



# 2024

## Community Health Needs Assessment

**SSM Health St. Louis - St. Charles County**

**SSM Health St. Joseph Hospital**

**St. Charles** | 300 First Capital Dr. | St. Charles, MO 63301

**Lake Saint Louis** | 100 Medical Plaza | Lake Saint Louis, MO 63367

**Wentzville** | 500 Medical Dr. | Wentzville, MO 63385

# Table of contents

## **Assessment**

Message to our community	pg. 2
Executive summary	pg. 3
About SSM Health	pg. 4
Definition of community	pg. 9
The CHNA process	pg. 11
Moving from health problem to CHNA priority	pg. 15
CHNA priority: Behavioral health	pg. 16
CHNA priority: Food/nutrition security	pg. 18
CHNA progress since 2021	pg. 20

## **Appendices**

Appendix A: Community health survey	pg. 23
Appendix B: Community health survey results summary report	pg. 29
Appendix C: Community stakeholder conversation summary report	pg. 34
Appendix D: Community conversations summary report	pg. 39

# Message to our community

SSM Health St. Joseph Hospital - St. Charles, Lake Saint Louis, and Wentzville, members of SSM Health, are committed to providing exceptional, compassionate care to our community. Inspired by our founding Franciscan Sisters of Mary and guided by our Mission – Through our exceptional health care services, we reveal the healing presence of God – we cherish the sacredness and dignity of each person as demonstrated through our Values of compassion, respect, excellence, stewardship and community.

Over the past 12 months, we have worked with our community and the St. Louis Regional Hospital Collaborative to conduct a Community Health Needs Assessment to identify top community health priorities for focused and intentional engagement for the next 3 years. We are grateful for the participation of community leaders, community members and hospital partners in the needs assessment process and truly look forward to their continued engagement as we develop strategies and interventions for these in priorities in our upcoming 2025-2027 Community Health Improvement Plan.

The health and well-being of our community is a priority for all of us and we look forward to continuing to deepen our relationships with community partners to address the pressing needs in our community related to Behavioral Health and Food/Nutrition Security.



Sincerely,

A handwritten signature in black ink, appearing to read 'Jake Brooks'.

Jake Brooks  
President  
SSM Health St. Charles Hospital -  
St. Charles & Wentzville

A handwritten signature in black ink, appearing to read 'Jerry Rumph'.

Jerry Rumph  
President  
SSM Health St. Charles Hospital -  
Lake Saint Louis

# Executive summary

Under the Patient Protection and Affordable Care Act, SSM Health hospitals are required to conduct and publish a Community Health Needs Assessment (CHNA) every three years. The goal of the CHNA process and this report is to provide a deeper understanding of the community-level health needs identified in partnership with community members and leaders and establish community health priorities to focus on in partnership over the next three years. The identified CHNA priorities outlined in this report will be further defined including strategies for engagement in our 2025-2027 Community Health Improvement Plan which will be available in early 2025. This CHNA report was conducted and published in accordance with IRS regulations and standards and approved by the SSM Health St. Louis Regional Board on November 25, 2024.



*SSM Health St. Joseph Hospital staff distribute fresh produce to community*

## Our CHNA Process

SSM Health St. Louis prioritized taking an intentional community-focused approach to our 2024 CHNA process building on lessons learned in past experiences, incorporating emerging best practices from national organizations such as the American Hospital Association and Catholic Hospital Association and deepening our collaboration with local hospital systems and community partners. The 4 hospital systems within the St. Louis region (BJC Healthcare, Mercy, St. Luke's and SSM Health) formed the St. Louis Regional Hospital Collaborative committing to not only working together for this CHNA process but also committing to further collaboration with our Community Health Improvement strategies resulting from the CHNA process. In addition, the hospital collaborative is continuing to deepen our relationships with local public health departments exploring further alignment with their Community Health Assessment and Improvement strategies. Fundamentally all partners involved acknowledge we serve the same geographic communities and the impacts of our efforts are magnified when we work together.

This CHNA report is specifically focused on to the community served by SSM Health hospitals located in St. Charles County . Through localized efforts including a community survey, stakeholder and community conversations, as well as the incorporation of publicly available data, SSM Health - St. Charles Market has identified the following as our 2024 Community Health priorities:



### Behavioral Health

- Mental Health/Wellbeing
- Substance Use



### Food and Nutrition Security

# About SSM Health

Nationally recognized for quality and innovation, SSM Health is a Catholic, not-for-profit, fully integrated health system working to advance health equity and empower all people to achieve their full potential. With care delivery sites in Illinois, Missouri, Oklahoma, and Wisconsin, SSM Health provides convenient access to high-quality community-based services as well as world-class academic medicine, clinical trials, and research studies. The organization’s footprint includes hospitals, physician offices, outpatient and virtual care services, senior care, comprehensive home care and hospice services, a fully transparent pharmacy benefit company, a health insurance company, and an accountable care organization. As one of the largest employers in every community it serves, the organization’s 40,000 team members and 13,900+ providers are dedicated to fulfilling SSM Health’s Mission: “Through our exceptional health care services, we reveal the healing presence of God.” Like our founding sisters, we care deeply for our communities -- SSM Health reported \$470 million in community benefit in 2023, including the provision of more than \$346 million in uncompensated care.

## SSM Health Fast Facts at a Glance

Community Benefit	\$470 million
Team Members*	40,000
Providers on Medical Staff*	13,900+
Dean Health Plan members**	485,000+
Navitus members**	14 million+ across 50 states
Inpatient Admissions	149,221
Outpatient Visits	21 million
Completed Medical Group Appointments	6.1 million
Outpatient Surgeries	94,588
Virtual Visits	229,574
Home Care Visits	240,189



*Through our exceptional healthcare services,  
we reveal the healing presence of God.*

*Fast Facts reflect 2023 totals, unless otherwise noted.*

*\* Values are approximate as of April 2024*

*\*\* Values for Dean Health Plan (including Prevea360) and Navitus as of January 2024*

# SSM Health St. Joseph Hospital - St. Charles and Wentzville



## Exceptional services

### SSM Health Heart & Vascular Care

SSM Health St. Joseph Hospital - St. Charles maintains a 60-minute average in door-to-balloon time for emergency cardiac care, exceeding the AHA guideline by a full 15 minutes. It also provides the only electrophysiology (EP) programs in St. Charles, Warren, and Lincoln counties.

### SSM Health Neurosciences

SSM Health St. Joseph Hospital - St. Charles is a Joint Commission-certified Primary Stroke Center, which recognizes our success in implementing a higher standard of stroke care, and ensures that patients receive treatment according to nationally accepted standards and recommendations.

### SSM Health Behavioral Health Inpatient Programs

SSM Health St. Joseph Hospital - Wentzville offers inpatient psychiatric programming for adolescents, and adults who have a serious behavioral health disorder requiring in-depth stabilization and support. The adolescent program is for ages 13-17; the adult program is for those 18-59.

### Outpatient Behavioral Health Programs

The outpatient programs at SSM Health St. Joseph Hospital - Wentzville helps individuals ages 18 and older work through stress, anxiety, depression, bipolar, and substance use disorders, as well as other mental health concerns. It is designed for those who would benefit from a highly supportive therapeutic environment.

### Long-Acting Injection Clinic

The Long-Acting Injection (LAI) Clinic at SSM Health St. Joseph Hospital - Wentzville is an alternative treatment option for adults and adolescents who are having trouble consistently taking daily/regular antipsychotic or addiction medicine in the form of tablets, capsules, or liquids. The LAI Clinic safely administers a patient's medicine in the form of a single injection, which steadily releases into the body over the course of several weeks. This approach can decrease the risk of illness, hospitalization, and other complications.

### Locations:

300 First Capitol Drive  
St. Charles, MO 63301

500 Medical Drive, Wentzville, MO 63385

### Contact:

636-947-5000 (St. Charles) 636-  
327-1000 (Wentzville)

### Licensed Beds:

329 (St. Charles); 77 (Wentzville)

### Key Statistics

Admissions: **6,176**

Emergency visits: **37,088**

Urgent care visits: **23,517**

Outpatient visits: **118,845**

Inpatient surgeries: **1,222**

Outpatient surgeries: **4,552**

## Awards

SSM Health St. Joseph's Hospital – St. Charles

American Heart Association 2023 Get With The Guidelines® - Stroke Silver Plus award; Target: Stroke Honor Roll award; and Target: Type 2 Diabetes Honor Roll award  
Critical Care Excellence Award™ (2023, 2022) Superior clinical outcomes in treating pulmonary embolism, respiratory system failure, sepsis, and diabetic emergencies.  
Patient Safety Excellence Award™ (2023, 2022) Top in the nation for providing excellence in patient safety by preventing infections, medical errors, and other preventable complications.



## Services offered at SSM Health St. Joseph Hospital

### St. Charles

- Cardiopulmonary Rehab
- Emergency Services
- Endoscopy/Gastroenterology
- Laboratory
- Pathology
- Primary Stroke Center
- Pulmonary
- Select Specialty Hospital (LTACH)
- SSM Health Behavioral Health
- SSM Health Cardinal Glennon Emergency Services
- SSM Health Cardinal Glennon Pediatric Sleep Center
- SSM Health Sleep Services (Adult)
- SSM Health Heart & Vascular Care
- SSM Health Imaging services
- SSM Health Neurosciences
- SSM Health Orthopedics
- SSM Health Pain Care
- SSM Health Physical Therapy
- SSM Health Vascular Services
- Urology

### Wentzville

- Emergency Services
- Inpatient Behavioral Health
- Long-Acting Injection Clinic
- Outpatient Behavioral Health



Through our exceptional health care services, we reveal the healing presence of God.



St. Joseph Hospital - St. Charles  
St. Joseph Hospital - Wentzville

# SSM Health St. Joseph Hospital - Lake Saint Louis



## Exceptional services

### SSM Health Women's Health

Whether it's a standard delivery or a high-risk pregnancy, women's health providers at SSM Health St. Joseph Hospital in Lake Saint Louis are prepared. We offer comprehensive pregnancy services, including prenatal, delivery, and nursery care for newborns. We have physicians who specialize in high-risk pregnancy available 24 hours a day. Our Level II neonatal intensive care unit can care for babies born at 32 weeks and older, but if a baby should require more specialized treatment, our neonatal transport team can move the baby quickly to the expert team at SSM Health Cardinal Glennon Children's Hospital.

### SSM Health Orthopedics

SSM Health Orthopedics at SSM Health St. Joseph Hospital - Lake Saint Louis offers the continuum of subspecialty expertise for foot and ankle, sports medicine, total joint, and spine care. With fellowship-trained physicians and a dedicated orthopedic floor, our surgical capabilities and outstanding patient satisfaction set our services apart. SSM Health St. Joseph Hospital - Lake Saint Louis also offers comprehensive imaging services, including an open MRI, as well as physical and occupational therapies.

### Location

100 Medical Plaza  
Lake Saint Louis, MO 63367

### Contact

636-625-5200

### Key Statistics:

Licensed Beds: **215**  
Employees: **953**  
Admissions: **10,389**  
Births: **1,086**  
Emergency visits: **36,922**  
Outpatient visits: **99,444**  
Inpatient surgeries: **1,551**  
Outpatient surgeries: **6,103**

### Awards

- 2023 Newsweek named SSM Health one of America's Greatest Workplaces for Women
- 2022 Leap Frog Grade A
- Baby-Friendly designation
- Level III Trauma Center
- Level II Time Critical Diagnosis STEMI
- Primary Stroke Center American Stroke Association "Get with the Guidelines" status
- U.S. News & World Report High Performer in:
  - Heart attack
  - Heart failure
  - Kidney failure
  - Stroke
  - COPD



**SSMHealth**

**St. Joseph Hospital**  
LAKE SAINT LOUIS

[ssmhealth.com](https://www.ssmhealth.com)

**SSM Health Cancer Care** SSM Health St. Joseph Hospital - Lake Saint Louis offers a wide range of oncology services, from outpatient procedures to dedicated inpatient services. It provides the latest treatments and technology, including prostate brachytherapy and bilateral breast MRI exams. Our oncology physician practices are certified through the Quality Oncology Practice Initiative by the American Society of Clinical Oncology. **SSM Health Heart & Vascular Care** SSM Health Heart & Vascular Care at SSM Health St. Joseph Hospital - Lake Saint Louis offers patients experienced cardiologists and electrophysiologists for both outpatient and inpatient services. Our Level II STEMI Center is one of the busiest in the region, providing exceptional care to patients along the western I-70 corridor. For patients recovering from cardiac events, we offer cardiac and pulmonary rehabilitation on site. Our services have been designated a high performer in U.S. News and World report for both heart attack and heart failure. We provide life-enhancing opportunities that are covered by Medicare and most insurance plans.

**Outpatient services**

From MRI, CT, and X-rays, SSM Health Imaging Services is committed to giving you fast, accurate results, discussed with you by your doctor. You can count on SSM Health to stay ahead of the curve, continually adopting new technologies to better care for you and your family.

**2024 Ministry Key Performance Indicators (KPIs)**

**Culture and Inclusion**

- Voluntary turnover
- Employee engagement
- Mission formation

**Community**

- Referrals to food bank for food insecure patients

**Growth and Sustainability**

- Net operating income
- Length of stay

**Exceptional Care and Performance**

- Patient experience - likelihood to recommend
- Safety: SSIs - Colo, Hyst
- Readmissions
- Inpatient mortality
- Glycemic management

**Through our exceptional health care services, we reveal the healing presence of God.**

**Services offered at SSM Health St. Joseph Hospital - Lake Saint Louis**

- Cardiopulmonary Rehab
- Endoscopy/Gastroenterology
- Emergency Services
- The Family Birthplace/SSM Health Women's Health
- Infusion
- Joint Commission Certified Primary Stroke Center
- Laboratory
- Level III Trauma Center
- Level II Time Critical Diagnosis STEMI
- Pathology
- Urology
- SSM Health Breast Care
- SSM Health Cancer Care
- SSM Health Cardinal Glennon pediatric emergency and subspecialty services
- SSM Health Heart & Vascular Care
- SSM Health Imaging Services
- SSM Health Neurosciences
- SSM Health Orthopedics
- SSM Health Pain Care
- SSM Health Physical Therapy
- SSM Health Sleep Services
- SSM Health Vascular Services



# How SSM Health St. Louis- St. Charles Market community is defined

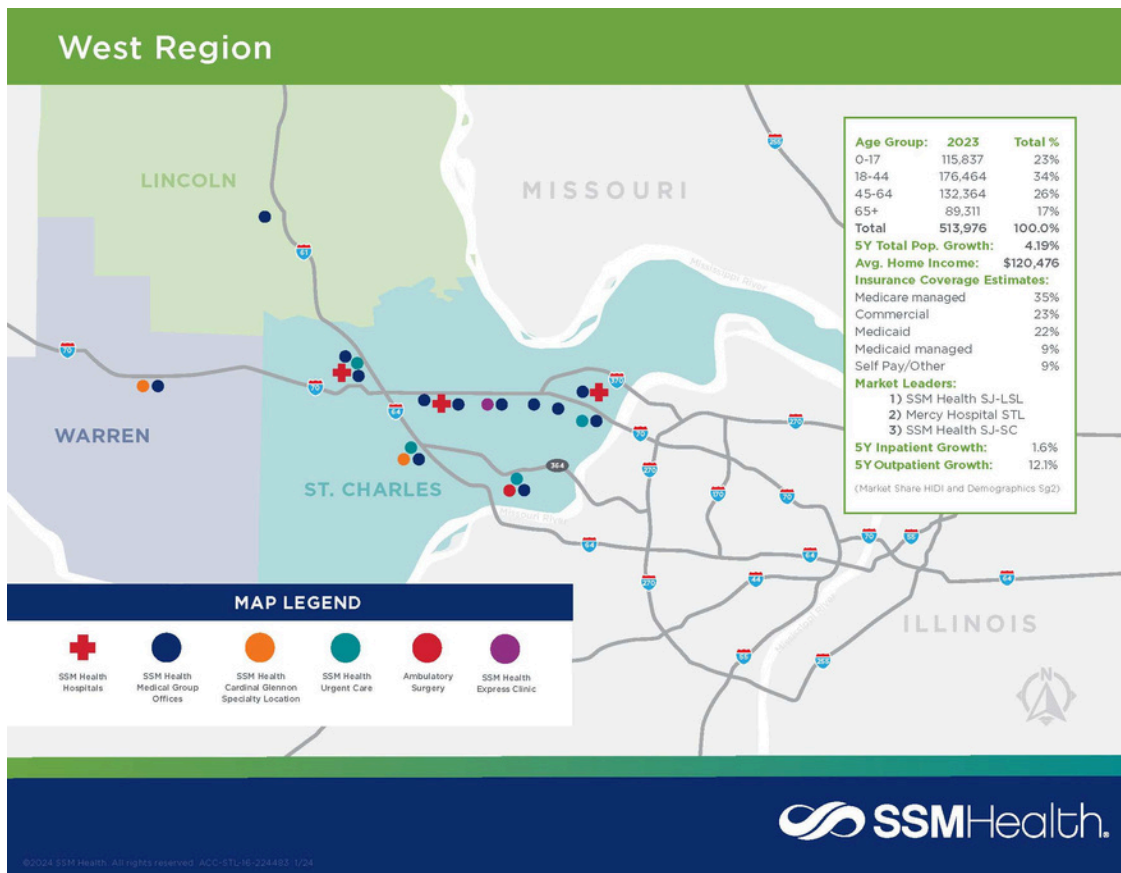
For the purpose of this Community Health Needs Assessment (CHNA), SSM Health St. Louis defines its St. Charles community as **St. Charles County**.



There are three SSM Health St. Joseph Hospitals within the St. Charles Market located in the **City of St. Charles, Lake Saint Louis, and Wentzville, MO**



**423,613 residents**  
Source: Advisory Board

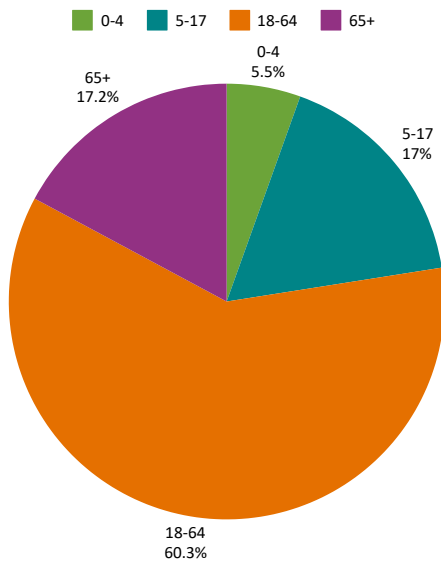


SSM Health St. Louis – St. Charles Market Zip Codes						
63332	63341	63348	63367	63366	63368	63373
63304	63301	63303	63376	63385	63386	63357

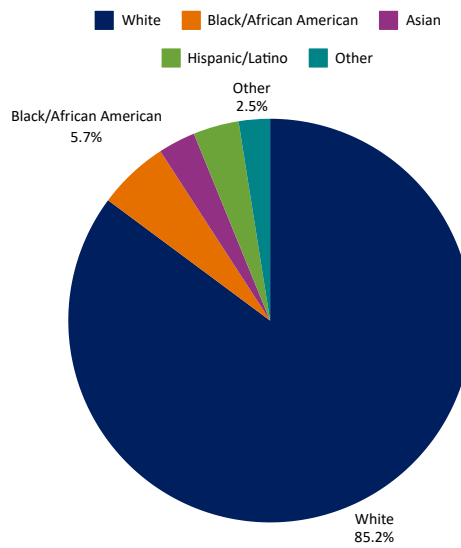
# About our community

SSM Health St. Louis – St. Charles Market Neighborhoods				
Augusta	Defiance	Lake Saint Louis	O Fallon	Mathasville
Lake Sherwood	Cottleville	Dardene Prairie	Saint Paul	Saint Peters
Portage Des Sioux	Saint Charles	Weldon Spring	Wentzville	West Alton

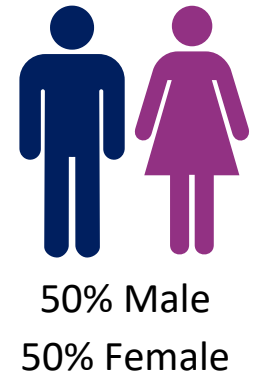
## Age



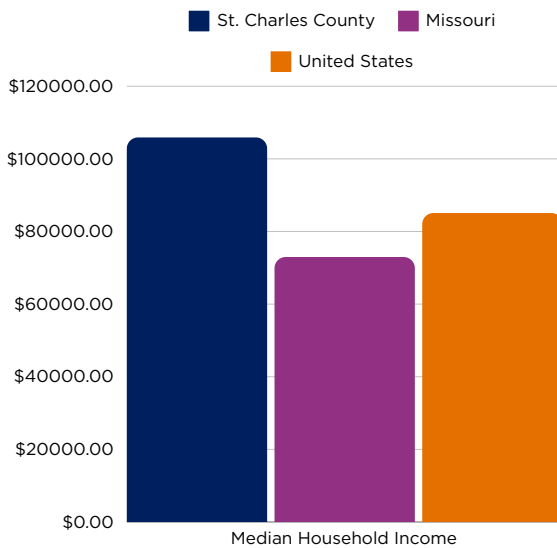
## Race/Ethnicity



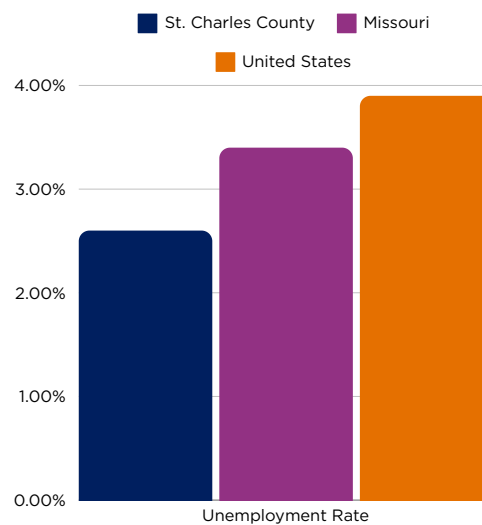
## Sex



## Median Household Income



## Unemployment Rate



Source: Advisory Board Demographic Profiler & exploreMOhealth

# The CHNA Process: Deepening Collaboration and Anchoring in Community Voice

## St. Louis Regional Hospital Collaborative

The St. Louis Metropolitan area has multiple hospitals, health systems, public health departments, medical schools, and community-based physical and behavioral health providers. Many of these organizations must conduct Community Health Needs Assessments (CHNA) and produce Community Health Improvement Plans (CHIP) and like many other regions across the country, SSM Health has learned through experience that collaboration across entities is key to all aspects of this process and the resulting efforts.

Collaboration ensures multiple hospitals and health systems are not taxing community leaders and community members with multiple surveys, conversation invitations and follow up engagement. It also ensures that health systems are working to align priorities and resulting strategies with the shared focus on collective impact in partnership with community. As Community Health Improvement work continues to focus efforts on root cause social and structural determinant of health factors, it is important to collectively identify priorities and collaboratively work towards improvement. Alone our efforts have less impact on structural issues affecting the health and well-being of our communities. Community Health Improvement efforts have better outcomes and stronger impact when we work together.



It is with this commitment to equity-focused collaboration that SSM Health partnered with BJC Health, Mercy and St. Luke's Hospital to create the St. Louis Regional Hospital Collaborative. In 2024, the Collaborative was committed to building on what had been carried out in past CHNA efforts to not only engage Community Stakeholders together (those that do community work professionally such as public safety, educator, elected leaders, nonprofit leaders, community-based service providers, etc.) but deepen our collaboration and process by focusing on direct community member engagement and anchoring our process in community voice. The St. Louis Regional Hospital Collaborative committed to improving our CHNA process this cycle with an eye on opportunities for continued deeper collaboration including exploring collective CHNA reporting and alignment with local public health departments in future cycles.

The hospital collaborative partnered with Key Strategic Group (KSG) for our collective CHNA work. KSG is comprised of community-focused consultants fostering engagement and implementation of effective strategies to reduce disparities, promote equity and drive systemic and political transformation. KSG convened Community Health Improvement staff from each of the participating hospital systems to plan, implement, and evaluate stakeholder and community conversations. KSG also provided insights and direction to the collaborative in planning for continued collaboration during CHIP implementation and proving a framework/playbook to the collaborative for future CHNA and CHIP efforts.



## 2024 Process

### Community Health Needs Survey

The St. Louis Regional Hospital Collaborative began working together in late 2023 to plan for the 2024 CHNA process agreeing to focus on a geographical region that included the City of St. Louis, St. Louis County and St. Charles County, with St. Louis County being further broken out into north, mid/west and south county to allow for more community focused analysis and reporting. In addition, the Collaborative acknowledged the importance of a specific focus on the needs of children and youth and added a 6th pediatric focused grouping inclusive of the entire geographic region.

We began our efforts by working to combine multiple earlier surveys into one community survey shared across the region from March through June 2024. The survey was primarily available electronically in both Spanish and English, however paper copies were available in multiple settings. The survey was open to anyone who called the St. Louis region home and efforts to invite participation in the survey included direct outreach to 3,500+ stakeholders and community organizations, presence at community events, and the use of various social and news media options. In total over 6,400 survey responses were collected from across the region.



#### SSM Health St. Louis - St. Charles Market Community Health Survey Response

752 Community Respondents from SSM Health St. Louis - St. Charles Market

#### Top Identified Health Problems for Adults

- Mental Health
- Obesity & maintaining healthy weight
- Age-related Illnesses
- Heart Conditions
- Diabetes and high blood sugar

#### Top Identified Health Problems for Children & Youth

- Mental Health
- Obesity & maintaining healthy weight
- Substance Use
- Intellectual/developmental disabilities
- Injuries

#### Community Resources Identified as Least Available

- Mental Health and Substance Use Services
- Public Transportation
- Affordable Housing

*Community Health Survey Data Summary located in Appendix B*

## Community Stakeholder Conversations

Following the community survey, data was disaggregated by each of the 5 defined regional markets. The collaborative then hosted 6 Community Stakeholder conversations, 1 in each of the defined markets plus 1 focused on children and youth in the region, to review the community survey data and have facilitated conversations to ask for the professional insights of participants on the top identified health problems and the social and structural determinant factors underlying those problems.

Over 150 participants attended the 6 Community Stakeholder conversations and represented public health, education, public safety, elected office, health providers and community-based organizations. Each Community Stakeholder Conversation was a 90-minute facilitated conversation that allowed participants to engage with the community survey data and each other in small group discussions. 108 of the stakeholder participants completed surveys at the end of the Community Stakeholder Conversations. Over 90% of those respondents shared the conversation was extremely effective or very effective in meeting its stated goals and objectives. Respondents also shared a commitment to continued conversations with the large majority requesting more time and more frequent scheduled conversations between CHNA cycles.



SSM Health St. Louis -  
St. Charles Market  
Community Stakeholder  
Conversation - July 25, 2024

23 professionals from the following organizations attended.

- Behavioral Health Network
- Boys & Girls Clubs of St. Charles County
- Catholic Charities of St. Louis
- Community Council
- Crossroads Clinic
- Eye Thrive
- Gateway Region YMCA - St. Charles County Branch and O'Fallon Branch
- Missouri SHIP - Area 2
- Operation Food Search
- Preferred Family Health Care
- PreventEd
- St. Charles City-County Library
- St. Charles County ambulance District
- St. Charles County Department of Public Health
- United Way of Greater St. Louis
- VITENDO4AFRICA
- Youth in Need

*Community Stakeholder Conversation Summary available in Appendix C*



*Photo taken from July 25th meeting held at St. Charles County Library - Spencer Road Branch*

## Community Conversations

Aligning with the Collaborative’s commitment to anchoring our shared CHNA efforts in community voice, the collaborative began a series of Community Conversations focusing on populations and communities not included in the survey response population and/or historically marginalized from surveys. Each conversation is centered on learning from the lived experience of 10-15 participants in a 60 or 90 minute facilitated conversation and all participants are compensated for their time and expertise. Working with community-based organizations, the Collaborative and the organization co-created opportunities for community members to provide insights and feedback. Partners in creating the initial 5 Community Conversations include:

- [St. Patrick’s Center](#)
- [International Institute](#)
- [Oasis](#)
- [Beyond Housing/24:1](#)
- [Vision for Children at Risk](#)



*Photo taken at International Institute*

Community Conversations are intended to be an on-going process, and the Collaborative is committed to continuing these conversations with other community partners beyond when any one collaborative partner may need to produce their Community Health Needs Assessment report. Additional conversations will occur after printing this report, and those continued learnings will be incorporated into our Community Health Improvement Plan (CHIP) and throughout SSM Health Community Health Improvement efforts moving forward.

## Inclusion of Secondary Data

Throughout the CHNA process, secondary data sources are used to offer additional insights on the communities we serve as well as priorities/needs raised throughout the CHNA process. Secondary data assist in providing a fuller understanding of the communities served by our hospitals and the disparities that exist within health and social outcomes. Secondary data used in our CHNA/CHIP process included but not limited to:

- County Health Rankings & Roadmaps <https://www.countyhealthrankings.org/>
- Think Health STL <https://www.thinkhealthstl.org/>
- Advisory Board <https://www.advisory.com/>
- Mo Health and Senior Services <https://health.mo.gov/data/>
- Explore MO Health <https://exploremohealth.org>
- US Census <https://data.census.gov/>

# Moving from identified Health Problem to CHNA Priority

Identifying a health problem experienced by community is not the same as identifying a community health priority. The St. Louis Regional Hospital Collaborative used our CHNA process to first identify problems through the survey and then dive deeper into root causes and social determinant of health factors impacting the health problems through intentional conversation with both stakeholders and community members. It is through this intentional process with active listening that CHNA priorities truly begin to emerge. SSM Health Community Health team members also worked to incorporate publicly available health data to further inform the process and regularly engaging hospital leaders in the CHNA process with many attending stakeholder and community conversations.

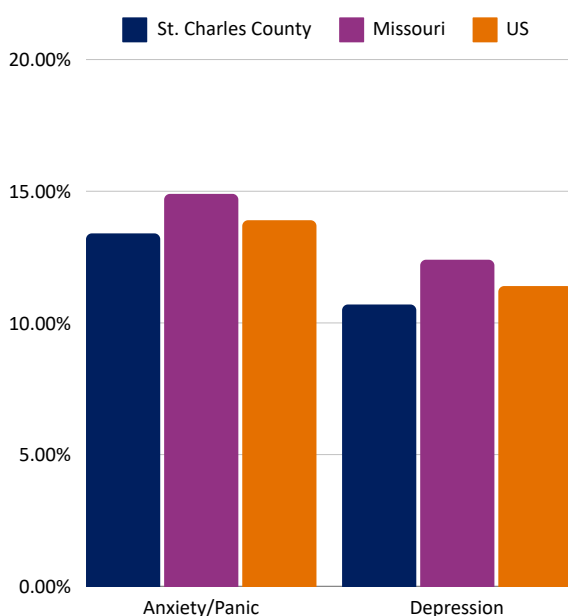
As SSM Health St. Louis worked to identify our 2024 CHNA priorities, the commitment was made to ensure all priorities and the resulting strategies be grounded in the following:



# Behavioral Health: Mental Health & Wellbeing and Substance Use



The American Medical Association describes Behavioral Health as “generally referring to mental health and substance use disorders, life stressors and crises, and stress related physical symptoms. Behavioral Healthcare refers to the prevention, diagnosis, and treatment of those conditions.” [1] With a focus on prevention, supporting individuals and communities, and increasing resilience, SSM Health St. Louis - St. Charles Market has chosen to identify a 2024 CHNA priority as Behavioral Health. With intention, SSM Health St. Louis - St. Charles Market is also further identifying Mental Health & Wellbeing and Substance Use as individually named priorities under the umbrella of Behavioral Health. Behavioral Health allows for both the intersectionality and the individuality of the 2 priorities to be focused on through various strategies. Mental health was definitively defined as the top health problem through the community survey and unanimously confirmed in stakeholder and community conversations. The Community Health Survey also had an additional question solely focused on behavioral health asking respondents for their top 3 behavioral health problems. Respondents in the SSM Health St. Louis- St. Charles Market identified depression, drug use, and alcohol for adults and bullying, anxiety and depression for children and youth. These answers, while also affirmed as top priorities by community stakeholders and members, further affirm the importance of the wholistic approach for improving Behavioral Health in our community while focusing individual strategies when appropriate on mental health and substance use.



Source: Advisory Board Demographic Profiler

Community Stakeholders also definitively shared their interpretation of the survey results and their professional experience that mental health being named as the top problem was not as much referring to diagnosable disorders (much of what is treated in acute hospital settings) but much more the general feelings of increased stress in community and overall feelings of depression and anxiety. Stakeholders shared that key factors like economic stability, poverty, food insecurity and other factors greatly impact the overall feelings of wellbeing in community and when left unaddressed lead to depression and anxiety for many – both children and adults.

[1] <https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health>

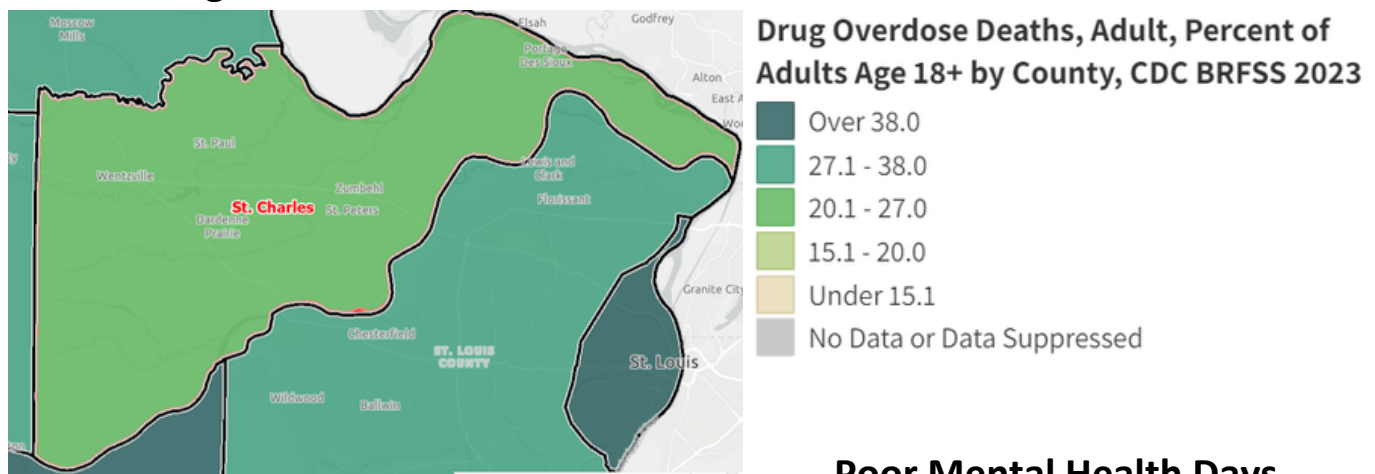
# Behavioral Health: Mental Health & Wellbeing and Substance Use



Community members in all community conversations focused much of their discussion on mental health and substance use concerns with a specific focus on the unique needs of their communities such as the stress of recently arriving in a new county, aging, living in poverty, experiencing housing insecurity or homelessness, or being a minority in the United States of America today.

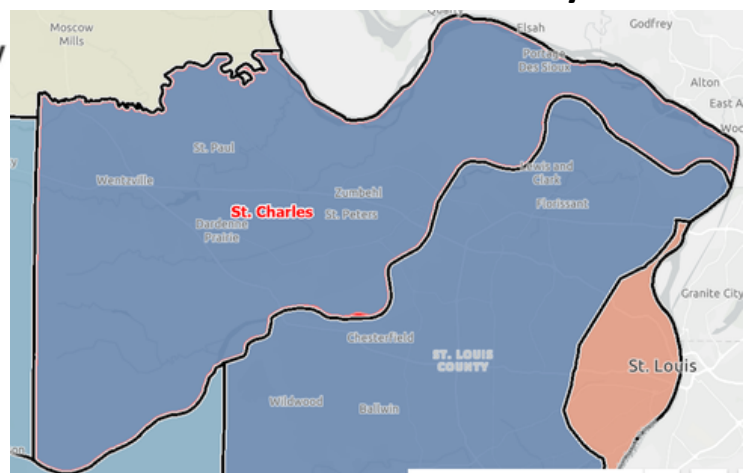
While mental health was clearly identified as the top health problem, substance use was not far behind and in all community conversations, stakeholders and community members stated that the connection between mental health, drug use and alcohol abuse were too connected to not address together. In the SSM Health St. Louis - St. Charles Market, substance use was the 7th rated health problem with alcohol use being the 3rd and drug use being the 4th highest rated concerns when asked specifically regarding behavioral health. Community partners in this CHNA process were clear and the data affirms the need for a CHNA Priority focused on Behavioral Health with specific focus areas of mental health & wellbeing and substance use.

## Drug Overdose Deaths



## Poor Mental Health Days

### Poor Mental Health Days, Rank by County 2023



Source: exploreMOhealth

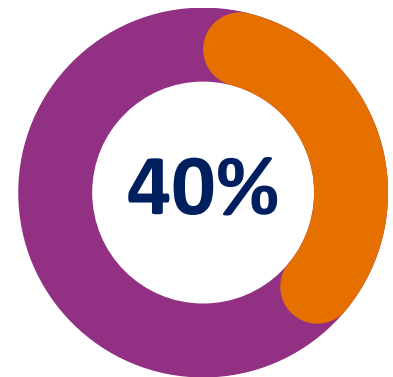
# Food & Nutrition Security



Neither food nor nutrition were identified health problems on the community health survey. They were not choices on the survey at all – yet when actively listening to community stakeholders and members throughout the CHNA process food insecurity and lack of knowledge on nutrition came up as root cause factors for multiple identified top health problems such as obesity and maintaining healthy weight, heart conditions, diabetes, and chronic diseases in general. Fundamentally, community loudly stated that “food is medicine” and needs to be a focused CHNA priority. They firmly believed that by naming it a priority, SSM Health St. Louis - St. Charles Market and its partners could positively impact multiple identified health problems experienced in our community.

## A 2019 study by Feeding America estimated that food insecurity costs the US health care system an additional \$53 billion annually.

The United States Food and Drug Administration (USDA) defines food insecurity as “a household-level economic and social condition of limited or uncertain access to food.”[1] Simply put, food insecurity is not having enough food to sufficiently feed yourself or your family on a regular basis. Feeding America, the nation’s largest network of food banks, pantries, and community-based organizations, further expands on the importance of addressing not only the need for food but ensuring that need is met with healthy foods that directly impact the health and well-being of individuals, families, and communities. Households experiencing food and nutrition insecurity have to choose less expensive food options often with less nutritional value creating a cycle that greatly impacts health. More than half of the households the Feeding America network serves have at least one member living with high blood pressure and more than one third have a member with diabetes[2]. Children experiencing prolonged food insecurity and hunger are at higher risk of both developmental and behavioral health problems.



**of those served by the St. Louis Area Foodbank have to choose between paying for food or medical care**



**1 in 7 households in our region are food insecure**

*Source: St. Louis Area Foodbank*

[1] <https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/>

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

# Food & Nutrition Security

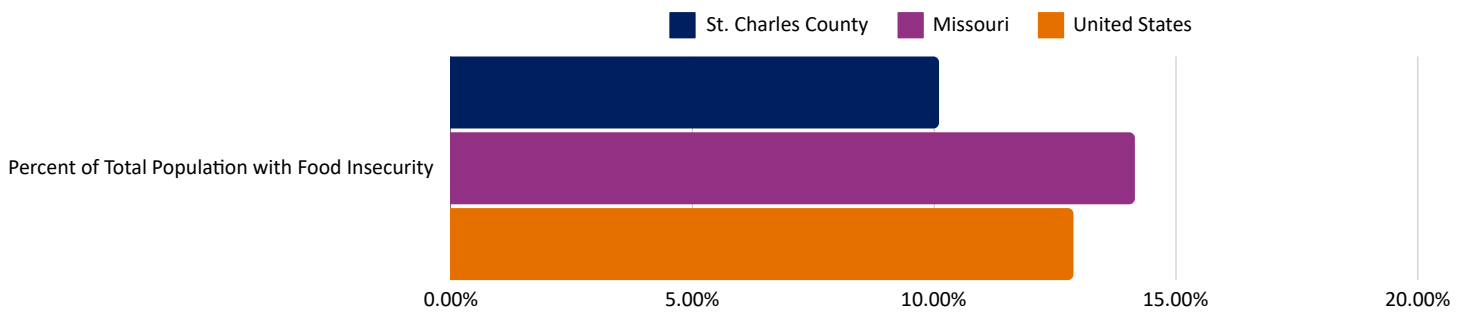


Participants throughout the 2024 CHNA process identified food and nutrition insecurity as fundamental factors impacting every health problem named and discussed and strongly believe that focusing on increasing the food and nutrition security of our community was paramount for eventually impacting the direct health outcomes of individual community members. Increasing the community’s knowledge of nutrition in culturally competent, age appropriate and age specific ways was also a theme in both stakeholder and community conversations.



**16.5%** Prevalence of Hypertension/High Blood Pressure in SSM Health St. Charles Market

Source: Advisory Board



Source: exploreMOhealth

## Moving Forward...

The CHNA process utilized by the St. Louis Regional Hospital Collaborative not only provided a robust process to learn from community for the identification of our 2024 CHNA priorities, but this process also revealed engaged and willing partners in this work moving forward. SSM Health St. Louis - St. Charles Market is looking forward to working with community partners to create meaningful strategies to address Behavioral Health and Food/Nutrition Security to be outlined in our 2025-2027 Community Health Improvement Plan and more importantly putting those strategies into action for the benefit of our community.

# Our CHNA Progress since 2021



## 2022-24 SSM Health St. Louis - St. Charles Market Priorities

Overweight/Obesity

Behavioral Health

Chronic Conditions

### Diabetes Support Group

Diabetes support group is designed to provide education and support to individuals living with diabetes. This group is open to public at no cost and allows community members to hear from experts on a variety of topics, including: nutrition/cooking demos, diabetes medications, exercise, problem solving, etc. **Since March 2022, over 150 people have engaged in this program.** Over 1,500 people receive a monthly email with support group information.

### Teen Drug Summit

SSM Health St. Joseph Hospitals are a proud sponsor of the Teen Drug Summit in St. Charles County. The intention of summit is to decrease the number of teens who ever engage in substance use and to increase the age of initial use of any substance. SSM Health offers schools participating in the summit a funding opportunity called, **Level up Leaders.**

The goal of Level Up Leaders is to educate and empower St. Charles County student leaders to return to their respective schools and spread the message about substances and substance use disorder. **In 2022 and 2023, SSM Health provided St. Charles County schools with \$32,727 to complete these student led projects.**

### CRUSH

St. Charles County CRUSH inspires a culture where the community emphasizes the importance of health and wellbeing by providing knowledge and empowerment to prevent and reduce harm caused by substance use in the community. SSM Health assists in the coordination of community events to provide every St Charles County neighbor the opportunity to experience ideal health that leads to a long life of purpose.



Source: [crush-scc.org](http://crush-scc.org)

# Bread Basket Program

SSM Health recognizes the importance of access to food and especially healthy foods has on overall health and wellbeing. In response, SSM Health St. Louis launched the Bread Basket Program in 7 area adult hospitals in 2023 and was fully operational in all locations at the start of 2024. Acknowledging the impact food security has on **CHNA priorities** such as **Obesity** and **Maintaining Healthy Weight, Hearth Health/Nutrition, and Management of Chronic Diseases**, the Bread Basket program provides specific components focused on SSM Health inpatients as well as the communities surrounding each hospital participating.

## Focus on Inpatients

SSM Health began screening all admitted inpatients for social determinant of health (SDOH) needs in January 2023, including 2 questions regarding food insecurity. When patients feel safe enough to share their experience and consent to being included in the Bread Basket program, they are provided with 2-3 days of food at discharge for their entire household as well as being directly referred to the Community Resource Team at the St. Louis Area Foodbank for additional and on-going support for up to 3 months.

The bags of food contain nonperishable food items to cover all meals with healthy, low or no sodium, high fiber, whole grain food options. The team from the St. Louis Area Foodbank reaches out to each patient referred to ensure they are aware of all food resources in their specific area as well as providing direct assistance in applying to programs such as Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Assistance Program for Women, Infants and Children (WIC).

## Focus on Community

Through our partnership with the St. Louis Area Foodbank, SSM Health St. Louis has hosted 18 food distribution events at all 8 hospitals in the St. Louis region in both 2023 and 2024. Food Distribution events are drive thru events and open to anyone in the community who could benefit. Households are provided with a variety of fresh fruits, vegetables, meat, dairy and nonperishable food items and cars can pick up for multiple families at a time. SSM Health staff volunteer their time to ensure these events occur throughout the year.

Year	Households	Individuals	Children	Volunteer Hours
2023	2,601	9,015	3,825	1,290
2024 (through September)	1,481	4,636	2,083	949



Through the first 9 months of 2024, **1,865** unique inpatients have been served by the Bread Basket Program.





**SSM**Health.

**2024**

Appendices

# Appendix A: Community Health Survey



## St. Louis Community Health Needs Assessment

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

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

## Tell Us About Your Community

### 1. What is your home ZIP code?

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

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

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

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

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

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

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

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

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Age-related illnesses (such as memory issues, movement issues, and falls)</li> <li><input type="checkbox"/> Cancers</li> <li><input type="checkbox"/> Chronic pain and pain management</li> <li><input type="checkbox"/> Diabetes and high blood sugar</li> <li><input type="checkbox"/> Heart conditions (such as heart diseases, high blood pressure, and stroke)</li> <li><input type="checkbox"/> Infectious diseases (such as Covid-19, Influenza, pneumonia, and measles)</li> <li><input type="checkbox"/> Maternal and infant health (such as preterm births and adequate care for birthing people and their babies)</li> <li><br/></li> <li><input type="checkbox"/> Not listed here or prefer to describe : _____</li> <li><input type="checkbox"/> Not sure</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Mental health (such as anxiety, depression, loneliness, and suicide)</li> <li><input type="checkbox"/> Motor vehicle accidents and injuries</li> <li><input type="checkbox"/> Obesity and maintaining healthy weight</li> <li><input type="checkbox"/> Oral (mouth) and dental health</li> <li><input type="checkbox"/> Reproductive and sexual health , including sexually transmitted infections (STIs and STDs)</li> <li><input type="checkbox"/> Respiratory and lung diseases (such as allergies, asthma, and COPD)</li> <li><input type="checkbox"/> Substance use (such as alcohol, drug, and tobacco use)</li> <li><input type="checkbox"/> Violence (such as assaults, domestic violence, and gun violence)</li> </ul> |
|---|---|

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

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

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Abuse and neglect</li> <li><input type="checkbox"/> Blood diseases (such as lead poisoning, anemia, and sickle cell)</li> <li><input type="checkbox"/> Cancers</li> <li><input type="checkbox"/> Diabetes and high blood sugar</li> <li><input type="checkbox"/> Infectious diseases (such as Covid-19, RSV, Influenza, pneumonia, and measles)</li> <li><input type="checkbox"/> Injuries (such as motor vehicle accidents and injuries, poisonings, drownings, and burns)</li> <li><input type="checkbox"/> Intellectual / developmental disabilities (such as autism, Down Syndrome, ADHD)</li> <li><input type="checkbox"/> Infant / baby health (such as low birth weight, health problems, and death before the age of one)</li> <li><input type="checkbox"/> Not listed here or prefer to describe : _____</li> <li><input type="checkbox"/> Not sure</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Mental health (such as anxiety, depression, loneliness, suicide, and bullying)</li> <li><input type="checkbox"/> Obesity and maintaining healthy weight</li> <li><input type="checkbox"/> Oral (mouth) and dental health</li> <li><input type="checkbox"/> Reproductive and sexual health , including teen pregnancy and sexually transmitted infections (STIs and STDs)</li> <li><input type="checkbox"/> Respiratory diseases (such as allergies and asthma)</li> <li><input type="checkbox"/> Substance use (such as alcohol, drug, and tobacco use)</li> <li><input type="checkbox"/> Violence (such as assaults, domestic violence, gun violence, and school shootings)</li> <li><input type="checkbox"/></li> </ul> |
|---|---|

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

Select all that apply.

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

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

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

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

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

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

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

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

## Tell Us About You

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

8. What is your age group?

Choose one answer.

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

9. Which of the following best describes you?

Choose all that apply.

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

10. Which of the following best describes you?

Listed in alphabetical order. Choose all that apply.

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

## 11. Which of the following best describes you?

Choose one answer.

- Hispanic
- Non-Hispanic
- Prefer not to disclose

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

Choose one answer.

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

## 13. Which languages do you speak at home?

Choose all that apply.

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

14. What best describes your employment status?

Choose one answer.

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

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

Choose one answer.

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

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

Thank you for your time and input!

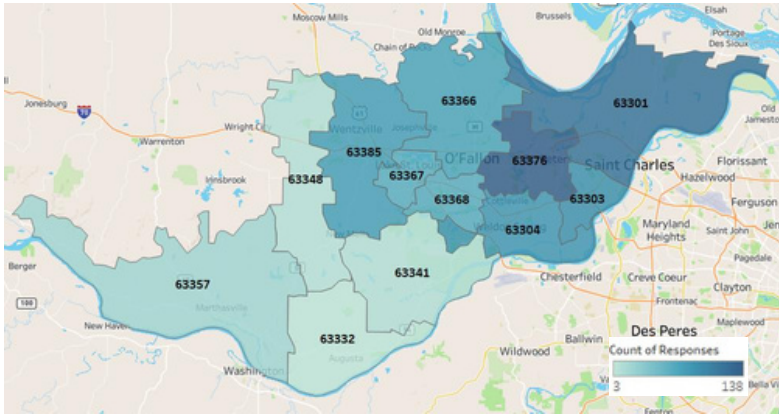
# Appendix A: Community Health Survey Summary Report

## St. Charles County Key Survey Findings



In St. Charles County, 752 community members responded to the community health needs survey. The number of survey respondents in St. Charles County ZIP codes ranged between 3 and 138.

## Survey Respondents by ZIP code




---



---



---



---

# Who responded to the survey?

About 20% of respondents in St. Charles County did not complete the optional demographic survey questions (non-respondents range from n=150 to 225, depending on the question).

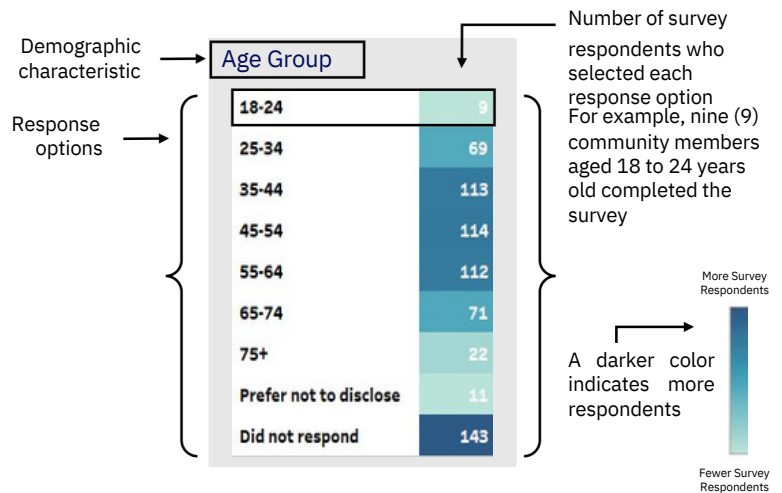
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=752).

Most respondents:

- Are between the age of 45 and 54 years old (20%)
- Are women (66%)
- Are White (69%)
- Are non-Hispanic (65%)
- Speak English at home (78%)
- Have a 4-year college/Bachelor's degree (23%)
- Are employed full time (55%)
- Have a household income between \$100,000 to \$149,999 (16%)

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

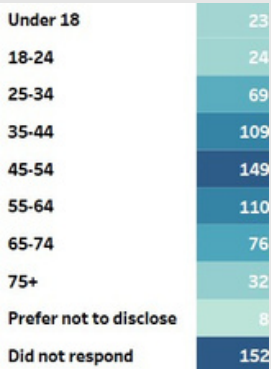
## Example: Survey Respondents by Age Group



# Who responded to the survey?

752  
Total Respondents in  
St. Charles County

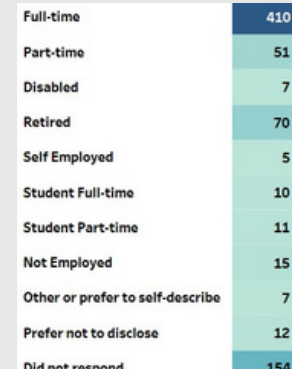
## Age Group



## Educational Attainment



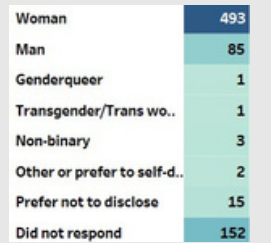
## Employment



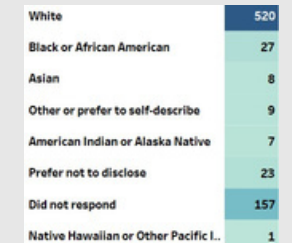
## Income



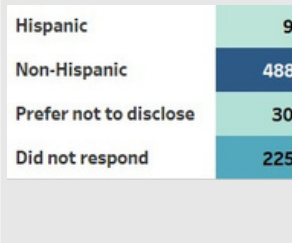
## Gender



## Race



## Ethnicity



## Language at Home

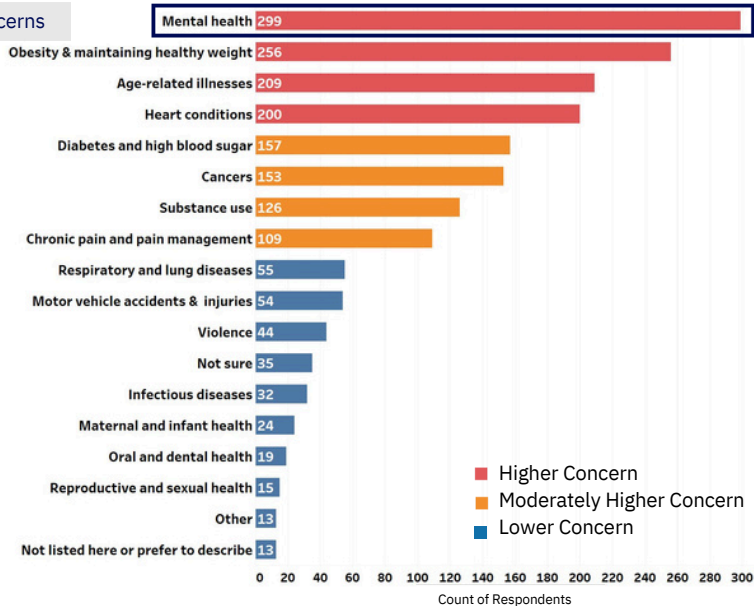


# Thinking about yourself or other adults in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

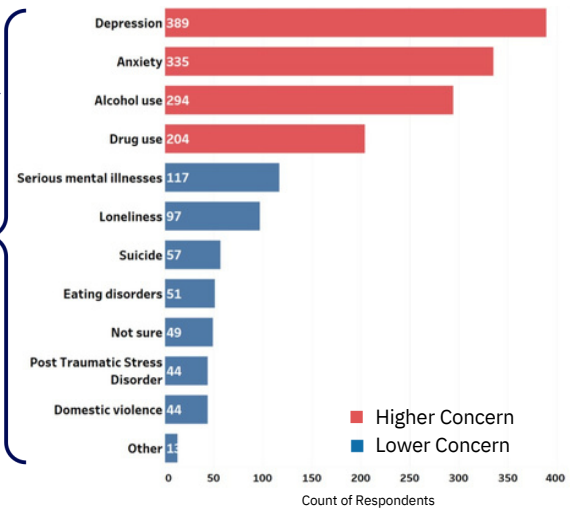
752  
Total Respondents in  
St. Charles County

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

## Health Concerns



## Mental Health & Substance Use Concerns



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

The table below details the top health concerns among respondents by race. Most of the top health concerns remained consistent across groups with some differences in the order of concerns. Notably, **violence** was identified as a top concern among Black or African American respondents. Additionally, **motor vehicle accidents & injuries** was identified as a top concern for respondents of another race.

### Health Concerns by Race

■ Higher Concern  
■ Moderately Higher Concern

Top Concerns	All Respondents n=752	White n=520	Black or African American n=27	Another Race* n=25	Did not respond or prefer not to disclose n=180
1	Mental health	Mental health	Mental health	Obesity	Age-related illnesses
2	Obesity	Obesity	Obesity	Mental health	Obesity
3	Age-related illnesses	Heart conditions	Substance use	Age-related illnesses	Mental health
4	Heart conditions	Age-related illnesses	Cancers	Heart conditions	Substance use
5	Diabetes	Diabetes	Age-related illnesses	Diabetes	Cancers
6	Cancers	Cancers	Heart conditions	Cancers	Heart conditions
7	Substance use	Substance use	Violence	Substance use	Diabetes
8	Chronic pain and pain management	Chronic pain and pain management	Diabetes	Motor vehicle accidents & injuries	Chronic pain and pain management

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

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

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

### Mental Health & Substance Use Concerns by Race

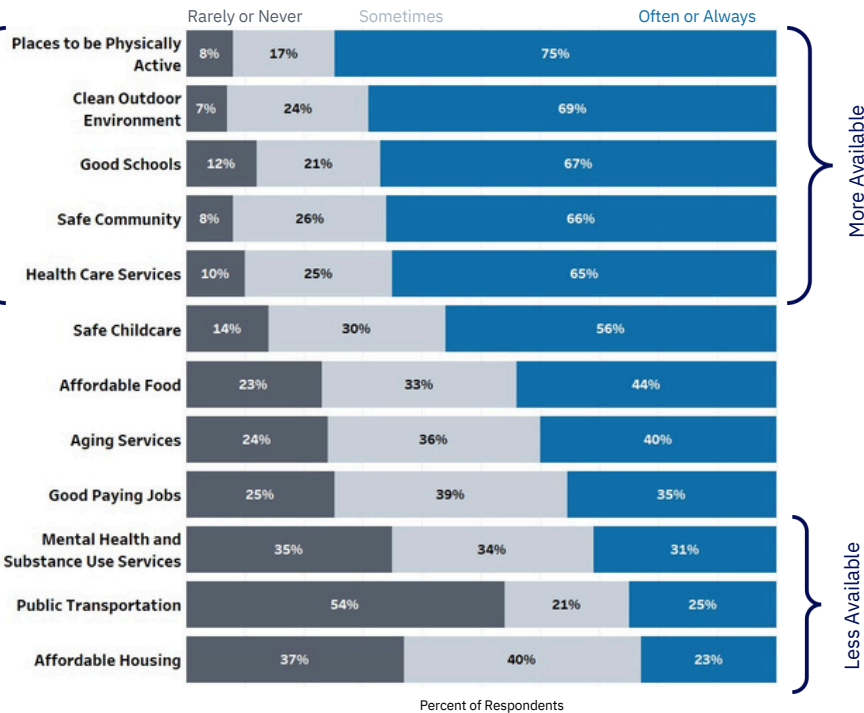
■ Higher Concern  
■ Lower Concern

Top Concerns	All Respondents n=752	White n=520	Black or African American n=27	Another Race* n=25	Did not respond or prefer not to disclose n=180
1	Depression	Depression	Depression Anxiety	Depression	Depression
2	Anxiety	Anxiety	Alcohol use Drug use	Drug use	Anxiety
3	Alcohol use	Alcohol use	Serious mental illnesses	Alcohol use	Drug use
4	Drug use	Drug use		Serious mental illnesses	Alcohol use
5	Serious mental illnesses	Serious mental illnesses		Anxiety	Serious mental illnesses
6	Loneliness	Loneliness	Post Traumatic Stress Disorder	Loneliness	Loneliness
7	Suicide	Suicide	Loneliness	Suicide	Suicide
8	Eating disorders	Not sure	Eating disorders	Post Traumatic Stress Disorder	Not sure

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

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

752  
Total Respondents in  
St. Charles County



Community members rated the availability of several resources in St. Charles County.

Places to be Physically Active, Clean Outdoor Environment, Good Schools, Safe Community, and Health Care Services were rated as being more available, with over 65% of respondents

indicating that the resources were often or always available in their community.

Mental Health and Substance Use Services, Public Transportation, and Affordable Housing were reported to be less available, with less than 35% of respondents indicating that the resources were often or always available in their community.

More Available

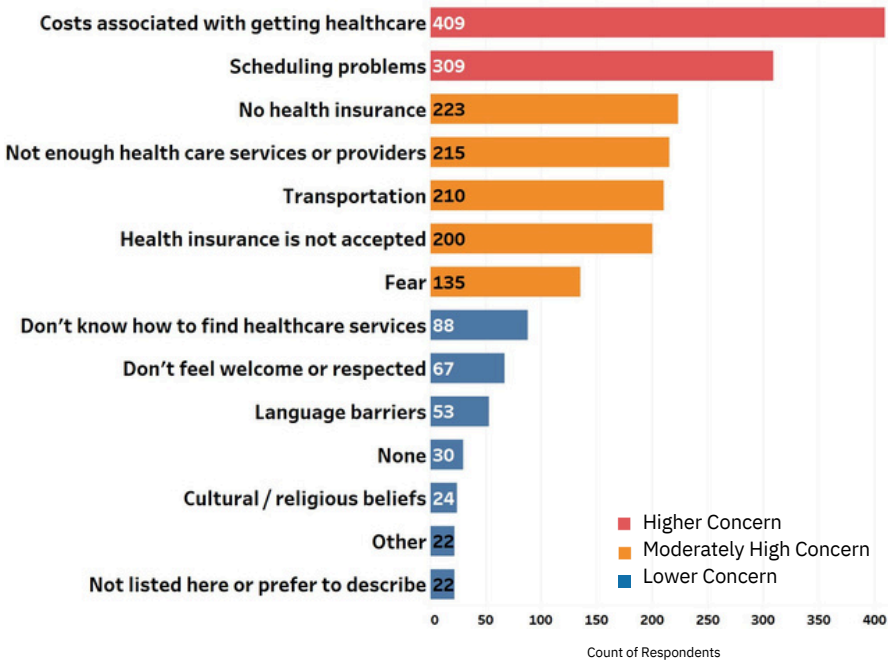
Less Available

Percent of Respondents

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

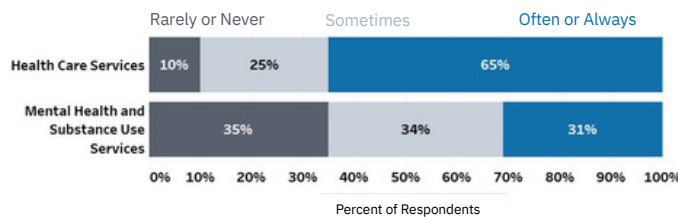
752  
Total Respondents in  
St. Charles County

### Barriers to Health Care Access



Sixty-fivepercent (65%) of community members who responded to the survey indicated that health care services were often or always available in St. Charles County. Only 31% indicated that mental health and substance use services had good availability. Costs, scheduling problems, and lack of insurance were most frequently identified as barriers to accessing health care.

### Health Care Service Availability



Percent of Respondents

Higher Concern  
Moderately High Concern  
Lower Concern

# Appendix C: Community Stakeholder Conversation Summary Report

## Stakeholder Conversation Summary Report

*Geographic Region: St. Charles*

*Location: St. Charles Library Date: July 25, 2024*

*Number of Participants: 23*

### Executive Summary

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

Mental health was identified as a top priority, with participants emphasizing the growing demand for services, particularly in underserved areas. Barriers such as long wait times for mental health providers and stigma associated with seeking care were common concerns. Social determinants like transportation, housing instability, and food insecurity also emerged as significant challenges. This report synthesizes these findings and provides practical recommendations for improving healthcare access, addressing social determinants of health, and fostering stronger community engagement in St. Charles.

### Introduction

On July 18 and July 25, 2024, several stakeholder conversations were held in the St. Charles region as part of the broader effort to conduct a Community Health Needs Assessment (CHNA) across the St. Louis region. Participants included representatives from community-based organizations, healthcare providers, and social service agencies, all focused on identifying critical health needs and addressing systemic barriers impacting the health and well-being of the region's residents.

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

# Appendix C: Community Stakeholder Conversation Summary Report

## Key Health Priorities and Recurring Themes

### Mental Health and Access Barriers

Mental health emerged as a top priority in nearly all discussions. Participants emphasized the growing demand for mental health services, especially in underserved communities, where long wait times—sometimes up to nine months for a psychiatrist—and a shortage of Medicaid-accepting providers were cited as major barriers. Stigma around mental health care, particularly within BIPOC and immigrant communities, remains a significant obstacle to seeking help. Participants proposed focusing on mental wellness rather than mental illness to reduce stigma.

Holistic family mental health care was also emphasized, with the idea that “mentally healthy kids come from mentally healthy adults.” This highlights the need to support entire households, not just individual children, to promote overall well-being.

### Violence and Trauma

Community violence and domestic violence were critical issues throughout the discussions. Participants noted that violence significantly contributes to trauma, particularly among children, exacerbating mental health challenges. Limited resources for domestic violence survivors, including shelters and mental health services, were seen as areas needing improvement. Participants expressed strong support for trauma-informed care and early intervention to help mitigate the impact of violence on health outcomes.

Violence was also connected to systemic issues like housing instability, which adds to stress and poor mental health outcomes in vulnerable populations.

### Social Determinants of Health (SDOH)

Several social determinants of health—such as transportation, housing instability, and food insecurity—were identified as major barriers to health and well-being. Access to reliable transportation, particularly for low-income and elderly populations, was a significant challenge. Housing instability, including homelessness and lack of affordable housing, was cited as a worsening problem in recent years.

Food insecurity was also highlighted, especially in rural areas of St. Charles, where demand for food assistance has surged. Participants linked the lack of access to fresh, nutritious food directly to poor health outcomes, including obesity and chronic conditions like diabetes.

### Access to Healthcare

Access to healthcare services, particularly dental and primary care, was identified as a significant barrier for many families. Participants stressed the need for free or sliding-scale dental services, as poor oral health often worsens other health conditions. While healthcare resources exist, many residents struggle to navigate them due to transportation, language barriers, and general unawareness of available services.

# Appendix C: Community Stakeholder Conversation Summary Report

## Challenges and Gaps Identified

### Underrepresentation in Survey Data

Participants raised concerns about the underrepresentation of certain populations, particularly Hispanic, immigrant, and refugee communities, in the CHNA survey data. Barriers such as language, mistrust of institutions, and limited access to technology were cited as reasons for this underrepresentation.

Participants called for more inclusive survey designs and distribution methods, such as partnering with trusted community leaders and offering surveys in multiple languages.

### Fragmentation of Services

One of the most significant challenges identified was the fragmentation of services. Despite the existence of various healthcare and social services, they are often difficult for residents to navigate, particularly for low-income families and individuals with complex needs. Participants emphasized the need for better coordination among healthcare providers, social services, and community organizations to ensure seamless care.

### Mistrust in Healthcare Systems

Mistrust in healthcare institutions, particularly among immigrant and BIPOC communities, was a recurring theme. This mistrust stems from experiences of systemic racism, previous negative encounters, and fear of judgment or discrimination. Participants urged healthcare providers to build trust by engaging regularly with the community, being transparent, and offering culturally competent care.

## Community Engagement Strategies

### Collaborating with Trusted Community Organizations

Participants emphasized the importance of partnering with trusted community organizations to engage residents effectively. Organizations such as food pantries, churches, and shelters already have established relationships with the community and can serve as valuable partners in distributing surveys, gathering feedback, and providing services.

### Meeting the Community Where They Are

Bringing healthcare and other services directly to the community was a key recommendation. Mobile health clinics, school-based health programs, and community wellness hubs were seen as effective ways to reduce transportation barriers and provide care in accessible, familiar locations. Schools, libraries, community events, and grocery stores were suggested as potential venues for outreach and engagement.

# Appendix C: Community Stakeholder Conversation Summary Report

## **Providing Incentives for Participation**

To encourage participation in surveys and community health initiatives, participants recommended offering incentives such as gift cards, transportation vouchers, and food. These incentives help reduce logistical barriers and show respect for community members' time and contributions.

## **Continuous Engagement and Trust-Building**

Participants emphasized the need for ongoing engagement and trust-building. Regular community meetings, transparent progress reporting, and advisory boards that include community members were suggested as ways to ensure continuous participation and foster long-term trust.

## **Opportunities for Improvement**

### **Expanding Mental Health Services**

Expanding mental health services was identified as a top priority. Participants recommended increasing the availability of culturally competent mental health providers, particularly in underserved areas. Embedding mental health counselors in schools and community centers, and providing mobile mental health services, were seen as critical strategies for addressing the mental health crisis.

### **Addressing Housing and Transportation Barriers**

Improving access to affordable housing and expanding transportation services were identified as critical needs. Housing instability was seen as a root cause of many health and social issues, and participants strongly supported investing in more affordable housing options. Expanding transportation services, including mobile health units, was also emphasized to overcome access barriers.

### **Strengthening Partnerships with Community-Based Organizations**

Participants strongly recommended strengthening partnerships between healthcare systems and community-based organizations. These partnerships can help address social determinants of health and ensure that residents have access to a comprehensive range of services.

# Appendix C: Community Stakeholder Conversation Summary Report

## Recommendations for Next Steps

- **Redesign Surveys to Be More Inclusive:** Co-design future CHNA surveys with input from community leaders and residents to ensure that the voices of all populations are captured. Offer surveys in multiple languages and distribute them through trusted community organizations.
- **Expand Mobile and School-Based Health Services:** Prioritize mobile health clinics and school-based health programs to address barriers such as transportation and access to care. These services can provide both physical and mental health care in accessible, familiar locations.
- **Invest in Trauma-Informed Care:** Given the high levels of violence and trauma in the community, healthcare systems should invest in trauma-informed care across all services. This includes providing mental health support for survivors of violence and training healthcare providers to recognize and respond to trauma.
- **Strengthen Collaboration with Community Partners:** Healthcare systems should build strong, long-term partnerships with community-based organizations to better address social determinants of health and ensure that residents have access to the full spectrum of services they need.

## Conclusion

The stakeholder conversations in the St. Charles region revealed significant health challenges, including mental health, violence, and social determinants of health. Addressing these challenges requires a coordinated, community-based approach involving healthcare systems, community organizations, and local governments. By expanding services, strengthening partnerships, and engaging the community in meaningful ways, healthcare providers can make significant progress in improving health outcomes for all residents.

## Acknowledgments

The St. Louis Regional Hospital Collaborative and Key Strategic Group extend our sincere thanks to the participants of the St. Charles stakeholder conversations for their time, insights, and commitment. We also thank the St. Charles Library for hosting the meeting and providing a welcoming space for these important discussions.

# Appendix D: Community Conversations Summary Report

St. Louis Regional Hospital Collaborative  
Community Conversation in Partnership with  
St. Patrick Center

*Thursday, September 24, 2024*

---



Executive Summary  
*Prepared by Key Strategic Group*

The St. Louis Regional Health Collaborative partnered with the St. Patrick Center to conduct a community conversation to understand the health needs, barriers, and strengths within the local community experiencing homelessness and housing instability. Nine participants attended this conversation, bringing their diverse perspectives and experiences to discuss their challenges, from navigating healthcare access to addressing mental health and substance use. Key themes included a strong call for improved transportation, better access to mental health services, and clear communication around Medicaid and primary care.

This report synthesizes the insights gathered during the conversation, providing a pathway for the Collaborative to address the pressing needs of the St. Patrick Center's community. The themes and solutions suggested by participants highlight the importance of consistent, accessible healthcare and a healthcare system that listens and adapts to the unique challenges faced by those dealing with housing instability.

## Introduction and Background

As part of the ongoing Community Health Needs Assessment (CHNA) in the St. Louis region, the St. Louis Regional Health Collaborative engaged with the St. Patrick Center to host a community conversation. St. Patrick Center, one of Missouri's largest providers of housing and support services for people experiencing homelessness, serves a population that faces significant barriers to healthcare. This community conversation offered participants an opportunity to share their perspectives on health, housing, and the resources needed to foster a healthier, more supportive community.

The purpose of this conversation was to gather insights directly from community members regarding their healthcare experiences, barriers to accessing services, and suggestions for improving health outcomes. The Collaborative aimed to capture authentic community voices and use this feedback to inform healthcare improvement initiatives prioritizing the needs of vulnerable populations in St. Louis.

## Methodology

In collaboration with St. Patrick Center, the St. Louis Regional Health Collaborative designed a structured conversation facilitated by staff familiar with the community's needs. The conversation included nine participants and was organized around open-ended questions, allowing attendees to share their experiences freely.

Key questions explored community health needs, specific barriers to accessing care, priority health issues, and ideas for collaborative solutions. Facilitators and scribes captured

participants' insights, quotes, and suggestions. Following the conversation, notes were analyzed to identify recurring themes, with a focus on understanding the unique needs of this population and determining actionable steps for the Collaborative to consider.

## Community Conversation Insights by Segment

### Segment 1: Identifying Community Health Needs

#### Purpose of this Segment

This segment aimed to explore participants' perspectives on a healthy community and identify critical resources they believe are necessary for well-being.

#### Insights from the Conversation

Participants expressed that a healthy community is one where people feel safe, supported, and empowered. They emphasized the need for “more community spaces and therapy groups” where individuals can come together, share experiences, and support one another. Additionally, participants highlighted the need for access to mental health services across shelters and safe spaces for those experiencing trauma.

Participants shared concerns over limited access to healthcare and the complexity of understanding insurance benefits, especially for those unfamiliar with Medicaid processes. They advocated for more group living facilities like St. Patrick Center’s Rosati housing, which provides a supportive environment for individuals facing similar struggles.

### Segment 2: Barriers to Health

#### Purpose of this Segment

This segment focused on understanding the specific challenges that prevent participants from accessing the healthcare they need.

#### Insights from the Conversation

Participants cited multiple barriers, with transportation emerging as a primary concern. Unreliable public transit, long wait times for Medicaid-sponsored transportation, and the location of healthcare facilities in unfamiliar neighborhoods make it challenging to keep appointments. They also mentioned that clinics are often too busy and, in some cases, confusing due to unclear signage. One participant noted, “Urgent Care don’t accept Medicaid,” underscoring a need for more accessible care locations.

Economic constraints, especially among those on fixed incomes, add to the burden. Participants described challenges with Medicaid spend-downs and the high costs of care

and medications, which they described as “astronomical.” They also highlighted a lack of health literacy and awareness about what Medicaid covers, which often leads to lapses in necessary medications when insurance changes.

### Segment 3: Prioritizing Health Issues

#### Purpose of this Segment

This segment sought to identify the most urgent health issues facing the community and prioritize these concerns for potential action.

#### Insights from the Conversation

Mental health services emerged as a top priority, with participants advocating for increased access to group therapy, peer support, and programs within shelters. Participants spoke about the need to address violence in their community and create opportunities for people to find meaningful work, as job availability has both economic and psychological benefits. One participant reflected, “It’s like a gone city...people need jobs to focus on something productive.” They shared that fear of violence often prevents community members from engaging with available resources.

### Segment 4: Building on Community Strengths

#### Purpose of this Segment

This segment focused on identifying existing resources that support health in the community and exploring ways to build on these strengths.

#### Insights from the Conversation

Participants emphasized the positive impact of case managers, who assist in navigating the healthcare system, accessing benefits, and arranging necessary transportation. They also praised therapy groups that facilitate personal growth and provide safe spaces for self-reflection. “Group living programs bring people together around shared experiences,” one participant shared, illustrating the therapeutic value of communal support. Medication delivery programs were also highlighted as crucial for those facing barriers to picking up prescriptions.

### Segment 5: Collaborative Solutions

#### Purpose of this Segment

This segment gathered participants’ ideas for how the healthcare system and community could work together to solve health challenges.

## Insights from the Conversation

Participants stressed the importance of healthcare providers coming directly into the community to establish trust and accessibility. They recommended creating more volunteer opportunities where community members could support one another, fostering a sense of purpose and mutual aid. They also suggested increasing staff presence in emergency departments to improve patient support and creating a platform for community voices to advocate for healthcare improvements.

Participants called for empathy from healthcare providers, encouraging them to “use their positions of power to help people.” They believe that by creating supportive, accessible environments, healthcare providers can better meet the needs of underserved communities.

## Themes from the Conversation

### 1. Transportation and Accessibility

Transportation remains a major barrier, with participants struggling to access reliable transit to and from appointments. The unreliability of Medicaid-sponsored transportation and distant healthcare facilities exacerbate this issue.

### 2. Financial and Insurance Barriers

Medicaid limitations and high healthcare costs prevent participants from accessing needed care consistently. The lack of clarity around Medicaid's benefits further complicates access, particularly when medication coverage lapses.

### 3. Mental Health and Substance Use Support

Participants consistently emphasized mental health as a critical need, advocating for more therapy groups, peer support, and safe spaces. Substance use issues also require increased attention, especially as they intersect with mental health challenges in the community.

### 4. Empathy and Community Connection

Participants called for healthcare providers to engage with empathy and come into the community to build trust. They value community spaces and volunteer opportunities as essential for building resilience and self-efficacy among community members.

## Conclusion

The St. Patrick Center community conversation highlighted the substantial barriers that unhoused individuals encounter in accessing healthcare. Common themes of transportation difficulties, complex Medicaid processes, and the urgent need for mental health support underscore a healthcare system that often falls short for vulnerable populations. Despite these obstacles, participants demonstrated resilience and a desire for collaborative, community-driven solutions.

The St. Louis Regional Health Collaborative has a valuable opportunity to work with trusted organizations like St. Patrick Center to bridge healthcare gaps. By prioritizing mental health services, enhancing Medicaid education, improving transportation options, and fostering empathy in healthcare interactions, the Collaborative can create a more inclusive and accessible healthcare system. These efforts can help cultivate a healthcare environment that not only addresses immediate needs but also fosters a sense of community, dignity, and empowerment among all residents.

# St. Louis Regional Hospital Collaborative Community Conversation in Partnership with St.Louis Oasis

Wednesday, October 16, 2024



# Executive Summary

The St. Louis Regional Health Collaborative partnered with St. Louis Oasis to conduct a community conversation to understand the unique healthcare needs, barriers, and priorities of older adults across the St. Louis region. St. Louis Oasis, a nonprofit dedicated to promoting healthy aging through lifelong learning, health programs, and volunteer opportunities, hosted this conversation, which included insights from twelve participants. These participants shared perspectives on the challenges of navigating Medicare, dealing with limited transportation options, and understanding complex insurance and healthcare systems. The conversation revealed a strong need for clearer healthcare communication, expanded mental health support, and accessible resources for chronic disease management.

This report synthesizes themes and recommendations derived from participants' insights, providing actionable steps for The Collaborative to address these needs and enhance healthcare accessibility for older adults in the region.

## Introduction and Background

As part of its Community Health Needs Assessment (CHNA), the St. Louis Regional Health Collaborative collaborated with St. Louis Oasis to hold a community conversation with older adults to explore healthcare accessibility and related needs. Oasis is widely recognized for its commitment to supporting the well-being of older adults through health education, social engagement, and wellness initiatives. To capture diverse perspectives, twelve participants were invited from across the St. Louis region, ensuring representation from different backgrounds and experiences. This conversation allowed older adults to share firsthand insights into the barriers they encounter in accessing healthcare and the resources they deem essential for maintaining health and well-being as they age. The Collaborative intends to use these insights to guide initiatives that address the distinct needs of the region's aging population.

## Methodology

In collaboration with St. Louis Oasis, the St. Louis Regional Health Collaborative designed a structured community conversation facilitated by Oasis staff familiar with the needs and experiences of older adults. The discussion included twelve participants, with facilitators leading through open-ended questions encouraging participants to share their experiences openly.

Key questions addressed community health needs, barriers to healthcare access, and ideas for collaborative solutions. Trained scribes documented the discussion, capturing key insights, participant quotes, and emerging themes. Afterward, the Collaborative reviewed the notes to synthesize common themes, concerns, and actionable recommendations aligned with the specific healthcare needs of older adults.

# Community Conversation Insights by Segment

## Segment 1: Identifying Community Health Needs

### Purpose of this Segment

This segment explored participants' visions for a healthy community, focusing on the resources and support needed to maintain well-being as they age.

### Insights from the Conversation

Participants defined a healthy community as one that offers accessible, safe spaces for physical activity, social connection, and mental well-being. They emphasized the importance of community programs that encourage engagement and physical movement, with one participant stating, "We need more places to walk and meet with others. It keeps us moving and connected." Safe, well-maintained community areas—such as parks, walking trails, and accessible sidewalks—were considered essential for fostering both physical and mental health.

Safety emerged as a major concern, with several participants expressing apprehension about certain areas due to crime. They advocated for community spaces that feel secure, where older adults can confidently engage in outdoor activities. In addition, participants emphasized the need for a community that is inclusive, welcoming, and attuned to the unique challenges that older adults face in staying active and engaged.

## Segment 2: Barriers to Health

### Purpose of this Segment

This segment examined specific challenges participants face when trying to access healthcare, including insurance complexities and transportation limitations.

### Insights from the Conversation

Navigating Medicare and private insurance presented significant challenges, with many participants expressing confusion over changing policies and benefits. One participant shared, "Insurance is so confusing. I have no idea what's covered or what I signed up for." Participants described relying heavily on family members, friends, and insurance agents to help them understand their healthcare options, revealing a need for clearer, more direct communication from insurers and healthcare providers.

Transportation was another prominent barrier. While some municipalities offer dedicated services for older adults, these are inconsistent across the region, limiting access to reliable transit. One participant cited Brentwood's "magic bus" service as helpful, but noted that such services aren't available everywhere. Many participants expressed concern over their ability to attend regular health appointments, indicating that transportation gaps hinder consistent healthcare access.

### Segment 3: Prioritizing Health Issues

#### Purpose of this Segment

This segment focused on identifying participants' most pressing health concerns and establishing priorities for potential action.

#### Insights from the Conversation

Mental health care emerged as a critical priority, with participants highlighting the difficulty of finding accessible providers and facing long wait times. Many older adults emphasized the impact of social isolation on mental health, particularly for those without family nearby. They advocated for increased mental health support, especially group therapy and peer support options that could help alleviate loneliness. "We need people to talk to and programs that don't make us feel alone," one participant remarked.

Participants also identified chronic disease management, including care for sleep apnea and preventive cancer screenings, as high-priority needs. They expressed frustration at the fragmented nature of healthcare information, which often prevents older adults from accessing preventive services or understanding their health status. The group agreed that a more integrated approach to chronic disease support would significantly improve their ability to manage ongoing health needs effectively.

### Segment 4: Building on Community Strengths

#### Purpose of this Segment

This segment explored existing resources that support health and well-being among older adults and ways to expand upon these strengths.

#### Insights from the Conversation

Participants highlighted several community resources that contribute positively to their health, such as the "Silver Sneakers" fitness program and local gym memberships covered by Medicare Advantage. These programs encourage physical activity and provide a social outlet, which participants greatly value. Additionally, they praised Oasis for its health education and wellness classes, which address knowledge gaps and provide a trusted source of information on health topics.

However, participants noted that awareness of these programs remains limited, particularly among those who may not know about resources outside of their immediate area. They suggested that healthcare providers and insurance companies actively connect older adults to these local resources, allowing them to access comprehensive support for both physical and social needs.

Segment 5: Collaborative Solutions Purpose of this Segment This segment captured participants' recommendations for collaborative efforts between the healthcare system and community organizations to address the unique needs of older adults. Insights from the Conversation Participants expressed a strong desire for healthcare providers to work closely with community organizations like Oasis to improve access to health-related resources. They suggested that clinics, hospitals, and insurance providers share information on programs available for older adults, helping connect them to community resources supporting preventive and ongoing care needs. One participant noted, "It would help if doctors told us about programs we could join." Transportation access remained a high priority, with participants advocating for investment in transit solutions that accommodate the needs of older adults, particularly those in underserved or remote areas. They also proposed hosting community health days, where local healthcare providers could visit neighborhood centers to answer questions, provide screenings, and build trust within the community. This initiative, they believed, could offer older adults convenient, localized access to care.

## Conversation Themes

### 1. Insurance Navigation and Healthcare Communication

Older adults find Medicare and private insurance plans difficult to navigate and often rely on external support to understand available options. The need for simplified, accessible information on insurance coverage and healthcare services emerged as a priority.

### 2. Transportation and Accessibility

Inconsistent transportation options restrict older adults' ability to access regular healthcare services. Participants called for expanded transportation solutions that meet the unique needs of aging adults across the region.

### 3. Mental Health and Chronic Disease Support

Participants expressed a pressing need for accessible mental health services, emphasizing support for social isolation and long wait times for counseling. Chronic disease management, including care for sleep apnea and cancer screenings, also emerged as high priorities.

### 4. Community-Based Resources and Social Engagement

Programs like Oasis, "Silver Sneakers," and other local wellness initiatives were recognized as valuable resources. Participants advocated for greater awareness and referrals from healthcare providers to connect more older adults to these beneficial programs.

## Conclusion

The community conversation at St. Louis Oasis highlighted the healthcare challenges older adults face in the St. Louis region, from understanding Medicare options to securing reliable transportation. Participants emphasized the need for collaborative, community-driven solutions that make healthcare navigation clearer, expand mental health access and support aging in place.

The St. Louis Regional Health Collaborative has an opportunity to respond to these needs by partnering with organizations like Oasis to bridge gaps in transportation, healthcare education, and social support. Prioritizing direct communication from healthcare providers, streamlined resource connections, and access to preventive care will empower older adults to manage their health more effectively. These initiatives can build a healthcare environment that respects, values, and enhances the lives of older adults across the region.

# St. Louis Regional Hospital Collaborative Community Conversation in Partnership with Vision for Children at Risk Monday, October 21, 2024



## Executive Summary

The St. Louis Regional Hospital Collaborative (the Collaborative) partnered with Vision for Children at Risk (VCR) to host a community conversation as part of the Community Health

Needs Assessment (CHNA), aiming to bring forward the perspectives of community members on local health needs, barriers, and potential solutions. VCR, a trusted St. Louis-based nonprofit dedicated to the well-being of underserved children and families, was chosen as a partner due to its deep community ties and strong relationships with parents, caregivers, and advocates. With VCR's involvement, the conversation provided a safe, supportive environment for residents to openly share their experiences, concerns, and hopes for improved healthcare.

The discussion highlighted several core themes: mental health as a pressing, unmet need; widespread mistrust of the healthcare system due to historical and ongoing biases; significant financial and logistical barriers to accessing care; and a deep desire for healthcare solutions that are both culturally relevant and community-centered. These insights underscore the community's need for culturally responsive care, greater transparency from healthcare providers, and an approach to care that empowers residents. This report organizes the conversation's findings into five themes: community health needs, health concerns and challenges, barriers to health, community priorities, and collaborative solutions. Each section provides specific, actionable recommendations for the Collaborative, including initiatives to enhance cultural competency, improve mental health support, and increase local access points for care. These findings present a compelling case for The Collaborative to build an inclusive, transparent, and culturally competent healthcare system that meets the unique needs of this community.

## Introduction and Background

~~Introduction and Background~~  
The St. Louis Regional Health Collaborative (the Collaborative) aims to understand and address community health disparities through an inclusive, community-centered approach. To better comprehend residents' unique health challenges, the Collaborative partnered with Vision for Children at Risk (VCR) to conduct a community conversation as part of its Community Health Needs Assessment (CHNA). VCR, a nonprofit based in St. Louis, is dedicated to enhancing the well-being of children and families, particularly those in underserved and vulnerable communities. With a deep connection to the community and trusted relationships with parents, caregivers, and advocates, VCR was selected as a partner to ensure the voices of those most impacted by health inequities were central to the assessment process.

Understanding the importance of meaningful engagement, VCR was eager to contribute to this dialogue, working with the Collaborative to foster a safe space where community members could openly share their experiences, concerns, and insights. The conversation surfaced significant themes, including mistrust in healthcare systems due to historical and systemic biases, barriers to accessing resources, and an urgent need for mental health support. These insights underscore the community's call for culturally responsive care, transparency, and the empowerment of residents to advocate for their health.

This report reflects the essential themes from the community conversation. It provides actionable recommendations for the Collaborative to develop equitable and impactful healthcare solutions that align with the needs and aspirations of the community.

### Methodology

To authentically capture community voices, the St. Louis Regional Health Collaborative and Vision for Children at Risk (VCR) collaboratively designed this community conversation, inviting a diverse group of parents, caregivers, and community advocates deeply familiar with local health challenges. Participants included young parents, long-term advocates, and other community members, each bringing unique perspectives on the healthcare needs of their families and neighbors.

In preparation, the Collaborative and VCR held several planning and logistics meetings to ensure a seamless process and a supportive environment. Together, they co-developed facilitation guides with structured, open-ended prompts to guide the conversation while allowing space for participants to share their experiences, perceptions, and ideas candidly. During the discussion, facilitators asked questions thoughtfully, creating a safe space to foster organic dialogue while dedicated scribes documented key insights, participant quotes, and emerging themes. This structured approach ensured a comprehensive conversation record and honored the authenticity of community contributions. The collected notes were later synthesized to identify recurring patterns and actionable recommendations.

## Segment 1: Identifying Community Health Needs

### *Purpose of this Segment:*

This segment explored participants' visions of a healthy community, identifying what is currently missing and what changes are essential to create a healthier environment.

Insights from the Conversation:

Participants described a healthy community empowering its residents with the resources and knowledge to advocate for their well-being. Education was noted as a cornerstone of health, with one participant emphasizing that "a healthy community is an educated community...able to advocate for itself and others." This statement reflects a powerful theme: health must go beyond physical care to include empowerment, knowledge, and self-advocacy.

Food security and access to healthy options were also discussed as core components of community health, with several participants pointing to food deserts and limited access to fresh, nutritious options as persistent issues in their neighborhoods. "Community access and local infrastructure are crucial," a participant observed, signaling a need for systems prioritizing equitable access to fundamental health resources.

Family support networks, lived experiences, and interdependence emerged as vital elements of a healthy environment. These themes underscore that health is not an isolated attribute but flourishes in connected, supportive communities where people feel valued and equipped to care for themselves and others. Participants clearly expressed that healthcare leaders must recognize and strengthen these foundational components for their community to thrive.

## Segment 2: Health Concerns and Challenges

### *Purpose of this Segment:*

This segment delved into the community's specific health concerns, particularly those affecting Black families and underserved residents, to highlight the most pressing issues.

### *Insights from the Conversation:*

Mental health surfaced as an urgent concern, particularly given the impact of trauma, stress, and financial hardship on both adults and children. One participant captured the sentiment well: "If there's no system for mental health in place, then everything falls." This statement illustrates the community's acute awareness that untreated mental health issues reverberate across all aspects of life, often destabilizing entire families. Participants voiced a collective call for integrated mental health support as an essential part of the healthcare system.

Racial inequity and systemic bias in healthcare were also prominent concerns, with many sharing experiences of misdiagnosis or inadequate care. "The system is skewed toward white people due to the many studies that are done only on white people," explained one participant, emphasizing the community's frustration with a healthcare system that frequently fails to consider the needs of Black patients. This discussion highlights a profound gap in culturally competent care that leaves community members feeling marginalized and distrustful of the healthcare they receive.

Health equity, particularly about socio-economic factors, was another key theme. Many participants expressed frustration at the lack of local healthcare facilities and the challenges of finding providers who accept Medicaid. This disparity forces community members to seek care outside their neighborhoods, creating additional barriers and exacerbating existing inequities. These insights reveal a clear need for the Collaborative to champion systemic changes that address health disparities and prioritize equitable access to care for all.

## Segment 3: Barriers to Health

### *Purpose of this Segment:*

This segment examined the barriers preventing community members from accessing care, emphasizing structural obstacles and interpersonal challenges.

### *Insights from the Conversation:*

Participants identified a range of barriers, with mistrust of healthcare providers as a significant deterrent to seeking care. For many, this mistrust is rooted in both historical injustices, such as the Tuskegee Study, and personal experiences of gaslighting or racial discrimination in medical settings. "The trust was never there to begin with," one participant remarked, underscoring the deep-seated apprehension that many Black residents feel toward the healthcare system. This lack of trust often leaves patients feeling isolated and unsupported in their health journeys, revealing the urgent need for healthcare providers to actively work toward rebuilding relationships with the community.

Financial strain, particularly around insurance coverage and medical expenses, was also highlighted as a barrier. Participants shared frustrations around opaque insurance policies, especially the limitations they encountered with Medicaid. "How do we bridge the gap regarding different insurance?" one participant asked, pointing to a lack of accessible

education on insurance options exacerbating existing financial barriers. This discussion underscores the need for transparency and education around insurance to empower residents with the tools needed to make informed healthcare decisions.

The absence of nearby health facilities was another key barrier, with participants expressing the need for “satellite offices” within their neighborhoods to reduce the logistical challenges of accessing care. These barriers paint a comprehensive picture of the community's structural and interpersonal difficulties, emphasizing the need for systemic reforms to eliminate the obstacles that prevent equitable access to care.

## Segment 4: Community Priorities and Potential Solutions

### *Purpose of this Segment:*

This segment focused on identifying the community's health priorities and gathering actionable ideas for addressing these issues through healthcare collaboration.

Insights from the Conversation:

Mental health support and culturally competent care emerged as immediate priorities, with participants emphasizing the need for healthcare that acknowledges and responds to the cultural contexts of Black families. One participant recommended that “mental health support should go hand in hand with physical health,” illustrating the community's desire for integrated care that addresses the mind-body connection. Many suggested that mental health programs be made available in schools to reach children early, providing preventive care and support for youth in need.

Participants also proposed the creation of advocacy roles within the healthcare system, such as community health workers or family support partners who can represent and advocate for patients during appointments. These advocates could help translate medical jargon, guide patients through treatment options, and serve as a bridge between providers and the community. “Without [community health workers], there's no hope,” one participant shared, capturing the importance of having community-based advocates who understand the unique challenges residents face and can assist them in navigating the healthcare system. The community also called for initiatives to build trust with healthcare providers, including panel discussions and open dialogues with hospital CEOs and other healthcare leaders. Participants believe these forums would allow residents to voice their experiences directly and help healthcare leaders understand the realities faced by their communities. Such initiatives reflect the community's desire for transparency and accountability from healthcare providers, fostering a sense of mutual respect and partnership.

## Segment 5: Collaborative Solutions and Next Steps

### *Purpose of this Segment:*

This final segment summarized collaborative actions that could be taken by healthcare providers and the community to address health issues, strengthen trust, and promote sustainable solutions.

Insights from the Conversation:

To rebuild trust, participants stressed the importance of culturally responsive training for healthcare providers, suggesting that providers be educated on implicit biases and how

these biases affect patient care. Participants were clear that for trust to be restored, healthcare providers must take active steps to demonstrate understanding, compassion, and respect for the community's lived experiences. This sentiment reflects a strong desire for healthcare systems to make tangible efforts to acknowledge and address the harm that has been done. Participants also advocated for community-based liaisons to help residents with health literacy, navigate insurance options, and ensure continuity of care. These liaisons, including family support partners and community health workers, would play a critical role in bridging the gap between healthcare providers and the community, especially for those who struggle to navigate complex healthcare systems alone. By investing in local health advocates, the Collaborative could significantly enhance the accessibility and cultural relevance of its services. Another recommended solution was expanding access points within the community through satellite offices or mobile health units. By creating these access points, healthcare systems can bring care closer to home for many residents, reducing logistical and transportation-related barriers. Participants expressed hope that localizing care could help strengthen relationships between providers and patients, cultivating a healthcare environment that feels accessible and genuinely supportive.

## Conversation Themes

### 1. Community Health Needs

Participants described a healthy community as empowering its residents to advocate for their health and providing access to essential resources, knowledge, and support systems.

#### □ Mental Health Support

Mental health emerged as an essential component of community health, with participants emphasizing the importance of accessible mental health services, particularly for youth and families. One participant noted, "If there's no system for mental health in place, then everything falls," underscoring the widespread impact of untreated mental health issues. Community members expressed a need for integrated mental health services accessible in schools and community centers to support children and parents.

#### □ Food Security and Access

Food deserts and limited access to nutritious food options were recurring concerns, with participants pointing to the need for affordable, healthy food in local grocery stores. The lack of nutritious options has tangible impacts on family health, and several participants suggested community gardens or subsidized grocery programs as potential solutions to bridge the food access gap.

#### □ Educational Empowerment

Education was highlighted as a cornerstone of health. Participants discussed the importance of health literacy in navigating the healthcare system and understanding how to advocate for oneself effectively. One participant remarked, "A healthy community is an educated community...able to advocate for itself and others." This reflects a strong desire for educational programs that build advocacy

skills and empower community members with the knowledge to make informed healthcare decisions.

## 2. Health Concerns and Challenges

The community identified various health concerns that disproportionately affect Black families and other marginalized groups, emphasizing the need for healthcare reform that addresses these inequities.

### □ Systemic and Racial Bias in Healthcare

A significant challenge for the community is the systemic bias that many experience in healthcare settings. One participant voiced a sentiment shared by others, stating, “The system is skewed toward white people due to the many studies that are done only on white people.” Participants described experiences of being dismissed or misdiagnosed, which has deepened their mistrust of healthcare providers. This points to a critical need for providers trained in cultural competency and aware of the unique challenges Black patients face.

### □ Economic Barriers

Financial challenges were discussed frequently, with many participants highlighting the high co-pay costs, insurance complexities, and limited access to affordable healthcare. These financial burdens deter people from seeking necessary care, particularly for preventive services. “Health insurance co-pays can be unaffordable,” shared one participant, emphasizing the need for accessible insurance education and financial support programs.

### □ Geographic and Logistical Barriers

Participants noted the absence of local healthcare facilities and the need to travel long distances for Medicaid-accepting providers. “There’s a medical office in Florissant that doesn’t take Medicaid...we have to drive far just to get basic care,” one participant explained, underscoring the limited health infrastructure in predominantly Black neighborhoods.

## 3. Barriers to Health

Participants identified additional obstacles that prevent access to quality care, often rooted in historical trauma and a lack of cultural awareness in healthcare settings.

### □ Historical Trauma and Mistrust

Mistrust of healthcare providers was a prominent theme, with participants citing historical events, such as the Tuskegee Study, and personal experiences of medical discrimination. “The trust was never there to begin with,” one participant said, reflecting on the persistent distrust in healthcare providers. This deep-seated mistrust presents a barrier to care, as many residents feel apprehensive about seeking medical support.

### □ Financial and Insurance Challenges

Complexity around Medicaid and private insurance coverage was discussed as a barrier, with participants expressing a need for more precise, more transparent insurance education. One participant questioned, “How do we bridge the gap

regarding different insurance?” suggesting that a lack of information compounds financial barriers.

- Insufficient Health Infrastructure

Participants recommended establishing more healthcare access points within the community, such as satellite clinics or mobile health units, to alleviate transportation challenges. This would allow residents to access care locally, reducing logistical burdens and improving continuity of care.

## 4. Community Priorities and Proposed Solutions

The community outlined vital priorities and actionable solutions to address these health challenges, emphasizing mental health and culturally responsive care.

- Integrated Mental and Physical Health Services

Participants voiced a strong need for healthcare that integrates mental health support with physical care, particularly in preventive and school-based programs. “Mental health support should go hand in hand with physical health,” suggested one participant, advocating for holistic care that addresses both mind and body.

- Establishing Healthcare Advocates and Navigators

Community health workers and family support partners were proposed as vital allies for patients, helping them navigate healthcare systems and advocate for their needs. “Without [community health workers], there’s no hope,” a participant shared, emphasizing the importance of culturally informed advocates understanding and representing community interests.

- Building Trust Through Transparency and Engagement

Participants recommended creating forums where healthcare leaders could engage directly with the community, listen to their experiences, and address their concerns. Such forums would foster transparency and demonstrate accountability, which the community views as essential to building trust in healthcare systems.

## 5. Collaborative Solutions and Next Steps

The final segment focused on collaborative actions that healthcare providers and the community can take to bridge current gaps and create sustainable health improvements.

- Culturally Responsive Training for Healthcare Providers

Participants strongly advocated ongoing implicit bias and cultural competency training to address discrimination and improve patient-provider relationships. They emphasized that healthcare providers must demonstrate understanding and compassion to rebuild trust.

- Investing in Community-Based Health Resources

Participants recommended establishing health literacy programs and additional access points like satellite clinics or mobile health units within the community. These resources would enhance accessibility and provide culturally relevant support to residents.

#### □ Expanding Preventive Care Initiatives

Regular community health events and partnerships with local organizations were suggested to provide preventive care, health education, and screenings.

Participants believe these efforts could create a more inclusive healthcare environment that proactively supports community health.

## Conclusion and Next Steps

This community conversation highlighted the significant gaps in healthcare access, cultural competency, and trust within the Black community and other marginalized populations. Moving forward, The Collaborative has an opportunity to address these issues by implementing culturally responsive training, establishing community health worker programs, and expanding mental health and preventive services. To ensure that the insights gathered here are honored, the Collaborative should maintain transparent, ongoing communication with the community, updating them on progress and ensuring their voices remain central to healthcare improvement efforts.

St. Louis Regional Hospital Collaborative  
Community Conversation in Partnership with  
the International Institute of St. Louis  
Wednesday, October 23, 2024



## Executive Summary

The St. Louis Regional Health Collaborative partnered with the International Institute of St. Louis (IISTL) to conduct a community conversation as part of its Community Health Needs Assessment (CHNA). IISTL, a nonprofit dedicated to fostering an inclusive community for immigrants and refugees, plays a vital role in supporting St. Louis' international populations by providing services across housing, employment, health, and education. Recognizing the St. Louis region's growing international community, the Collaborative sought insights into the unique health challenges, needs, and perspectives of recent immigrants.

This conversation engaged ten participants from three groups: Spanish-speaking individuals, Afghan refugees, and Eritrean immigrants. Key themes included language barriers, cultural competency in healthcare, the need for accessible mental health resources, and enhanced health literacy. Each group shared their experiences with navigating healthcare in the U.S., including specific cultural barriers and community-based solutions. The Collaborative aims to utilize these insights to create a healthcare system prepared to serve St. Louis' diverse populations.

This report presents themes and insights from each group individually, followed by a cross-group analysis to identify areas of alignment and unique needs. The concluding section offers recommendations and a call to action for fostering a culturally responsive, inclusive healthcare environment in St. Louis.

## Introduction and Background

The St. Louis Regional Health Collaborative aims to understand and address health disparities by prioritizing community voices, especially those of underserved populations. In collaboration with the International Institute of St. Louis (IISTL), a leading organization serving immigrant and refugee populations, the Collaborative conducted a community conversation to engage with the region's international residents and gather insights into their healthcare experiences and needs. With a rapidly growing international population, the Collaborative recognizes the importance of preparing the healthcare system to meet the unique needs of these communities.

The conversation involved ten participants across three language and cultural groups: Spanish-speaking individuals, Afghan refugees, and Eritrean immigrants. Each group contributed distinct insights into the challenges they face, from language barriers to cultural misunderstandings, offering essential perspectives to guide improvements in healthcare accessibility and quality.

### Methodology

To authentically capture community voices, the Collaborative and IISTL developed a facilitation guide specifically tailored to the experiences of immigrants and refugees. The guide included culturally relevant, open-ended questions to encourage participants to share their unique perspectives on healthcare access, experiences, and potential improvements. The facilitation approach and questions were refined through several planning meetings to ensure relevance to each international group.

The community conversation involved three sessions, with ten total participants from the Spanish-speaking, Afghan, and Eritrean communities. Facilitators created a supportive

environment that encouraged open sharing while dedicated scribes documented key insights, quotes, and emerging themes. The notes from each session were synthesized to identify overarching themes and specific needs unique to each group, as well as shared priorities across groups.

## Conversation Themes

The conversation yielded five primary themes that reflect the unique healthcare needs and perspectives of each international group. Below, insights are presented by segment for each group, followed by a cross-group analysis to identify common challenges and recomm

### Spanish-Speaking Group

#### Segment 1: Identifying Community Health Needs

##### Purpose of this Segment

This segment aimed to understand participants' perspectives on what a healthy community requires, focusing on essential resources and services.

##### Insights from the Conversation

Participants emphasized the importance of accessible healthcare as a foundation for a healthy community. Many highlighted the financial burdens they face, noting that high healthcare costs prevent them from seeking treatment, even for pressing health issues. One participant shared, "I have inflammation in my lymph nodes but haven't gone to the doctor because of the cost."

The group expressed concern about the limited Medicaid coverage available to South American immigrants, as Missouri's policies only extend Medicaid benefits to immigrants from certain countries. This lack of coverage leaves many without options for regular medical care, which exacerbates chronic conditions and increases the risk of severe illness. They voiced frustration about needing a thorough orientation to the healthcare system upon arrival in the U.S., as many enter without knowing how to navigate healthcare effectively. Participants also discussed the toll that healthcare costs take on their mental well-being. The financial stress of even a minor illness creates fear about seeking care, as a simple visit could lead to debt. They pointed out that, unlike in their home countries, emergency services in the U.S. are prohibitively expensive. "Don't use the ambulance!" one participant warned, illustrating the hesitation to seek emergency care due to cost.

#### Segment 2: Barriers to Health

##### Purpose of this Segment

This segment explored the obstacles preventing Spanish-speaking participants from accessing healthcare.

##### Insights from the Conversation

Participants repeatedly highlighted financial challenges, explaining that healthcare costs, limited Medicaid access, and unreliable financial assistance from hospitals create significant barriers. Many described situations where they applied for financial aid only to receive no response or, in some cases, have aid withdrawn unexpectedly.

Transportation also emerged as a major barrier, as most participants rely on public transit due to limited access to personal vehicles. They explained that infrequent public

transportation schedules make it difficult to attend appointments on time, especially when providers are located far from their neighborhoods. They stressed that transportation limitations further hinder their ability to obtain consistent care.

### Segment 3: Prioritizing Health Issues

#### Purpose of this Segment

This segment focused on identifying the urgent health concerns within the Spanish-speaking community.

#### Insights from the Conversation

Participants ranked access to affordable healthcare and insurance as top priorities for addressing community health needs. They raised concerns about substance abuse in their neighborhoods, describing how it compromises community safety and leads to a lack of trust in the healthcare system. They also highlighted mental health as a critical area of need, pointing out that cultural stigma around mental health care often leaves them without support.

The group discussed the mental health toll of immigration, sharing how experiences of trauma during migration impact their well-being. One participant recalled a tragic event, stating, "I saw a two-year-old die while being transported from Mexico." This comment underscored the profound impact that traumatic experiences have on immigrants' mental health.

### Segment 4: Building on Community Strengths

#### Purpose of this Segment

This segment recognized strengths within the community and existing resources that contribute to health and well-being.

#### Insights from the Conversation

Participants expressed appreciation for the U.S. healthcare system's policy of providing emergency treatment regardless of a patient's ability to pay. They acknowledged that, despite the financial burdens, the availability of emergency care in the U.S. stands in contrast to their home countries, where lack of payment can mean no treatment. One participant remarked, "At least here, we are alive to pay the bill."

The group highlighted local resources that help them meet basic needs, such as food assistance from churches and housing support from the International Institute. They expressed gratitude for these services but raised concerns about the lack of affordable winter clothing, as many are unaccustomed to the colder climate and find the cost of appropriate clothing prohibitive.

### Segment 5: Collaborative Solutions

#### Purpose of this Segment

This segment captured participants' recommendations for improving healthcare access and fostering a supportive healthcare network within the Spanish-speaking community.

#### Insights from the Conversation

Participants recommended expanding Medicaid access for immigrants and increasing

transparency around healthcare costs. They suggested establishing translation services specifically for phone conversations with healthcare providers, as language barriers during calls often create misunderstandings. The group also proposed creating community events to build support networks and increase awareness of available resources.

They expressed a need for a stronger local Latin American community, with one participant noting, “It would be helpful to be connected to more Latin Americans.” Participants emphasized the importance of trusted organizations like the International Institute in advocating for better healthcare access and representing their voices within the broader healthcare system.

## Path Forward

The conversation with the Spanish-speaking community revealed significant barriers they face in accessing healthcare, including financial challenges, limited Medicaid coverage, and language obstacles. Participants shared powerful stories that illustrate the stress of navigating a complex healthcare system without adequate support. They expressed an urgent need for affordable healthcare options and accessible mental health services. Despite these challenges, the community demonstrated resilience and voiced a strong desire for solutions that build on existing strengths, such as local food and housing assistance, along with a healthcare system that recognizes and addresses their unique needs.

Participants called for greater transparency around healthcare costs, improved language services, and community-driven outreach to connect Spanish-speaking residents with resources. The St. Louis Regional Health Collaborative can address these needs by partnering with trusted organizations like the International Institute. Through culturally sensitive policies and expanded access to healthcare services, the Collaborative can bridge gaps in care and empower the Spanish-speaking community to pursue health and well-being with confidence and support.

## Afghan Refugee Group

### Segment 1: Identifying Community Health Needs

#### Purpose of this Segment

This segment explored Afghan refugees' perspectives on what a healthy community looks like and the resources needed to support their well-being in the U.S.

#### Insights from the Conversation

Participants shared that healthcare in the U.S. is significantly different from their experiences in Afghanistan. They explained that in Afghanistan, hospitals offer general care without the need for appointments, and access to medication is straightforward, often without prescriptions. The concept of scheduled appointments and the need for prescriptions in the U.S. present challenges. One participant remarked, “Appointments are difficult,” describing the system’s unfamiliarity.

Participants noted that even with Medicaid, they often struggle to understand what services are covered and face difficulties in making appointments. One participant expressed frustration with the multiple appointments required for dental care, as this is not the norm in

Afghanistan. They stated, “In Afghanistan, all screenings and procedures happen in the same appointment,” highlighting a key cultural difference in healthcare delivery. Some refugees did find quick service at local clinics, but overall, the group voiced concerns about the complexity and accessibility of healthcare in the U.S.

## Segment 2: Barriers to Health Purpose of this Segment

This segment examined the specific challenges Afghan refugees face in accessing healthcare services, including logistical and systemic barriers.

### Insights from the Conversation

Transportation emerged as a major obstacle. Many participants rely on public transit, which is often delayed and difficult to navigate. Participants shared how long commutes and bus delays make attending appointments difficult. “Some appointments are very far away from where we live,” one participant explained, underscoring the impact of transportation challenges on consistent healthcare access.

Participants also described the difficulty of finding translators and understanding how to make appointments. They suggested that hospitals hire more translators for new refugees to help them understand the healthcare process and navigate language barriers. They further recommended that healthcare facilities develop systems to better connect patients with disabilities to resources, as their experiences highlighted gaps in understanding and accessibility for individuals with special needs.

## Segment 3: Prioritizing Health Issues

### Purpose of this Segment

This segment aimed to identify the most pressing health issues within the Afghan community and determine priorities for action.

### Insights from the Conversation

Participants identified mental health as a critical concern due to the stress of adjusting to a new environment, learning a new system, and coping with trauma from past experiences. One participant noted, “Depression is very high for new refugees due to the stress of learning how to live in a new country.” Participants expressed that mental health support, particularly culturally competent services that understand their background, would help them adapt more comfortably.

Participants also discussed the challenge of finding reliable information and making appointments. One participant explained that they often have to use Google to find healthcare providers, which sometimes leads to incorrect contacts and further delays in receiving care. The group shared frustrations around follow-up communication, describing how they often do not receive callbacks for appointments or receive limited information on available resources.

Segment 4: Existing Community Solutions Purpose of this Segment This segment focused on identifying any community-based solutions or strengths within the Afghan refugee community that support health and well-being. Insights from the Conversation The group acknowledged that fellow refugees serve as a vital support network. Many rely on each other to learn about healthcare processes, share experiences, and navigate transportation and other logistical challenges. One participant mentioned that their connection with other refugees helped them find resources and advice on scheduling appointments. This informal community network has become a valuable source of information and emotional support. Participants expressed gratitude for the classes provided by the International Institute, which cover basic information about the U.S. healthcare system, including emergency contacts like 911. While they found these resources helpful, they recommended more comprehensive orientation sessions on navigating healthcare services, particularly for dental and specialty

care.

#### Segment 5: Collaborative Solutions

##### Purpose of this Segment

This segment explored potential collaborative solutions between the healthcare system and the Afghan community to address identified needs and challenges.

##### Insights from the Conversation

Participants recommended that healthcare providers offer documentation on refugees' health history prior to their arrival in the U.S. One participant suggested that having access to refugees' health check-up records conducted before they receive U.S. visas could help healthcare providers understand patients' backgrounds and tailor their care accordingly. Participants also recommended increased training for healthcare staff to better understand the refugee experience and how it impacts health.

They further emphasized the need for more streamlined access to healthcare resources and clearer guidance on using health insurance. One participant suggested establishing a dedicated service to assist new refugees with scheduling and transportation for medical appointments, which could alleviate some logistical burdens they face.

##### Conclusion and Path Forward

The Afghan refugee community highlighted the profound challenges they face in adjusting to a complex healthcare system that differs significantly from the one they knew in Afghanistan. Participants voiced concerns about transportation, language barriers, and the difficulty of navigating an appointment-based healthcare system. Despite these challenges, they demonstrated resilience and a willingness to adapt, drawing strength from their connections with other refugees and the support of organizations like the International Institute.

Participants advocated for improved mental health services, increased language support, and more accessible transportation options. By partnering with trusted organizations and developing culturally competent, refugee-centered services, the St. Louis Regional Health

Collaborative can bridge gaps in healthcare access and build a more supportive healthcare environment for the Afghan community. Implementing these recommendations will help foster trust, improve health outcomes, and support the integration of Afghan refugees into the healthcare system.

## Eritrean Refugee Group

### Segment 1: Identifying Community Health Needs

#### Purpose of this Segment

This segment explored the Eritrean refugees' views on what constitutes a healthy community, focusing on essential resources and services.

#### Insights from the Conversation

Participants emphasized that personal health and freedom are central to a healthy life. However, as recent arrivals (between four months and two years in the U.S.), they found it difficult to address community-wide needs fully. After expanding the discussion to include social determinants of health, they shared that housing stability, health insurance, and dental care access were among their primary concerns. Participants described struggles with finding stable housing and issues with receiving mail reliably, which complicates managing healthcare-related communications.

Dental care emerged as a particularly urgent need. Participants noted that even with medical insurance, obtaining dental services remains challenging. They described repeated experiences with painful dental issues, difficulty scheduling appointments, and inconsistent care. One participant shared that despite scheduling a dental appointment three months in advance, the clinic lost their record of the visit, requiring them to start the process again. Another participant expressed frustration over the lengthy wait times and being turned away due to limited appointment availability, which prolongs their discomfort and affects daily life.

### Segment 2: Barriers to Health

#### Purpose of this Segment

This segment addressed the structural and systemic barriers Eritrean refugees encounter in accessing healthcare services.

#### Insights from the Conversation

Participants identified several barriers, starting with the lengthy process to obtain MoHealthNet medical cards, which limits access to affordable care. Without insurance, they often face out-of-pocket costs, which become a significant financial burden. They also noted that their limited understanding of the healthcare system restricts their options, as many were unaware of other clinics and providers besides Affinia that accept Medicaid. This lack of awareness led them to believe that Affinia was their only option, highlighting a need for broader health system navigation support.

The group also expressed concerns over finding emergency dental care, as many were unsure where to go when urgent issues arose. Participants suggested that healthcare providers should clarify what services are available during visits and be transparent about wait times and alternative care options. One participant stressed the importance of keeping

scheduled appointments and honoring patients' time, noting how missed or rescheduled appointments disrupt their healthcare experience.

### Segment 3: Prioritizing Health Issues

#### Purpose of this Segment

This segment aimed to pinpoint the most pressing health concerns within the Eritrean community and prioritize actions to address these issues.

#### Insights from the Conversation

Participants identified the lack of accessible, affordable dental care as an urgent issue due to the daily pain many endure from untreated dental conditions. Additionally, they cited financial and insurance barriers that prevent consistent access to needed services.

Navigating the healthcare system ranked as another top priority, as recent arrivals often lack foundational knowledge about accessing care in the U.S.

To address these issues, participants recommended distributing informational brochures detailing key health navigation resources and instructions. They believe that simple, well-translated guides would make a meaningful difference for newcomers unfamiliar with the complexities of U.S. healthcare. They also emphasized the importance of healthcare providers maintaining strong relationships with community organizations like the International Institute to facilitate information-sharing and support.

### Segment 4: Existing Community Solutions

#### Purpose of this Segment

This segment explored the ways Eritrean refugees currently manage their healthcare needs and any community resources they rely on.

#### Insights from the Conversation

Participants shared that the International Institute plays a crucial role in helping them understand their healthcare rights, such as the availability of translation services during medical visits. They explained that IISTL staff often assist in making appointments and provide guidance on accessing Medicaid services. While transportation initially posed a challenge, most participants have adapted to public transit or received help from family and friends, improving their ability to attend healthcare appointments.

Despite these strengths, participants expressed a need for clearer information about other healthcare facilities that accept Medicaid, as many mistakenly believed that Affinia was the only option. They suggested that healthcare providers work with organizations like IISTL to educate the community on available healthcare services, enhancing their ability to seek care independently.

### Segment 5: Collaborative Solutions

#### Purpose of this Segment

This segment captured participants' recommendations for improving healthcare access and fostering collaboration between the healthcare system and the Eritrean community.

## Insights from the Conversation

Participants recommended that healthcare providers establish stronger relationships with organizations like the International Institute to ensure accurate, timely information reaches the Eritrean community. They suggested that healthcare events geared toward the Eritrean population should occur at IISTL, allowing providers to connect directly with recent arrivals. They also encouraged healthcare providers to maintain open communication with IISTL so that community members know about any health-related events or services that may benefit them.

Participants emphasized the need for straightforward navigation assistance and clear instructions for accessing both general and emergency healthcare services. They believe that such support will empower them to make informed decisions and access care more easily. Additionally, participants requested that healthcare providers commit to honoring scheduled appointments, as missed or delayed visits disrupt their ability to maintain consistent care.

## Path Forward

The conversation with the Eritrean refugee community underscored the numerous barriers they face, including difficulties with insurance access, dental care, and navigating a complex healthcare system. Participants shared their experiences of enduring daily pain due to limited dental services, struggling with transportation, and needing support to understand their healthcare options. Despite these challenges, the Eritrean community showed resilience and a desire to find collaborative solutions to improve their healthcare experience.

By strengthening partnerships with trusted organizations like the International Institute and implementing culturally competent, accessible services, the St. Louis Regional Health Collaborative can bridge these gaps in healthcare access. Addressing the community's needs for better navigation resources, honoring scheduled appointments, and expanding access to dental care will support the Eritrean community's health and well-being, fostering a healthcare environment that respects and serves its growing international population.

## Cross-Group Analysis

In examining the insights from the Spanish-speaking, Afghan, and Eritrean refugee groups, several key themes emerged across all three communities. These themes illustrate the shared barriers, needs, and aspirations among diverse international populations, highlighting areas where targeted improvements could significantly impact access to and trust in the healthcare system.

### 1. Language and Communication Barriers

Language consistently surfaced as a significant barrier in healthcare access. All three groups stressed the need for more robust translation services, particularly for scheduling appointments and communicating with providers. Participants across the groups shared instances where miscommunication led to frustration, distrust, and inadequate care. They advocated for reliable interpretation services and materials translated into their native languages to ensure they fully understand medical instructions and their healthcare options.

## 2. Navigating the U.S. Healthcare System

Each group expressed challenges in understanding the complexities of the U.S. healthcare system. The concept of scheduled appointments, insurance coverage limitations, and the need for referrals were often unfamiliar and confusing. Participants requested more accessible, culturally adapted resources that provide clear guidance on navigating healthcare processes, from insurance enrollment to finding local clinics that accept Medicaid.

## 3. Financial and Insurance-Related Barriers

High healthcare costs and limited access to insurance presented significant obstacles for all three communities. Participants shared concerns about the affordability of services and medications, especially where Medicaid or other financial aid programs fell short. The Afghan and Eritrean groups, in particular, noted the prolonged wait times and financial strain caused by lack of insurance coverage for dental and specialty care. Many participants expressed a need for clearer information on how to manage healthcare expenses and navigate available aid programs.

## 4. Importance of Culturally Competent Care

Each group underscored the importance of culturally aware healthcare that respects their backgrounds and experiences. Participants expressed concerns about misdiagnoses, feelings of being dismissed, and a lack of cultural sensitivity from providers. They emphasized the value of building trust between healthcare providers and community members through empathy, understanding, and acknowledgment of their unique healthcare needs. The Afghan group specifically called for mental health support that is both trauma-informed and culturally tailored, recognizing the impact of past experiences on current mental health needs.

## 5. Community-Based Solutions and Support Networks

The presence of strong community networks and support from organizations like the International Institute was a shared strength across all groups. Participants valued the assistance of fellow community members and trusted organizations in helping them navigate healthcare, access basic needs, and build social connections. They encouraged healthcare providers to work with these community networks to create health education initiatives, in-person outreach, and culturally relevant resources that improve access to care.

## Conclusion

This community conversation underscored the shared challenges faced by Spanish-speaking, Afghan, and Eritrean refugees in accessing healthcare within the St. Louis region. Common themes of language barriers, complex healthcare navigation, financial obstacles, and the need for culturally competent care reveal a healthcare system that, while extensive, remains difficult to access for recent immigrants and refugees. Despite these challenges, each group demonstrated resilience and desired a healthcare environment that respects their needs and facilitates their well-being.

The St. Louis Regional Health Collaborative has a unique opportunity to bridge these gaps through strategic partnerships with trusted community organizations like the International

Institute. By prioritizing translation services, improving health literacy resources, and fostering cultural competency among providers, the Collaborative can foster a more inclusive healthcare system. Implementing these recommendations will not only improve health outcomes for international residents but will also promote a sense of belonging, trust, and empowerment within the community. As the Collaborative moves forward, continued engagement with these communities will ensure that healthcare initiatives remain responsive to the evolving needs of St. Louis' diverse international populations.

St. Louis Regional Hospital Collaborative  
Community Conversation in Partnership with  
Beyond Housing  
Tuesday, October 29, 2024



## Executive Summary

The St. Louis Regional Health Collaborative (the Collaborative) partnered with Beyond Housing to conduct a community conversation for the Community Health Needs Assessment (CHNA). Beyond Housing, a nonprofit focused on transforming underserved communities by addressing housing, education, economic development, and health, provided a trusted environment for residents to share their perspectives. This collaboration allowed participants to openly discuss their health experiences, highlight barriers, and propose solutions. The conversation revealed themes critical to understanding the community's health needs, including the necessity of accessible mental health resources, barriers like transportation and healthcare costs, and a strong desire for culturally responsive care that values community expertise. The report organizes findings into critical sections: Identifying Community Health Needs, Barriers to Health, Impact of Not Feeling Heard by Providers, Existing Community Solutions, and Building on Community Strengths. Each section includes insights and recommendations that guide the Collaborative in creating an inclusive, responsive healthcare system.

### Introduction and Background

The St. Louis Regional Health Collaborative aims to understand and address health disparities in local communities by prioritizing the voices of those most impacted by inequities. In collaboration with Beyond Housing, the Collaborative hosted a community conversation to gather insights on residents' health challenges, strengths, and suggestions for improvement. Beyond Housing's extensive engagement in the St. Louis region, we made it an ideal partner for fostering a welcoming and supportive space.

Participants identified several priorities, including access to mental health resources, affordable healthcare, and a need for respectful, culturally responsive care. This report synthesizes these themes and provides actionable recommendations for the Collaborative to address community needs effectively.

### Methodology

The Collaborative and Beyond Housing designed this community conversation collaboratively, inviting diverse community members, including parents, caregivers, and advocates who know firsthand the health challenges faced in their neighborhoods. To prepare, the Collaborative and Beyond Housing held planning and logistics meetings, developed facilitation guides with open-ended prompts, and worked to create a supportive environment for candid dialogue. Facilitators posed questions thoughtfully to foster a safe space while dedicated scribes documented insights, participant quotes, and emerging themes. This structure ensured the conversation was accurately captured, reflecting participants' voices authentically.

## Conversation Themes

The conversation surfaced several themes representing community members' views on health needs, barriers, and potential solutions. Each segment includes insights and quotes from participants.

### Segment 1: Identifying Community Health Needs

#### Purpose of this Segment

Participants shared their visions for a healthy community, identifying essential resources and systems to achieve it.

#### Insights from the Conversation

Participants expressed that a healthy community is one where residents feel supported and empowered. Many advocated for community-centered events like health-themed block parties to foster engagement and connect neighbors. One participant noted, “A community get-together, like a block party with a health theme, would be helpful... It’s more impactful than emails or flyers because everyone is there, understanding each other and looking out for one another.”

Food accessibility also emerged as a pressing concern. Many expressed frustration over limited nutritious food options and highlighted the need for affordable grocery stores and community gardens. One resident emphasized, “We need grocery stores that offer fresh produce and affordable options,” highlighting how food insecurity affects community health.

### Segment 2: Barriers to Health

#### Purpose of this Segment

This segment explored obstacles that prevent community members from accessing structural and personal healthcare.

#### Insights from the Conversation

Financial challenges, exceptionally high co-pays, and medication costs stood out as significant barriers. Participants noted that healthcare costs often force them to make difficult choices; as one participant shared, “Sometimes, I have to choose between paying for my medication or buying groceries.”

Transportation issues also restrict access to care. Participants recounted difficulties scheduling appointments and traveling to healthcare facilities, especially for providers outside their community. One resident explained, “I have trouble scheduling appointments...you’re told to refill your medication, but then the office is booked for months.” These barriers delay necessary care, compounding health issues for residents who need continuous support.

### Segment 3: Impact of Not Feeling Heard by Providers

#### Purpose of this Segment

Participants discussed the impact of feeling dismissed by healthcare providers, which led to distrust and reluctance to seek care.

#### Insights from the Conversation

Many participants recounted experiences where they felt unheard by their healthcare

providers. One participant shared, “In 2020, I had a rough delivery at St. Mary’s...the doctor wouldn’t stop when I was in pain, and they never apologized.” Another participant echoed this sentiment, saying, “My doctor didn’t listen when I said the medication was causing pain, so I stopped taking it. I got a new doctor who prescribed something better.”

These stories highlight the need for healthcare providers who actively listen and respond to patients’ concerns with empathy. When participants feel dismissed, it damages trust and reduces the likelihood of seeking further care, impacting their health outcomes.

#### Segment 4: Existing Solutions in the Community

##### Purpose of this Segment

Participants discussed community-led actions that support health, illustrating the resilience and strength within the community.

##### Insights from the Conversation

Participants spoke highly of Beyond Housing’s support and described personal contributions to community health, such as sharing resources and helping those experiencing homelessness. One participant shared, “My son and I go downtown to feed the homeless and provide resources...we tell people where they can charge their phones and find shelter.”

Participants suggested that healthcare providers build on these grassroots efforts by holding regular health education sessions and creating a community calendar for health screenings and resources. Many felt these additions would provide consistent health engagement opportunities, especially for residents needing help seeking information.

#### Segment 5: Building on Community Strengths

##### Purpose of this Segment

This segment focused on leveraging community strengths to develop a more supportive healthcare system.

##### Insights from the Conversation

Participants emphasized the value of grassroots initiatives and suggested using high-traffic locations like schools and community centers to raise awareness of available health resources. Establishing peer support networks was another recommendation, as participants noted that these networks could foster accountability and strengthen bonds within the community. One participant reflected on the power of such outreach and recalled, “This reminds me of when my mom worked for Grace Hill, and they went door-to-door sharing information.”

Participants expressed a need for frequent, accessible health programming and outreach efforts. They believed consistent community health events could build trust and foster a positive relationship between residents and healthcare providers.

### Conversation Themes

During the community conversation with Beyond Housing, five main themes emerged that reflect the residents’ perspectives, concerns, and hopes regarding healthcare access and needs in their community. These themes provide a foundational understanding of the

systemic and personal challenges community members face and their ideas for building a more inclusive, supportive healthcare environment.

### 1. Holistic Community Health Needs

Residents envisioned a healthy community empowering its members through accessible resources and support systems. They stressed the importance of community-centered events, educational opportunities, and access to nutritious food as core components of health. Many participants expressed that health goes beyond physical care, including emotional support, connections with neighbors, and a strong sense of community.

### 2. Barriers to Accessing Healthcare

Participants identified several significant barriers to accessing healthcare, including financial strain, transportation limitations, and scheduling challenges. They highlighted how high co-pays and medication costs often force difficult trade-offs, while limited local healthcare options and long wait times exacerbate these obstacles. These logistical and financial hurdles make consistent healthcare access difficult for many residents.

### 3. Importance of Trust and Communication with Healthcare Providers

A strong theme in the conversation was the impact of feeling unheard or dismissed by healthcare providers. Many participants shared personal experiences where they felt disregarded or misunderstood during medical appointments, leading to a lack of trust in the healthcare system. Participants voiced a need for healthcare providers who listen, respond to their concerns, and approach care with empathy and respect.

### 4. Resilience through Community-Led Solutions

Despite numerous challenges, participants demonstrated resilience by creating and supporting community-led health initiatives. Residents actively contribute to community health by sharing resources, helping vulnerable individuals, and forming support networks. These grassroots actions reflect a strong culture of mutual aid within the community, suggesting a foundation upon which healthcare providers could build.

### 5. Strengthening Community Partnerships and Support Networks

Participants highlighted the potential for strengthening community health through collaborative partnerships with healthcare providers. They recommended creating peer support networks, establishing more visible healthcare resources in high-traffic areas, and holding regular health-focused events. By building on the community's strengths and forming closer partnerships, participants believe healthcare systems can foster a more accessible and trustworthy environment for all residents.

### Conclusion and Next Steps

The Beyond Housing community conversation highlighted pressing health needs and systemic barriers facing residents, including limited access to mental health resources, chronic health management, and the need for culturally competent care. Moving forward, the St. Louis Regional Health Collaborative has an opportunity to address these challenges by implementing culturally responsive training for providers, establishing local health access points, and expanding mental health resources. Engaging the community as active partners and providing regular updates on progress will be essential to ensuring that residents' voices continue to shape healthcare improvements.