Diabetes
  - Very large community and hospital impact

Prioritization Process – Nominal Group Technique

Prioritization Criteria

Identified Health Need	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Need 1						
Need 2						
Need 3						
Need 4						

Prioritization Process – Nominal Group Technique

Example Individual Scoring Table

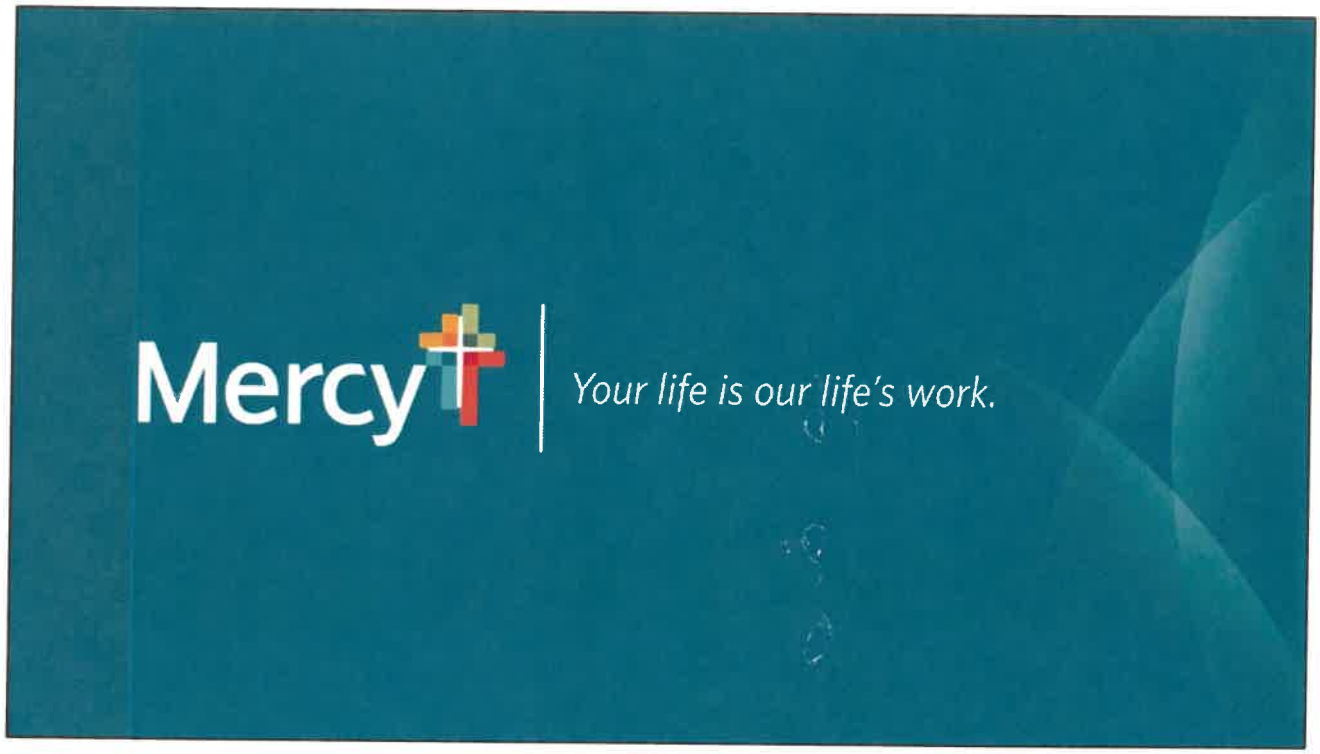
Prioritization Criteria

Identified Health Need	Magnitude	Feasibility	Mission/ Strategic	Resources	Community	TOTAL POINTS
Example Need: Transportation	1	4	4	4	1	14
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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Nominal Group Technique
Group Summary

Participant Total Points

Identified Health Need	1	2	3	4	5	6	7	8	9	10	GRAND TOTAL
Access to Care 19	19	15	19	16	16	15	17	12	19	16	183
Transportation 16	14	10	16	13	12	10	19	10	19	7	146
Behavioral Health 19	18	17	19	17	19	16	17	15	15	14	186
COVID-19 10	11	14	10	16	5	12	12	14	14	7	125
Substance Abuse 16	19	13	18	15	14	15	18	14	12	14	168
Obesity / Diabetes 11	15	11	10	11	12	15	16	14	17	15	147

Instructions:

1. Write in each identified health need from the strategy grid process in the first box of each row. This table can be copied on to a white board for group participation.
2. From each participant's individual ranking grid, enter their total points for each of the identified health needs.
3. Add up the points in each row and enter the grand total points for each need in the column on the right.