Needs Assessment

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Executive Summary

The 2025 Compass Health Network Needs Assessment provides a comprehensive analysis of the health and behavioral health needs across its service areas in Missouri. Utilizing a mixed-methods approach, the assessment integrates quantitative data analysis with qualitative insights from interviews, focus groups, and stakeholder input to identify and prioritize the most pressing needs. The findings highlight significant disparities in health outcomes, access to care, and socioeconomic factors across different regions, with a particular focus on behavioral health, access to services, and underserved populations.

Key Findings

1. **Behavioral Health Needs**:
    - **High Demand Across All Regions**: Behavioral health services are in high demand, with long waitlists and a shortage of providers. The COVID-19 pandemic has exacerbated these needs, particularly in the ADAPT region, which reports higher rates of mentally unhealthy days.
    - **Youth Mental Health Crisis**: There is a growing need for mental health services for children and adolescents, especially in rural areas. The pandemic has worsened mental health issues among youth, with increased rates of anxiety, depression, and suicidal ideation.
    - **Substance Use Disorders**: Substance use, particularly opioid and alcohol use disorders, remains a significant concern. The ADAPT and Southern regions show higher rates of excessive drinking and substance use disorders.
2. **Regional Disparities**:
    - **ADAPT and Southern Regions**: These regions consistently show worse health outcomes across multiple indicators, including higher rates of premature mortality, smoking, teen births, uninsurance, and severe housing problems. The ADAPT region, in particular, faces significant challenges with mental health, substance use, and access to care.
    - **Eastern Region**: While generally reporting better health outcomes, disparities still exist, particularly in access to care and chronic disease management.
3. **Access to Care**:
    - **Uninsured/Underinsured Populations**: Many regions report that uninsured and underinsured individuals struggle to access services, particularly in rural areas where provider shortages are more pronounced.
    - **Rural Areas**: Rural populations face significant barriers to accessing primary care, behavioral health, and dental services due to transportation challenges and a lack of providers.
    - **Insurance Acceptance**: Difficulty finding providers who accept certain insurances, particularly in the Western region, further limits access to care.
4. **Specific Health Concerns**:
    - **Chronic Diseases**: Chronic conditions such as diabetes, hypertension, and obesity are prevalent across all regions, with higher rates in the Southern and ADAPT regions.
    - **Maternal and Child Health**: Differences in maternal and child health are evident, with varying rates of low birthweight across regions. The ADAPT region reports significantly higher rates of low birthweight infants.
    - **Oral Health**: Access to dental services, particularly for Medicaid patients, is a significant unmet need, with a lack of dental providers in many regions.

5. **Socioeconomic Factors**:
    - **Poverty and Housing Instability**: High rates of poverty, housing instability, and food insecurity, particularly in the Southern and ADAPT regions, significantly impact health outcomes.
    - **Education and Employment**: Lower educational attainment and higher unemployment rates in the ADAPT and Southern regions contribute to economic instability and limited access to healthcare resources.

Prioritized Needs and Recommendations

Based on the assessment, the following health and behavioral health needs are prioritized for action:

Tier 1: Critical and Immediate Needs

- **Expanding Access to Mental Health and Substance Use Services**: Increase provider capacity, expand tele-behavioral health, and develop crisis diversion units.
- **Affordable Housing Solutions**: Partner with housing authorities and nonprofits to develop housing-first programs and step-down units.
- **Transportation Solutions**: Collaborate with transit authorities and ride-sharing services to improve access to healthcare.
- **Chronic Disease Prevention and Management**: Implement community-based wellness initiatives and use telehealth for ongoing support.

Tier 2: High-Priority Needs

- **Youth and Transitional-Age Services**: Expand early intervention programs and school-based mental health services.
- **Dental Care Access**: Recruit and retain dental providers and implement oral health education programs.
- **High Quality Care**: Enhance competency training and recruit a talented and robust workforce.
- **Telehealth Expansion**: Promote and expand telehealth services to overcome geographic and transportation barriers.

Tier 3: Important but Less Immediate Needs

- **Food Security Initiatives**: Develop community gardens, nutrition education programs, and partnerships with local food banks.
- **Economic Stability Programs**: Invest in workforce development, job training, and financial literacy programs.
- **Staff Training and Retention**: Provide additional training for staff and implement retention strategies.
- **Prevention Services**: Expand prevention efforts, particularly for substance use, and focus on secondary and tertiary prevention programs.

The 2025 Compass Health Network Needs Assessment provides a data-driven roadmap for addressing the most pressing health and behavioral health challenges within its service area. By focusing on expanding access to care, addressing social determinants of health, and ensuring high quality services, Compass Health can significantly impact the health and well-being of the communities it serves. Long-term investments in healthcare infrastructure, workforce development, and community partnerships will be essential to sustaining these improvements and promoting overall community well-being.

Introduction to the 2025 Compass Health Network Needs Assessment

Background and Definitions

Needs assessments are essential tools used by health service organizations to better understand and address the needs of their communities. These assessments are referred to by various names, including "needs assessment," "health needs assessment," "community health needs assessment," and "health care needs assessment." While the terminology may differ, the core purpose remains consistent: to identify health priorities, allocate resources effectively, and improve community well-being. Below are some key definitions that highlight the scope and intent of these assessments:

- **National Institute for Clinical Evidence** (UK):
  A systematic method for analyzing the health issues affecting a population, leading to agreed-upon priorities and resource allocation aimed at improving health outcomes.
- **Manitoba Community Health Needs Assessment**:
  A dynamic, ongoing process designed to identify community strengths and needs, establish shared priorities, and foster collaborative action planning to enhance community health status and quality of life.
- **Health Needs Assessment** (BMJ):
  A systematic approach to ensuring that health resources are used efficiently to maximize improvements in population health.

These definitions underscore the importance of needs assessments as strategic, community-focused processes that drive meaningful change in health care delivery and outcomes.

Why Do a Needs Assessment?

Evidence-Based Insights

Understanding the needs of customers is critical for any organization. In sectors like health care, education, and community services, needs assessments are routinely conducted to identify "real needs"—those that align with specific definitions or criteria relevant to the industry. These assessments operate on the premise that certain common needs exist within a group of patients or customers, and these needs can—and should—be proactively addressed by primary care, oral health care, and behavioral health practices. The term *proactive* is key here: it signifies an approach that goes beyond merely reacting to individuals as they seek services. Instead, a proactive approach involves identifying shared needs and implementing strategies to address them efficiently and effectively.

Future-Focused Planning

While health care providers rely on clinical guidelines and tools to assess the needs of individual patients, evaluating the needs of entire populations or service areas is a more complex undertaking. Preparing for the future requires recognizing that the patients who walk through Compass's doors today—or the issues

demanding immediate attention—may not reflect the long-term health needs or emerging opportunities for improvement in the communities we serve. Needs assessments enable us to look beyond the present and plan for the evolving health landscape.

Anticipating Demographic and Community Changes
The regions served by Compass are in a constant state of flux. Demographic shifts and population growth are reshaping the demand for services, challenging our current capacity. To remain responsive and effective, we must anticipate and prepare for the changing needs of our communities three to five years into the future. Needs assessments provide the foresight required to adapt and thrive in this dynamic environment.

Meeting Accreditation and Certification Requirements
Accreditation standards, such as those set by CARF, SAMHSA, HRSA, and the IRS's requirements for hospitals, require organizations to establish a systematic, ongoing process for assessing needs, engaging stakeholders, and integrating their feedback into strategic planning. Conducting regular needs assessments ensures compliance with these standards while also fostering a culture of continuous improvement and accountability. See Appendix D for a crosswalk of the needs assessment criteria of various agencies incorporated herein.

The Compass Health Needs Assessment Process

The Compass Health Needs Assessment process follows a structured, step-by-step approach established and approved by executive leadership and a Needs Assessment Steering Committee. Each step is designed to ensure a comprehensive understanding of community needs and to guide strategic decision-making. The process includes the following steps:

Step 1: Define the Community
Defining the community is a critical first step, as it sets the scope for the assessment and subsequent interventions. For Compass, the community is defined by its service area, which includes six internally designated regions—now expanded to include Jefferson County as a standalone region.

Step 2: Identify and Engage Stakeholders
Engaging a stakeholders is essential to capturing a holistic view of community needs. Compass involved both internal and external stakeholders, including leadership, Boards of Associates, customers, and other community representatives. This engagement was achieved through internal meetings, surveys, focus groups, and other collaborative efforts.

Step 3: Collect, Compile, and Analyze Data
This step involves gathering and analyzing both primary data (collected directly by Compass) and secondary data (existing or archival data from other sources). The data includes qualitative insights from patient and community perspectives—gathered through surveys, interviews, and focus groups—as well as quantitative findings. Together, these data provide a comprehensive picture of (a) existing and emerging health and behavioral health needs, and (b) the assets and resources available to address them.

Step 4: Select Priority Needs and Community Health Issues
Using the data compiled in Step 3, Compass identified and prioritized the most pressing community

health needs. While quantitative data highlights the scope and severity of specific issues, qualitative input from stakeholders adds context and urgency, ensuring that the prioritization reflects both data-driven insights and community voices.

Step 5: Document and Communicate the Needs Assessment
The final step involves documenting the findings in this needs assessment report, which will inform Compass Health Network's strategic planning process. This report serves as a foundation for aligning resources, programs, and initiatives with the identified priorities to improve community health outcomes.

Sections of the Report

The remainder of this report comprises the following sections:

- A review of background, prevalence and trends (focused on behavioral health) with relevance to strategic planning for Compass Health Network.
- A socio-demographic and health status overview of Compass Health service area, including statistical comparisons by region, and a demographic analysis of Compass customers compared to regional populations.
- Thematic interview results showing needs identified by Compass Health directors, senior managers, and executives
- Thematic interview results of community stakeholder and partners input: a survey of needs identified by Missouri Division of Behavioral Health, Missouri Behavioral Health Council. Missouri Hospital Association, Missouri Primary Care Association, and regional community leaders
- Needs identified by clients through focus group findings and structured needs assessment of customers with SMI
- Prioritized population health needs across Compass Health regions drawn from community health needs assessments
- Conclusion: prioritized needs to guide strategic planning

Literature Review: Background, Prevalence, and Trends Relevant to Compass Health Network Needs Assessment and Strategic Planning

This chapter will provide essential background and context from national, state, and local literature sources, with a particular focus on behavioral health. We will outline a range of known or emerging issues with clear relevance to strategic planning for health and behavioral health services, including: (1) transportation and public health, (2) unhoused populations and mental health, (3) jail to community pipeline model, (4) best practices for supportive housing and supported community living for individuals with mental illness in the U.S., (5) nutrition and encouraging healthy eating, and (6) social and political changes on health.

Transportation & Public Health

According to the CDC 1/3 of adults and 17% of young people in the United States are obese. Many people have associated some of the obesity epidemic in the United States to a lack of physical activity including a severe lack of active transportation options (like bicycling and walking) that are safe and reliable. The main reason for unsafe active transportation is the speed and amount of traffic in the areas. The US Department of Transportation has published findings on the impact of transportation options on public health. Active transportation is a good way to prevent chronic diseases for many Americans (Active transportation and health, 2024). The CDC found that 150 minutes of light exercise per week can dramatically reduce the likelihood of chronic diseases later in life (Adult activity: An overview, 2023). Older adults and people with disabilities are especially at risk of having limited access to education, employment, and opportunities for recreation.

Transportation in rural Missouri is a necessity and primarily relies on personal motor vehicles due to the geographic distance between individual's homes and their places of work, food resources, education facilities, places of worship, and healthcare facilities. While some options are available in the more urban counties of Missouri, the rural counties have very few alternatives to owning and operating a personal automobile (Transportation and Health in rural Missouri, 2018).

The Missouri Times in 2021 published a Q&A with Kimberly Cella about the state of public transportation in Missouri. Cella stated that in 2020 and 2021 the state of Missouri spent $1.7 million on public transportation that was then spread to 34 separate agencies across the state. The money made up less than 1% of their annual budgets. On a per capita basis, Missouri ranks 45th of all states on public transportation spending, amounting to about 28 cents per capita. One final issue facing public transportation in Missouri is the employee shortage. While this is an issue facing many fields currently, without sizable financial investment there seems to be no end in sight for public transportation's employee shortage. Despite the woes of public transpiration in Missouri, the industry does help generate $3.6 billion directly and indirectly in economic returns.

The rural counties of Missouri also face increased and increasing transportation issues in the healthcare industry. Healthcare worker shortages have led to larger distances that need to be travelled in order to meet healthcare needs. While telehealth has alleviated some of the need to travel, in-person services are

still needed in many fields. In 2018 much of rural Missouri was designated as a Health Professional Shortage Area (HPSA) meaning the ratio of population to healthcare workers falls below a specified level. There are 101 rural counties in Missouri and of those, 99 are medical HPSAs, 97 are mental HPSAs, 95 dental HPSAs (Transportation and Health in rural Missouri, 2018). Improving transportation options and bringing necessary medical, mental, and dental care must be top priorities to improve the health of Missouri communities.

Improving public transportation in Missouri will not be easy because of the rurality and geographic nature of the state. However, some general priorities for that transportation are The MOBILIZE Learning Lab published the findings of a group of researchers on what were the most important characteristics of good public transportation. Their results follow:

- Must have significant public investment and public oversight
- Service must be good and reliable for widespread usage
- Transportation must be built on the needs of the public and community
- Must communicate the ongoing information needs efficiently
- Data must be at the center of informing and improving
- Must work hand in hand with area land usage and management

Unhoused Populations and Mental Health

Homelessness remains a pressing issue across the United States, with a significant proportion of unhoused individuals experiencing severe mental health challenges. According to the U.S. Department of Housing and Urban Development, over 770,000 people experienced homelessness on a single night in January 2024, an 18% increase from 2023 (Casey, 2024). Likewise, a portion of the population reports having mental health conditions such as depression, PTSD, and substance use disorders. In Missouri, these challenges are compounded by regional disparities in housing and mental health resources. As of 2023, Missouri had over 6,000 individuals experiencing homelessness, with higher concentrations in urban areas like St. Louis and Kansas City (Sanchez, 2024). Mental health conditions and co-occurring substance use disorders are prevalent, reflecting national patterns.

In Southern Missouri, homelessness is often associated with extreme rural poverty and the absence of mental health services. Many rural counties in this region lack shelters, forcing individuals to travel long distances to find assistance. Limited employment opportunities and the opioid crisis have further exacerbated the situation, increasing the number of individuals who experience chronic homelessness. Community-based initiatives and faith-based organizations provide some relief, but long-term solutions remain scarce. According to the Cicero Institute, homelessness in Missouri is evolving due to policy gaps, making it crucial to implement targeted solutions that account for rural community needs (Kurtz, 2024).

Eastern Missouri's rural counties also face significant homelessness challenges, particularly in areas outside of St. Louis. Many unhoused individuals in these regions are displaced due to economic instability and a lack of affordable housing. According to Empower Missouri, recent policies that criminalize sleeping in public spaces have made it even more difficult for unhoused individuals in rural areas to access critical services. The criminalization of homelessness disproportionately affects rural

communities where alternative housing solutions are scarce (Sanchez, 2024). Unlike in urban centers, rural communities often lack outreach teams and emergency shelters, leaving residents with few options.

In Western Missouri, many rural counties struggle with hidden homelessness, where individuals stay temporarily with family or friends rather than in shelters. The lack of public transportation makes it difficult for those experiencing homelessness to access resources, forcing them into more precarious living situations. While Kansas City has several initiatives aimed at tackling homelessness, surrounding rural counties often see less investment in emergency housing and mental health services. Additionally, Empower Missouri points out that restrictive policies and a lack of tenant protections exacerbate homelessness in these areas, making it harder for individuals to secure stable housing. The Cicero Institute highlights how a lack of affordable housing and employment instability in these rural areas contributes to the growing homelessness crisis.

Central Missouri's rural areas, including counties surrounding Columbia and Jefferson City, present a unique challenge where unhoused populations often go unnoticed. With few homeless shelters available, many individuals resort to living in cars, abandoned buildings, or makeshift encampments. The presence of universities, such as the University of Missouri, has led to some collaborative efforts to address homelessness, but rural counties still lack sufficient funding and mental health resources to meet demand.

Future Implications

The intersection of homelessness and mental health is driven by factors such as limited access to affordable housing, inadequate mental health care, and the effects of trauma and poverty. In Missouri, economic challenges, limited affordable housing options, and inadequate mental health infrastructure exacerbate the issue. Additionally, the state's opioid crisis has further strained resources, disproportionately affecting those experiencing homelessness.

If homelessness in Missouri remains unaddressed, the state will likely see continued challenges in health outcomes and economic mobility. Without significant investment in rural housing-first initiatives and expanded mental health services, unhoused individuals will continue to struggle with instability. Policy changes that focus on rural-specific solutions, such as mobile outreach services and increased funding for transitional housing, could significantly improve conditions in these areas. Addressing the criminalization of homelessness through policy reform, as Empower Missouri suggests, could also provide more opportunities for long-term recovery and housing stability. Furthermore, the Cicero Institute warns that failure to address rural homelessness will lead to greater economic strain on local governments, emphasizing the need for sustainable housing policies.

Jail to Community Pipeline

The intersection of mental health issues, substance use disorders, and incarceration has been extensively studied, revealing significant insights into the pathways leading individuals from community settings to correctional facilities.

Prevalence of Mental Health and Substance Use Disorders in Incarcerated Populations

A substantial proportion of incarcerated individuals in the United States suffer from mental health disorders. Studies indicate that approximately 50% to 75% of youth entering juvenile detention centers meet the criteria for a mental health disorder (Kaneda, 2019). Similarly, a significant number of adult inmates have been diagnosed with mental illnesses, with some reports suggesting that up to 4% of the prison population has schizophrenia, a rate higher than that in the general population (Financial Times, 2024). Substance use disorders are also prevalent among incarcerated populations. Research has documented that drug users in the general population are more likely than non-users to commit crimes, often linked to motivations such as obtaining money to support drug use or being exposed to environments that encourage a deviant lifestyle (Institute for Social Research, 2011).

Pathways from Community Settings to Incarceration

Several factors contribute to the increased likelihood of individuals with mental health and substance use disorders becoming involved with the criminal justice system:

- **Deinstitutionalization**: The closure of state mental hospitals without adequate community-based mental health services has resulted in individuals with serious mental illnesses lacking proper care, increasing their risk of incarceration.
- **School-to-Prison Pipeline**: Punitive disciplinary policies in schools disproportionately affect students with mental health issues, leading to higher dropout rates and subsequent involvement with the criminal justice system (Mallett, 2015).
- **Inadequate Community Support**: Limited access to mental health and substance use treatment in the community leaves many individuals without necessary care, increasing the likelihood of encounters with law enforcement (Fisher, 2023).

Interventions and Models for Diversion

To address these issues, various models and interventions have been proposed:

- **Sequential Intercept Model (SIM)**: This framework identifies points ("intercepts") at which individuals with mental health disorders can be diverted from the criminal justice system to community-based services, aiming to prevent deeper system involvement.
- **Holistic Defense Models**: Integrating legal representation with social support services addresses underlying issues such as addiction, homelessness, and mental health, aiming to reduce recidivism and improve outcomes for individuals involved in the criminal justice system (Baksi, 2024).

Challenges and Considerations

Despite these interventions, challenges remain:

- **Resource Limitations**: Many correctional facilities lack adequate funding and resources to provide comprehensive mental health and substance use treatment (Fisher, 2023).
- **Stigma and Misunderstanding**: Individuals with mental health disorders often face stigma, leading to misinterpretation of symptoms as noncompliance or criminal behavior, resulting in punitive responses rather than therapeutic interventions.

- **Policy and Barriers**: Issues, such as policies that prioritize incarceration over treatment and lack of coordination between mental health services and the criminal justice system, hinder effective intervention (Onah, 2018).

Addressing the incarceration of individuals with mental health and substance use disorders requires a multifaceted approach, including policy reform, increased funding for community-based services, and the implementation of diversion programs that prioritize treatment over incarceration.

Best Practices for Supportive Housing and Supported Community Living for Individuals with Mental Illness in the U.S.

Supportive housing and supported community living are critical components of mental health care systems, offering stable housing and wraparound services to individuals with mental illness. Research highlights several best practices that have been effective across the U.S.:

1. Housing First Model

The Housing First approach prioritizes providing permanent housing without preconditions (e.g., sobriety or treatment compliance). Studies show it reduces homelessness, hospitalizations, and emergency service use while improving mental health outcomes (Tsemberis et al., 2004; Padgett et al., 2016). This model is cost-effective and aligns with recovery-oriented care principles.

2. Integrated Services

Effective programs integrate mental health care, substance use treatment, and primary care within housing settings. Co-locating services improves access and continuity of care, leading to better health outcomes (Druss et al., 2018). Case management and peer support are also key components.

3. Person-Centered and Recovery-Oriented Care

Programs that emphasize individualized care plans and recovery goals foster greater autonomy and engagement. Peer support specialists, who have lived experience with mental illness, are particularly effective in promoting recovery (Davidson et al., 2012).

4. Community Integration

Successful programs focus on helping residents build social connections and access community resources. This includes vocational training, educational opportunities, and recreational activities (Wong & Solomon, 2002).

5. Trauma-Informed Care

Many individuals with mental illness have experienced trauma. Trauma-informed approaches create safe environments and address trauma-related needs, improving outcomes (Hopper et al., 2010).

6. Cross-Sector Collaboration

Partnerships between housing providers, mental health agencies, and government entities are essential for funding and service coordination. Collaborative efforts like the Affordable Care Act's Medicaid expansion have increased access to supportive housing (Mancuso & Charlifue-Smith, 2018).

Implications for Strategic Planning

1. Adopt Evidence-Based Models: Prioritize permanent housing as a foundation for recovery.
2. Integrate Services: Co-locate mental health, primary care, and substance use services within housing programs.
3. Leverage Peer Support: Incorporate peer specialists to enhance engagement and recovery.
4. Promote Community Integration: Provide access to vocational, educational, and social opportunities.
5. Implement Trauma-Informed Practices: Train staff to recognize and address trauma.
6. Foster Collaboration: Build partnerships across sectors to secure funding and streamline services.

Nutrition and Encouraging Healthy Eating

Access to Nutritious Foods

Proper nutrition is a significant public health challenge in the United States, affecting millions of households. Factors such as income differences, geographic barriers, and inflation have heightened food insecurity, leaving many without consistent access to healthy meals. According to the U.S. Department of Agriculture (USDA), 10.2% of American households (13.5 million) experienced food insecurity in 2021. Among these, 3.8% experienced very low food security, meaning that household members regularly skipped meals or ate less than needed due to financial constraints (Rabbitt et al., 2023). The Consumer Price Index (CPI) for food rose 10.4% in 2022, driven by increases in the prices of fresh fruits, vegetables, and lean proteins. This trend continued into 2023, exacerbating financial strain for low-income families reliant on federal assistance programs. Food deserts, defined as areas where residents lack access to affordable, nutritious food within a reasonable distance, disproportionately affect low-income neighborhoods. Residents in these areas were 20% less likely to live near a grocery store compared to higher-income populations. Poor dietary habits linked to food insecurity have contributed to a surge in diet-related illnesses. Trust for America's Health reported in 2023 that 42% of American adults were classified as obese, with low-income households disproportionately affected. Food-insecure children face developmental delays, poor academic outcomes, and higher risks of chronic conditions like diabetes and hypertension. As of 2023, nearly 42 million Americans participated in SNAP, which aims to alleviate food insecurity by providing monthly benefits. However, the average benefit of $6.10 per person per day often falls short of meeting the cost of a nutritious diet. Temporary expansions during the COVID-19 pandemic allowed free school meals for all students, though many districts reverted to income-based eligibility in 2023. Advocacy for reinstating universal free school meals continues to grow.

In Missouri, the issue is particularly pronounced, with high rates of food insecurity and limited access to fresh, affordable produce in rural and urban communities alike. In 2021, 11.2% of households experienced food insecurity. Rural areas and urban centers like St. Louis and Kansas City face the most severe challenges, according to Feeding America's "Map the Meal Gap" report (2023). Approximately 20% of rural Missourians live in food deserts, while St. Louis County alone accounts for more than 50

food deserts. Even more, the Missouri Department of Health and Senior Services reported in 2024 that nearly 35% of adults in the state are obese, with low-income households bearing the greatest burden. However, all hope is not lost. Organizations like the Missouri Food Bank Association distributed over 120 million meals statewide in 2022, supporting families in both rural and urban areas. Additionally, the Food Bank for Central and Northeast Missouri provided over 22 million meals across its service area in 2023, reflecting a significant rise in demand for food pantries (Sharing Food Bring Hope, 2024). In 2025, the challenges of food insecurity persist amid economic uncertainty, inflation, and the lingering effects of the COVID-19 pandemic. Nationally and in Missouri, solutions must focus on increasing access to affordable, nutritious food through policy reforms, local initiatives, and federal support. Expanding SNAP benefits, enhancing food bank networks, and addressing food deserts are critical steps to improve health through access to healthy meals for all Americans.

Efforts to Encourage Health Eating

Promoting healthy eating remains a public health priority as diet-related illnesses such as obesity, diabetes, and cardiovascular diseases continue to rise. Efforts to encourage healthy eating have expanded in recent years, with strategies ranging from policy interventions to community-based programs. These initiatives aim to improve access to nutritious foods, increase awareness about healthy eating, and address the barriers that limit dietary choices.

1. **Policy Interventions**:
    - **Expansion of SNAP Benefits**: The Supplemental Nutrition Assistance Program (SNAP), serving over 42 million Americans as of 2023, has included financial incentives for purchasing fruits and vegetables. Research from the USDA in 2022 showed that SNAP participants using these incentives increased their fruit and vegetable intake by 26%.
    - **Nutrition Standards for Schools**: The National School Lunch Program provided meals to over 30 million children annually, with updated nutrition standards emphasizing whole grains, low-fat dairy, and reduced sodium (USDA, 2025).
    - **Food Labeling**: The FDA proposed updates to front-of-package labeling aim to make nutritional information clearer, encouraging consumers to choose healthier products. Early studies suggest such labels increase healthy purchases by up to 10% (2025).
2. **Public Awareness Campaigns**:
    - **MyPlate**: Introduced by the USDA, MyPlate continues to educate Americans on balanced eating. In 2023, the program reached 15 million people through workshops and online resources, emphasizing portion control and nutrient-rich foods (USDA).
3. **Community-Based Programs**
    - **Farmers' Markets:** The number of farmers' markets in the U.S. increased by 30% between 2015 and 2023. Programs like Double Up Food Bucks, which match SNAP spending at farmers' markets, have boosted access to fresh produce for low-income families (Fair Food Network, 2024).

- **School and Community Programs:** Farm-to-school programs connect local farmers with schools to supply fresh produce for student meals. As of 2023, over 67% of U.S. school districts participated, reaching nearly 42,000 schools nationwide (USDA, 2023).
- **Food Pantries**: In 2020, 6.7% of U.S. households reported using a food pantry, an increase from 4.4% in 209. In 2021, 53 million people (a one third increase compared to pre-pandemic figures) sought assistance from food banks, food pantries, and meal programs. By 2022, one in six Americans relied on hunger relief programs (Feeding America, 2022).

Social and Political Changes in Health

Missouri, like many states, is constantly under political and social pressures to change and adapt to the needs of its citizens. Tracking these changes can help to understand the context of the healthcare challenges facing residents of the state.

Medicaid expansion was voted into the Missouri Constitution in August of 2020 and after a brief legal battle was upheld as constitutional and enacted in the following year. The expansion helped many people with no other insurance and limited income gain access to funding for healthcare they would not have otherwise been able to afford (MO DSS). Medicaid expansion allowed for the coverage of an estimated 275,000 Missourians. It also cost the state very little in funding because for the first three years after expanding Medicaid, the Affordable Care Act would cover the costs and after that the fund matching is 9:1 (Challa, 2021). As of April 2024, 333,801 individuals in the Adult Expansion group (AEG) were enrolled in Medicaid (Mcbride, 2024).

Despite a heretofore unseen increase in Medicaid enrolled individuals, a study published in *The American Journal of Managed Care* reported that 70% of respondent agencies had capacity to take on more clients. There was no evidence found in the survey results that there were significant differences in large metropolitan areas compared to the rest of the state (Haselswerdt, 2024). Missouri saw a peak enrollment in Medicaid of 1.5 million individuals in April 2024, but those numbers recently saw a decline of 13% to 1.32 million in June 2024. Interestingly 56% of those who lost coverage were children despite children having lower requirements to be enrolled in Medicaid than adults (McBride, 2024). One thing is certain, Medicaid expansion in Missouri and its ramifications are going to play major factors in the health of Missourians for years to come.

Missouri has some social factors that also affect the health outcomes of its citizens. According to the americashealthrankings.org 2023 Annual Report, the following factors are the most negatively impactful to Missouri health outcomes.

- Exercise (45th)
- Smoking (44th)
- Adverse Childhood Experiences (34th)
- Homicide (45th)
- Fruit and Vegetable Consumption (45th)

The year 2024 saw one of the most stressful elections of many people's lives. An APA survey of respondents from 2024 found that 77% of U.S. adults were significantly stressed by the future of the Nation. The research shows stress surrounding politics is getting worse. The same survey found that 69%

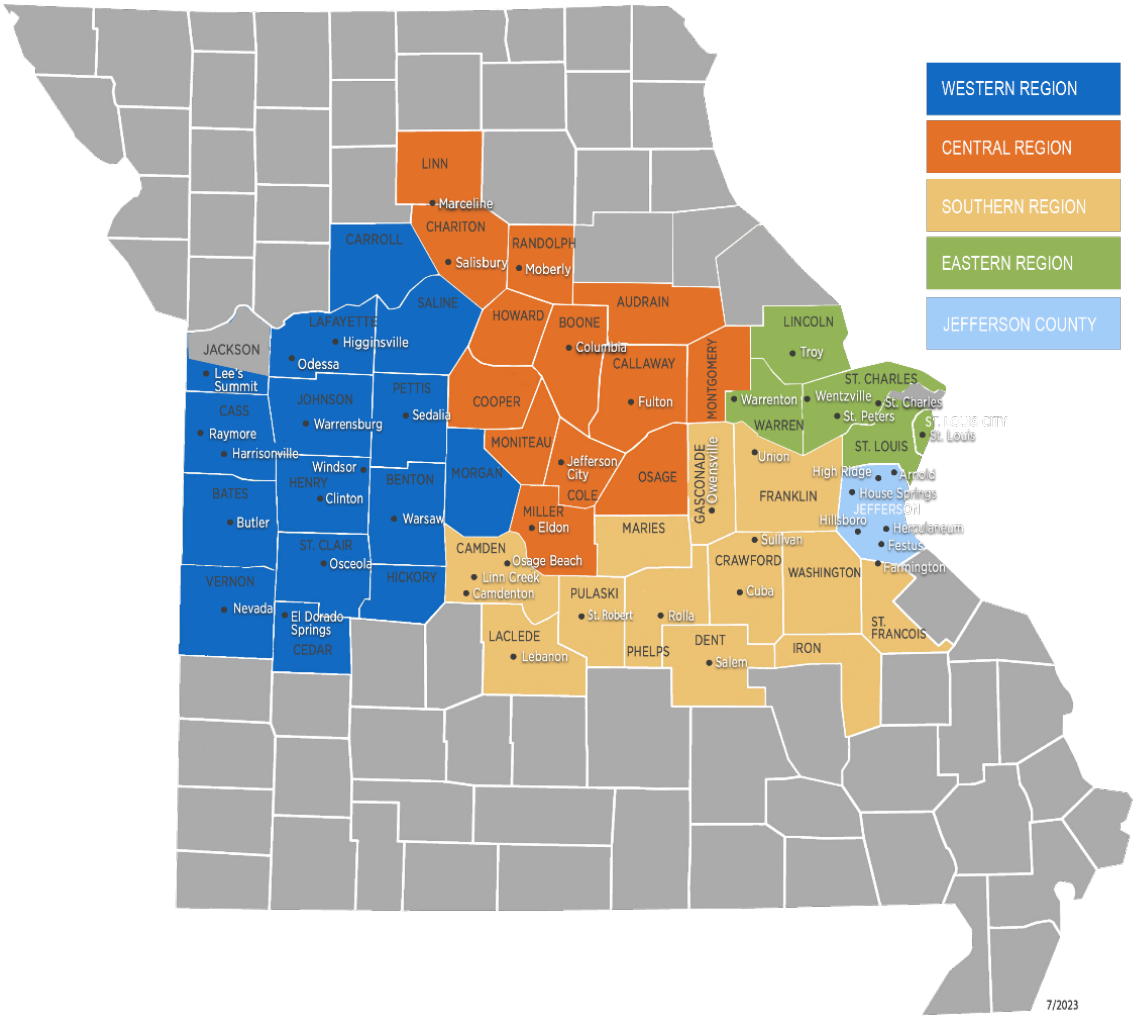
of adults had significant stress around the presidential election, up from 52% in 2016. The survey also found Americans are concerned about the future of their country with 74% worried that the election results could lead to violence (Abrams, 2024).

Brett Ford, PhD, associate professor of psychology at the University of Toronto makes the case that politics is a form of chronic stress for many people. Like other forms of chronic stress, it not only harms our psychological well-being, but it also takes a toll on our physical health. In both national surveys and diary studies, respondents report politics and/or political events are affecting sleep, tempers, obsessive thoughts, emotional reactivity, and worsening physical health (Abrams, 2024). The trends of political stress are consistent across the political spectrum as well. For conservatives, liberals, and moderates, alike, on a day-to-day basis the ups and downs of partisan politics are taking a toll on everyone. Although the effects are impacting people across all ages, politics, and races, there are trends for those who are most at risk of negative effects. Younger people and liberals are both consistent predictors of being more affected. People with politics as an interest or hobby are also more likely to be impacted. One final group most likely to be negatively impacted are partisans who are particularly distrustful of their political opposites, meaning conservatives who are distrustful of liberals and vice versa (Mils & Payne. 2024).

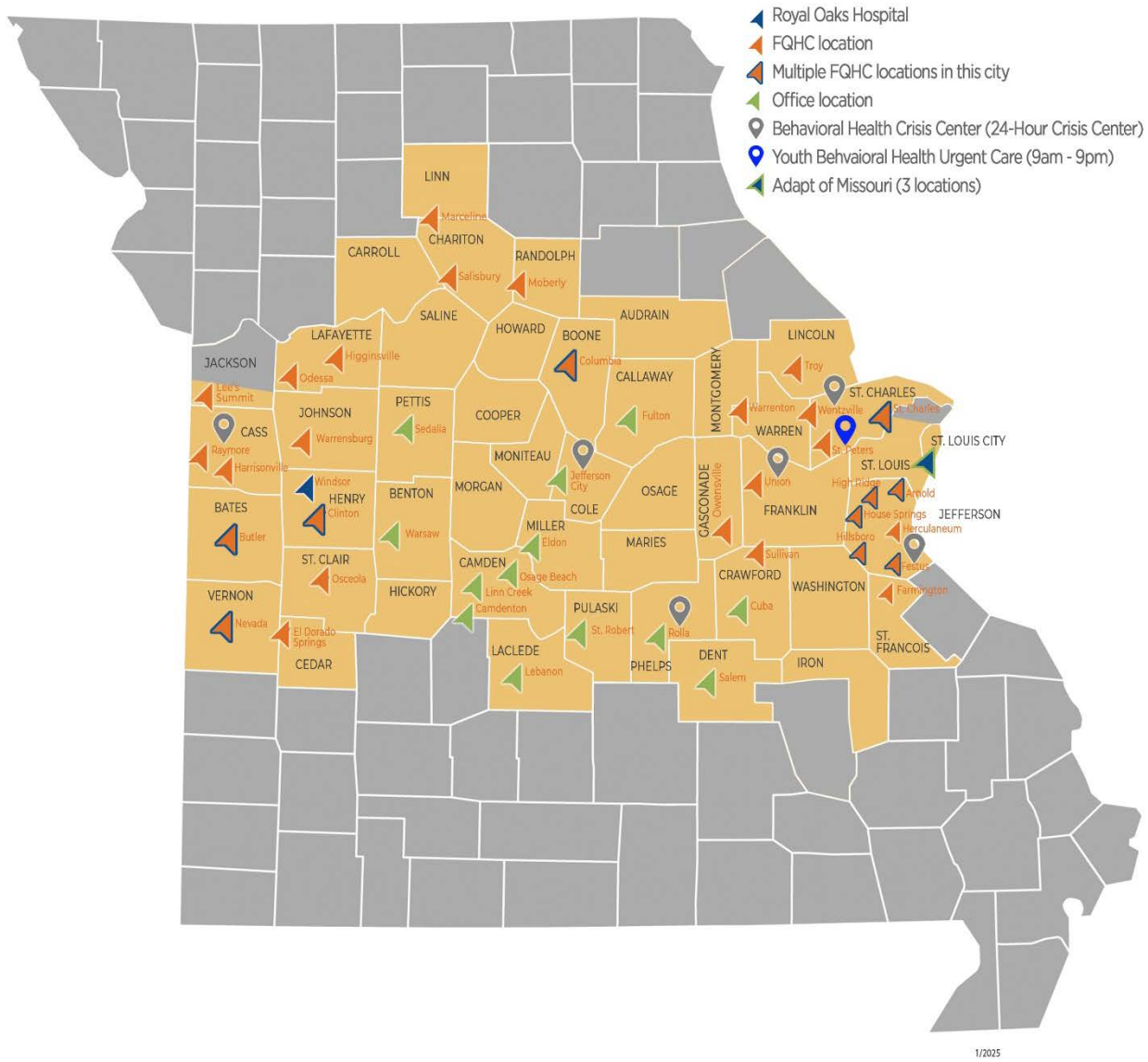
Along with the political divide comes mistrust of public health agencies that are trying to keep citizens as healthy as possible. The only solution for division is trust according to Kai Ruggeri, professor at Columbia University Mailman School of Public Health. Polarization, the movement of an individual or group away from the ideological center and towards ideological extremes, in either direction, is strongly correlated with the decrease in their physical and mental health (Devitt, 2024). It is important to note that with any political leadership changes, the downstream implications will be varied, widespread, and take time to analyze.

Sociodemographic and Health Status Overview of Compass Health Service Areas

This section provides an overview and analysis of important sociodemographic, health status, health outcomes, and health risk factors, drawn primarily from County-by-County Health Rankings to paint a data-based picture of potential existing and emerging health needs in the Compass Health service area (see Appendix A for a "data dictionary" and references to better understand the source materials for the tables starting on the next page). For purposes of this assessment, the 45-county and St. Louis City Compass Health service area was analyzed by county according to Compass Health's internal designation of geographic/programmatic areas, including ADAPT (St. Louis City), Central, Eastern, Jefferson County, Southern, and Western Missouri regions (please see the basic service area map for Compass Health Network below). For the purposes of this analyses, St. Louis County falls under the data for the eastern region while ADAPT is represented by St. Louis City data. The analyses described in this chapter allow for regional comparisons and enrich our understanding of "hot spots" and emerging needs.



Please note that beginning with the current (2025) needs assessment process, Royal Oaks Hospital will be considered in an ancillary fashion herein but will be the focus of its own independent Community Health Needs Assessment (CHNA) process (due end of calendar year 2025), done in accordance with criteria established by the IRS for non-profit hospitals. This process for Royal Oaks will be conducted contemporaneously with the Compass systemwide needs assessment every two years (exceeding the minimum IRS criterion of every three years) and the resultant report will be published following dissemination of the Compass systemwide needs assessment report. Please see the service area map below for a better view of the expanse and complexity of Compass Health Network's presence in Missouri at present:



Description and Analysis of Compass Health Regions

The indicators selected for this profile were chosen after a compilation process from multiple sources (see Appendix A), yielding several hundred potential indicators. That field was sifted through and windowed down to a manageable and meaningful set of indicators most predictive of, or related to, length of life, quality of life, health risk, and social determinants of health. The tables beginning on page 28 present all selected indicators averaged or tabulated across the Compass regions (i.e., county level data are the individual unit of analysis). All indicators were subjected to a one-way analysis of variance (i.e., ANOVA, using SPSS statistics software) by region, whereupon any indicator showing statistically significant differences between regions (meaning the differences are unlikely to be attributable to chance or random error, using a significance level of .05) were further analyzed to determine where any significant differences occurred. A look at the tables below (beginning on the next page) indicates the following differences across regions, which may suggest the need for targeted approaches to better understand and address the identified concerns:

Health Indicators and Sociodemographic Profile of Compass Regions

	Missouri	Central	Western	Southern	Eastern	ADAPT	Jeff Co
Quality and Length of Life							
Premature death (years of potential life lost rate)	9,478	8,371	9,705	11,721	8,330	14,717	9,663
Poor or fair health	16.0%	17.5%	19.4%	19.5%	15.3%	20.2%	15.8%
Poor physical health days	3.7	4.1	4.3	4.4	3.7	4.3	3.9
Poor mental health days	5.2	5.3	5.5	5.5	5.1	6.2	5.3
Low birth weight	9.0%	7.6%	7.5%	8.7%	8.3%	12.7%	8.0%
Health Behaviors							
Adult smoking	18.0%	20.5%	22.5%	22.9%	17.6%	20.3%	19.5%
Adult obesity	38.0%	38.6%	39.3%	39.5%	38.8%	36.5%	37.3%
Food environment index	6.9	7.8	7.2	7	8.5	7.5	7.9
Physical inactivity	24.0%	26.3%	28.1%	28.9%	23.6%	26.6%	24.6%
Access to exercise opportunity	77.0%	55.4%	53.4%	62.3%	77.0%	98.2%	72.7%
Excessive drinking	19.0%	17.2%	16.2%	16.6%	19.2%	19.3%	17.7%
Sexually Transmitted Infection (Chlamydia)	517.4	330.2	310.8	252.4	355.2	1246.1	574.0
Teen births	20	20	25	27	15	29	16
Clinical Care Factors and Availability							
Uninsured	11%	12%	14%	14%	9%	13%	10%
Primary care physicians	1421:1	4529:1	3505:1	1316:1	7013:1	1033:1	3927:1
Dentists	1596:1	3716:1	3309:1	3196:1	3277:1	1500:1	2364:1
Mental health providers	406:1	2391:1	1241:1	1025:1	864:1	187:1	960:1
Preventable hospital stays	3,016	2,699	2,718	3,175	2,874	4,050	3,238
Mammography screening	45%	44%	40%	40%	47%	38%	47%
Flu vaccinations	45%	43%	36%	33%	51%	46%	51%
Social & Economic Factors							
High school graduation	91%	90%	89%	88%	92%	90%	91%
Unemployment	2.5%	2.3%	2.7%	2.9%	2.4%	3.1%	2.4%
Children in poverty	17%	16%	21%	20%	11%	33%	10%
Income inequality	4.5	4.2	4.2	4.4	4.0	6.1	3.7

	Missouri	Central	Western	Southern	Eastern	ADAPT	Jeff Co
Children w single parents	24%	19%	20%	21%	22%	47%	23%
Social associations	11.4	12.5	12.0	12.6	7.8	14.3	7.5
Injury deaths	100	78	100	114	99	184	129
Severe housing problems	13%	10%	12%	12%	11%	20%	10%
Other Health and QOL Indicators							
Frequent physical distress	12%	12%	13%	14%	11%	13%	12%
Frequent mental distress	17%	18%	19%	19%	16%	18%	17%
Diabetes prevalence	10%	10%	11%	11%	9%	13%	9%
HIV prevalence	252	150	122	114	152	1074	101
Food insecurity	12%	11%	13%	14%	9%	14%	10%
Limited access to healthy food	7%	6%	9%	9%	4%	4%	8%
Drug Overdose mortality	30	18	16	49	34	93	49
Motor vehicle crash death rate	16	17	23	22	16	17	18
Insufficient sleep	34%	33%	35%	35%	33%	36%	35%
Clinical Care							
Uninsured adults	13%	14%	17%	16%	11%	15%	12%
Uninsured children	6%	7%	8%	8%	6%	4%	5%
Social & Economic Factors							
Disconnected youth	7%	5%	14%	12%	9%	9%	5%
Median household income	$64,873	$61,201	$56,151	$54,941	$82,701	$52,278	$78,297
Residential segregation black/white	71	51	47	67	50	63	65
Homicides	11	5	9	7	6	49	4
Suicides	19	23	22	23	18	13	25
Firearm fatalities	22	23	19	21	16	56	19
Demographics							
Population	6,177,957	445,681	1,122,119	445,363	1,504,632	286,578	229,336
% below 18 years of age	22.1%	22.2%	22.0%	21.3%	23.0%	18.0%	22.4%
% 65 and older	18.0%	19.1%	21.7%	20.1%	17.4%	18.0%	16.8%
% Non-Hispanic Black	11.5%	4.2%	3.5%	2.3%	8.8%	43.3%	1.3%
% Amer Indian and Alaska Native	0.6%	0.6%	0.8%	0.8%	0.4%	0.3%	0.3%

	Missouri	Central	Western	Southern	Eastern	ADAPT	Jeff Co
% Asian	2.3%	1.0%	0.8%	1.0%	2.3%	3.7%	0.9%
% Native Hawaiian/Other Pacific Islander	0.2%	0.1%	0.3%	0.1%	0.1%	0.0%	0.0%
% Hispanic	4.8%	2.7%	4.6%	3.2%	3.4%	4.5%	2.4%
% Non-Hispanic white	78.4%	89.7%	88.1%	90.9%	83.2%	45.8%	93.4%
% Not proficient in English	0.83%	0.36%	0.71%	0.29%	0.45%	1.45%	0.30%
% Females	50.55%	49.26%	49.84%	48.66%	50.35%	51.47%	49.85%
% Rural	30.5%	72.1%	70.3%	72.3%	38.1%	0.0%	34.8%

Narrative Summary of Regional Differences Across All Health and Demographic Indicators

The statistical analysis identified significant regional differences across numerous health and demographic indicators, highlighting disparities in outcomes, behaviors, and access to resources. Below is a detailed summary for all significant indicators:

1. Premature Death

- **Central vs. Eastern**: Higher mortality rates in the **Central region** compared to the **Eastern region**.
- **Southern vs. Eastern**: **Southern regions** showed significantly higher mortality rates than **Eastern regions**, indicating differences in health outcomes and possibly access to healthcare.

2. Years of Potential Life Lost (YPLL) Rate

- The **ADAPT region** experienced significantly higher rates of premature mortality compared to **Central**, **Eastern**, and **Western regions**.
- **Southern regions** showed worse outcomes than **Eastern regions**, highlighting geographic health differences.

3. % Fair or Poor Health

- **Eastern vs. Southern/Western**: Individuals in the **Eastern region** reported significantly better overall health compared to those in **Southern** and **Western** regions.

4. Average Number of Physically Unhealthy Days

- **Eastern region** residents experienced fewer physically unhealthy days on average compared to those in **Southern** and **Western regions**.

5. Average Number of Mentally Unhealthy Days

- The **ADAPT region** had significantly higher reports of mentally unhealthy days compared to **Central** and **Eastern regions**, indicating a need for targeted mental health interventions.

6. % Low Birthweight

- Significant differences were found, with the **Eastern region** reporting lower percentages of low birthweight infants compared to **Southern regions**, reflecting differences in maternal and child health.

7. % Adults Reporting Currently Smoking

- Smoking rates were higher in the **ADAPT** and **Southern regions** compared to the **Central** and **Eastern regions**, highlighting differences in health behaviors and potential public health priorities.

8. Food Environment Index

- The **Eastern region** showed a significantly more favorable food environment compared to **Southern** and **ADAPT regions**, suggesting differences in access to healthy food options.

9. % Physically Inactive

- Physical inactivity was more prevalent in the **Southern region** compared to the **Eastern region**, potentially contributing to poorer health outcomes in the former.

10. % Excessive Drinking

- Higher rates of excessive drinking were observed in the **ADAPT region** compared to **Central** and **Eastern regions**, pointing to potential challenges with substance use.

11. Chlamydia Rate

- Rates of sexually transmitted infections, such as chlamydia, were significantly higher in the **Southern** and **ADAPT regions** compared to **Eastern regions**, reflecting differences in sexual health outcomes.

12. Teen Birth Rate

- Teen birth rates were notably higher in the **Southern** and **ADAPT regions** compared to the **Eastern region**, highlighting potential gaps in access to reproductive health education and services.

13. % Uninsured

- Uninsurance rates were significantly higher in the **Southern** and **ADAPT regions** compared to **Eastern regions**, emphasizing differences in healthcare access.

14. % Vaccinated

- Vaccination rates were significantly higher in **Eastern regions** compared to **Southern** and **ADAPT regions**, underscoring differences in public health outreach and access.

15. % Some College

- Educational attainment (as measured by % with some college) was significantly lower in the **ADAPT** and **Southern regions** compared to **Central** and **Eastern regions**, indicating differences in educational opportunities.

16. % Unemployed

- Unemployment rates were significantly higher in the **Southern region** compared to the **Eastern region**, reflecting economic variability across regions.

17. % Children in Poverty

- **Southern regions** reported significantly higher child poverty rates compared to **Eastern** and **Central regions**, emphasizing economic challenges.

18. % Children in Single-Parent Households

- Rates were significantly higher in the **Southern** and **ADAPT regions** compared to **Eastern regions**, pointing to demographic and social differences.

19. Injury Death Rate

- Injury-related deaths were significantly higher in the **ADAPT** and **Southern regions** compared to **Central** and **Eastern regions**, reflecting differences in safety and prevention measures.

20. % Severe Housing Problems

- The **ADAPT** and **Southern regions** reported significantly higher rates of severe housing problems compared to the **Eastern region**, indicating variability in housing quality and affordability.

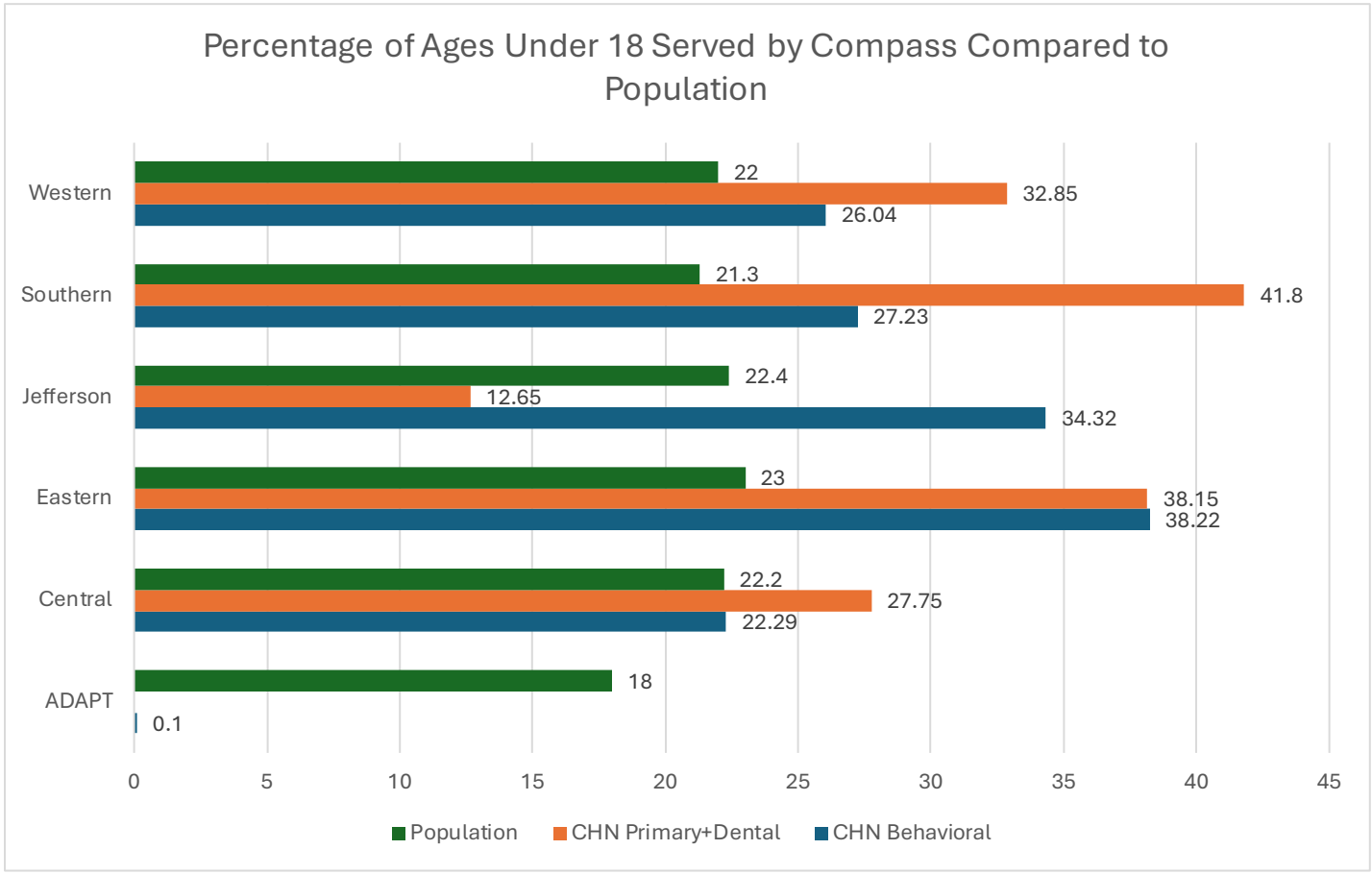
Possible Implications:

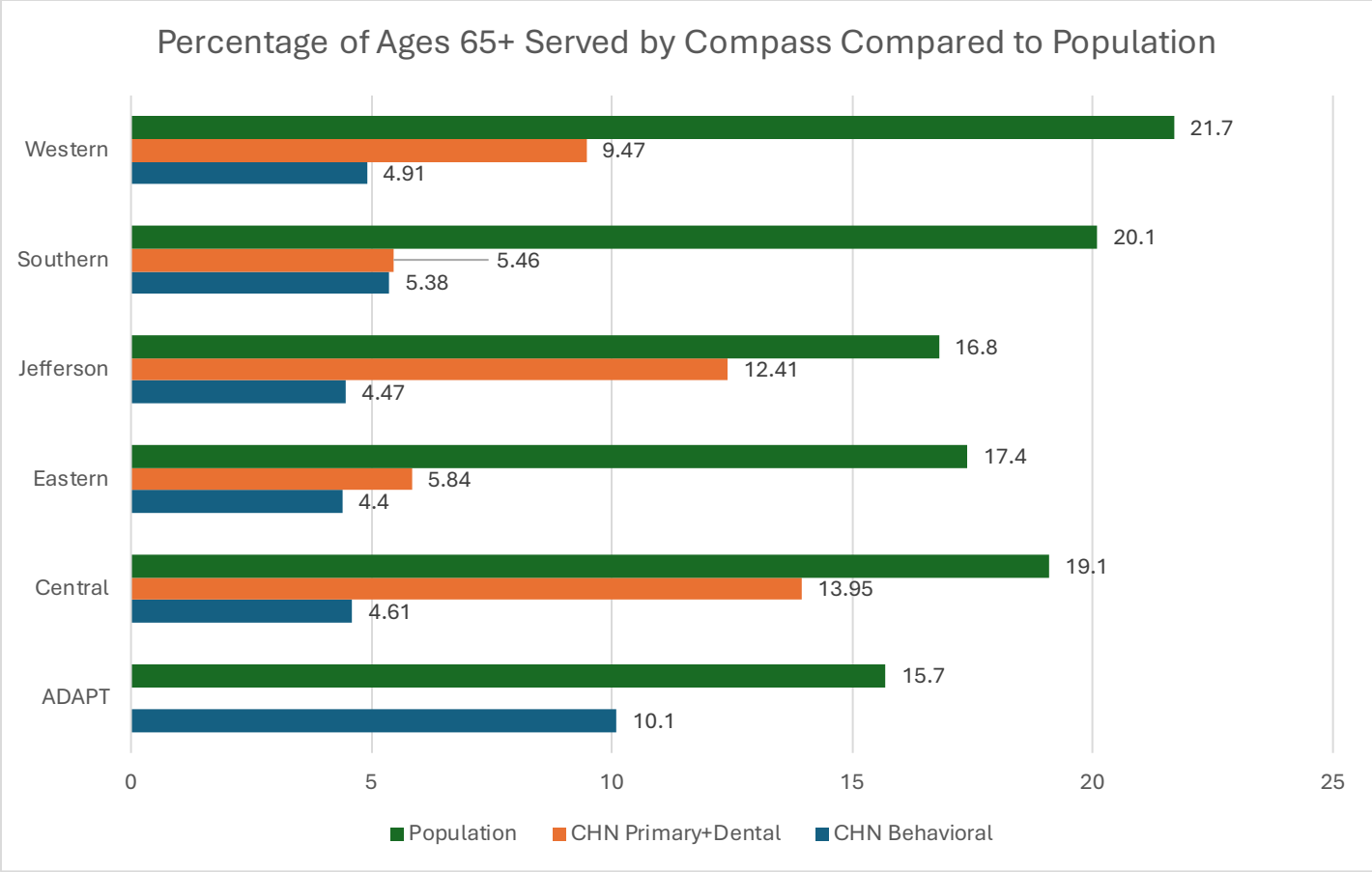
1. **Targeted Health Initiatives**: Regions like **ADAPT** and **Southern** consistently perform worse across multiple indicators, suggesting a possible need for concentrated health and social service interventions.
2. **Mental and Physical Health Resources**: High rates of mentally and physically unhealthy days in **ADAPT regions** may suggest the need for enhanced mental health services and chronic disease management programs.
3. **Economic and Social Support**: Child poverty and single-parent household rates in **Southern regions** may highlight the need for economic development and family support programs.
4. **Public Health Campaigns**: Differences in smoking, physical inactivity, and excessive drinking suggest opportunities for region-specific public health campaigns to promote healthier lifestyles.
5. **Healthcare Access**: Uninsurance and low vaccination rates in the **Southern** and **ADAPT regions** highlight a need for improved healthcare outreach and accessibility.

Comparative Description of Compass Customers Served by Region

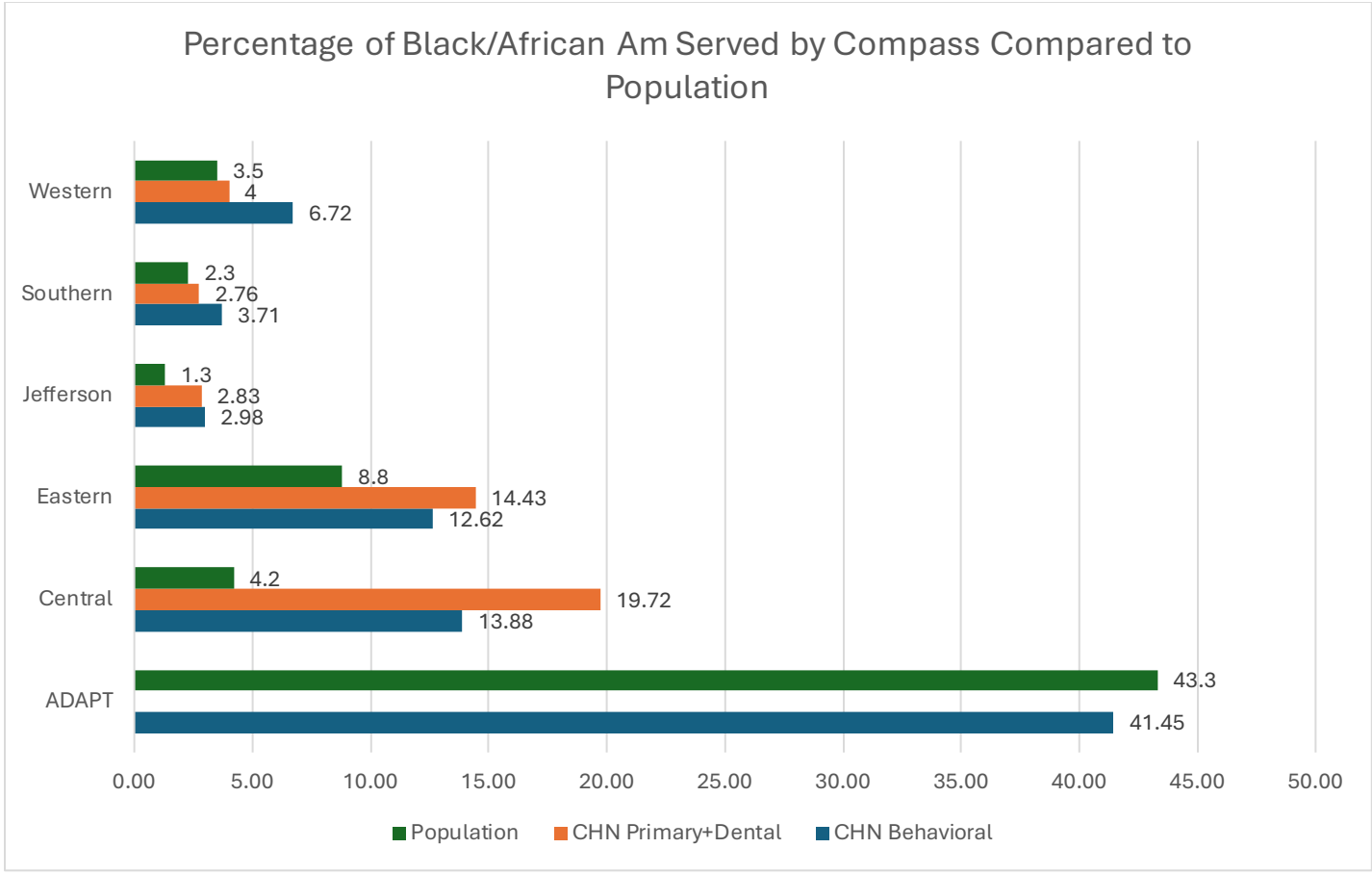
The following section (beginning on the next page) provides a sociodemographic description of clients served by CHN for the calendar year 2024. These data were extracted from two electronic health record systems (MyAvatar and NextGen). The two separate systems house data for behavioral health services (MyAvatar) and primary/dental services (NextGen). After collection, these data were cleaned and analyzed using basic descriptive statistics to provide a reference for penetration rates in CHN regions. Please note, the ADAPT region, at the time, did not provide primary, dental, or youth services.

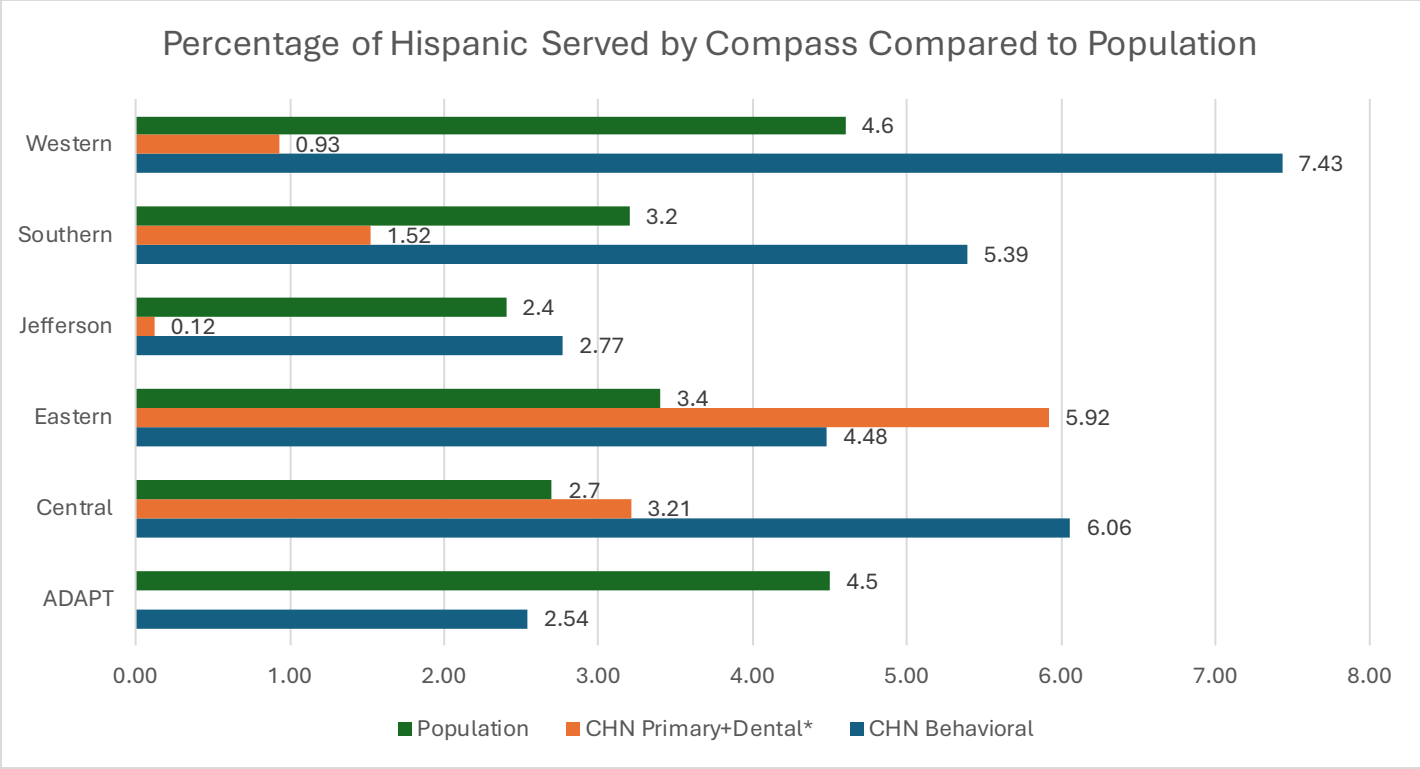
Customers Served by Key Demographics with Comparisons to Regional Populations





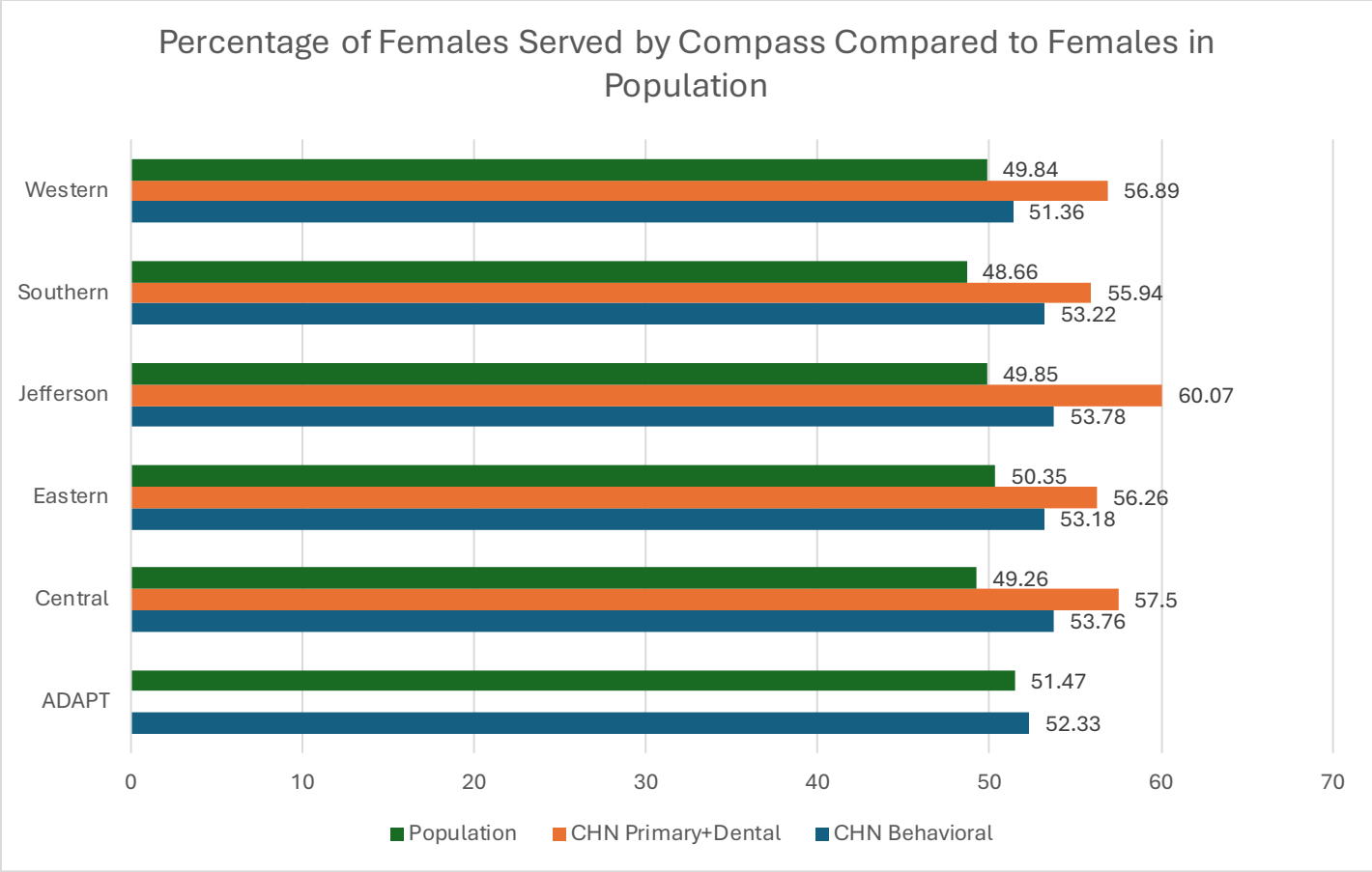
Age Groups: CHN serves youth (under age 18) in significantly higher proportions than they appear in the population in every region, with the highest disparity appearing in the Southern region (over 20 percentage points difference). This overrepresentation of younger customers would appear to be good news in light of the ongoing youth mental health crisis. However, the opposite pattern holds true for those on the other end of the age spectrum. Clients aged 65 and older are dramatically underrepresented among CHN clients when compared to the general population in each region. The underrepresentation of those aged 65 and older is also consistent with CHN payer data presented later in this chapter. These trends in the age of clients served are also consistent with previous Needs Assessment findings.


Percentage of Black/African Am Served by Compass Compared to Population
Western
3.5
4
6.72
Southern
2.3
2.76
3.71
Jefferson
1.3
2.83
2.98
Eastern
8.8
14.43
12.62
Central
4.2
19.72
13.88
ADAPT
43.3
41.45
0.00
5.00
10.00
15.00
20.00
25.00
30.00
35.00
40.00
45.00
50.00
Population
CHN Primary+Dental
CHN Behavioral

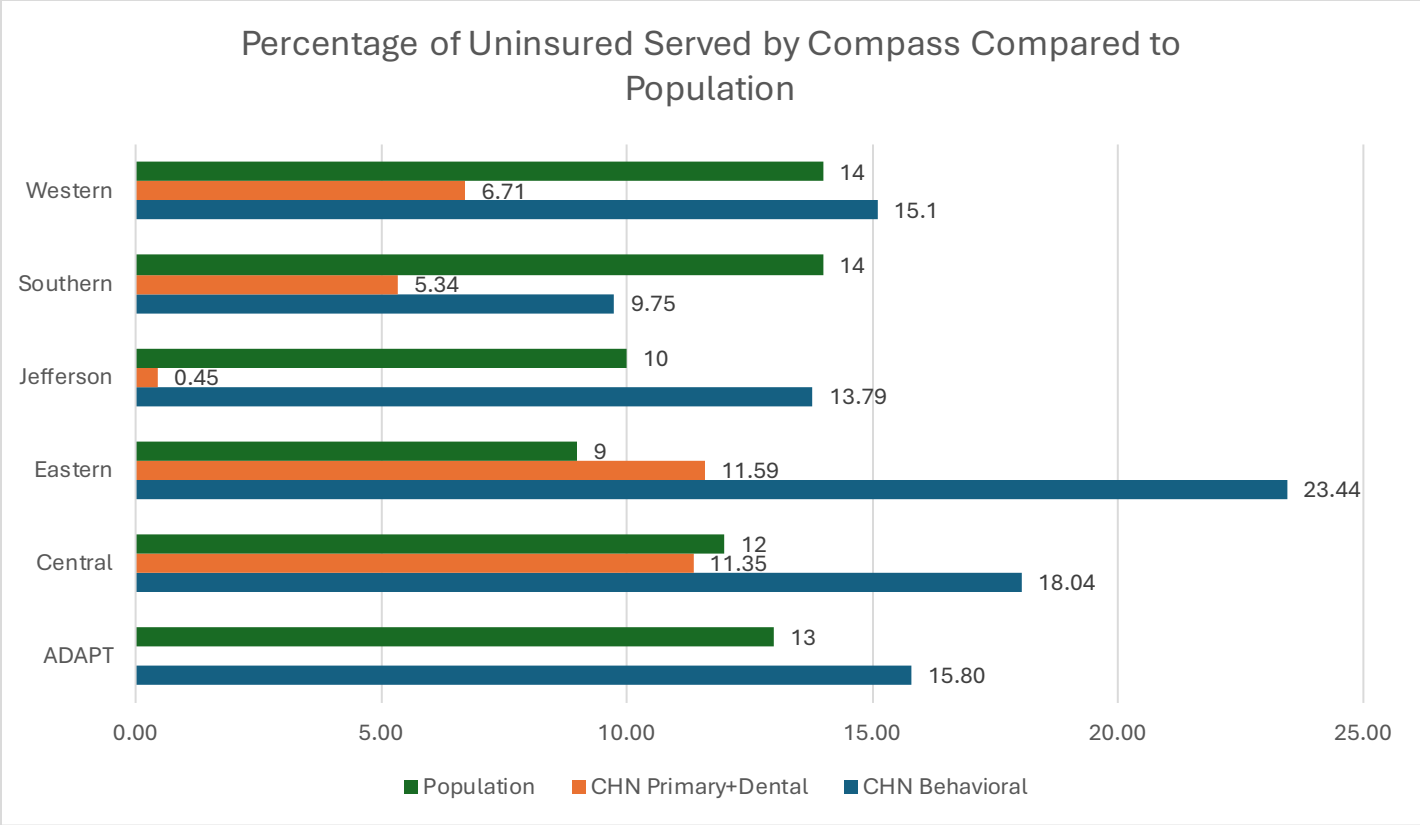


*Ethnicity responses are not required in our electronic health record (EHR) for primary and dental services. As such, our ability to draw conclusions is limited in those areas.

Compass serves persons identifying as Black/African American in proportions slightly to much higher than they appear in the population in all regions except the ADAPT region, where CHN serves less than the proportional amount, although the discrepancy is not large (43.3% compared to 41.5% served by CHN). The ADAPT region should also be noted as the substantial outlier when it comes to population make-up. This region almost five times higher percentage than the next highest region (Eastern) which has more than double the percentage of population of Black/African American persons than the next highest region (Central).Compass serves persons identifying as Hispanic in proportions that significantly exceed their representation in the population across all regions, with the exception of the ADAPT region. The Western region and ADAPT region have the highest percentage of persons identifying as Hispanic. Even so, the Western region serves the Hispanic population at higher proportion to the population in the area.



CHN provides behavioral health services for females in proportions appreciably and consistently higher than they appear in our regional populations, with no single region standing out as particularly different. This may be attributable to the general tendency for females to be more willing to seek care of all kinds but may also indicate a need to be more proactive in engaging males in care. In primary and dental care the disproportionate number of female clients is even more pronounced. The Jefferson County region stands out as the population data shows CHN serves females at a 10% higher rate than the population would suggest.

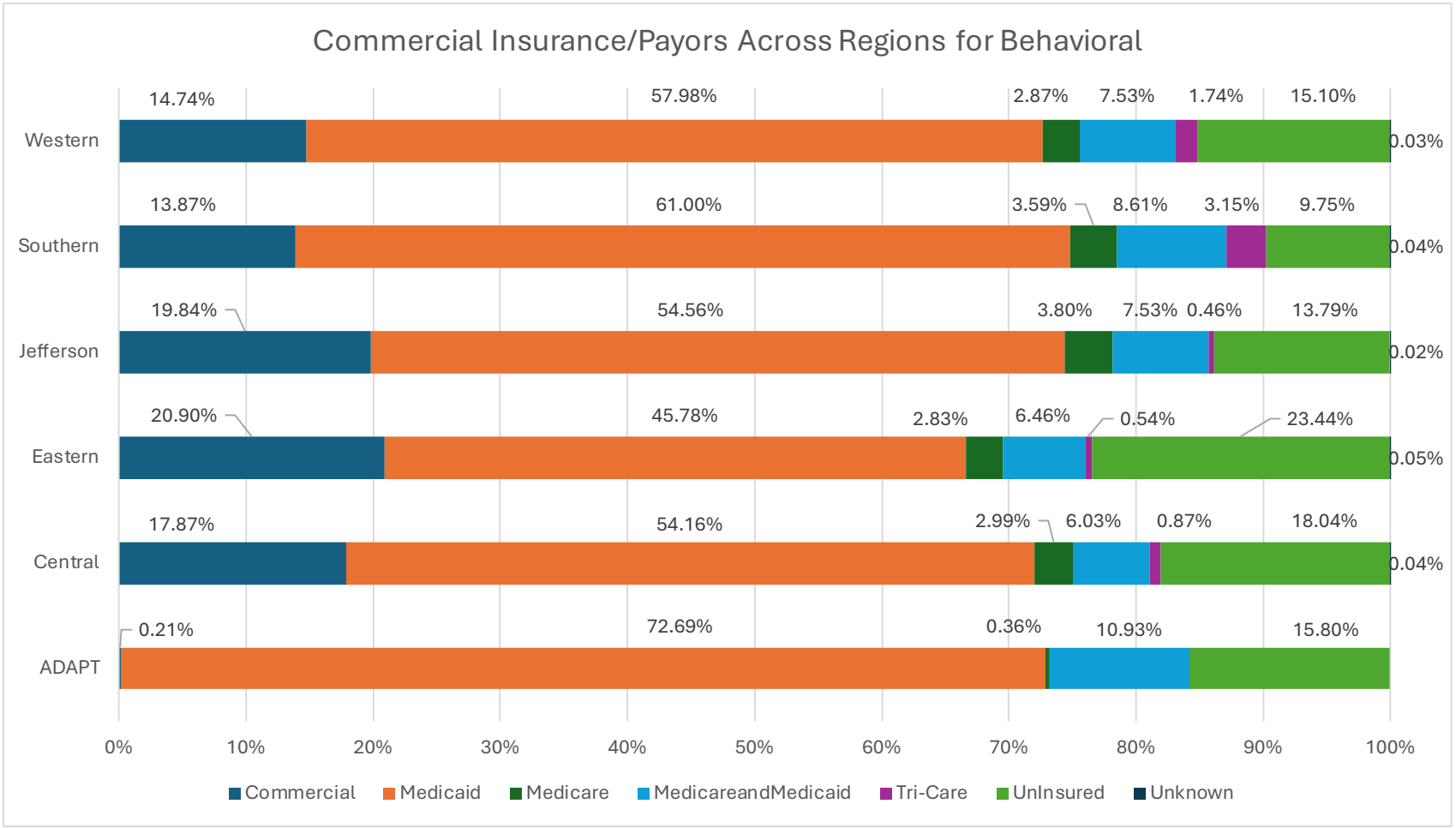


The available data for CHN Primary and Dental were not able to exclude self-pay from the uninsured. Although this is a limitation of the data, it does show the percentage of clients how either did not or could not rely on insurance to help pay for their treatment.

In every region, except for Southern, Behavioral Health clients were more likely to be uninsured than their Primary Health counterparts, a dramatic reversal of the findings in the previous CHN Needs Assessment where only the Eastern region overserved uninsured individuals (Thomlinson, et al., 2023). Also of note, the Southern region is the only one that served the uninsured in lower proportions than they exist in the population (9.75% vs. 14%). CHN behavioral health clients are far more likely to be uninsured in the Eastern region than any other and are far more likely to be uninsured than the general population or the same region. The Eastern region also has the smallest percentage of the general population that report being uninsured. It is worth noting, as well, CHN currently does not provide Primary or Dental care in the ADAPT of Missouri region.

Further analysis of the payors represented among CHN clients yielded the following: For behavioral health clients, straight Medicaid covers 55% of clients 30.5% of consumers across regions (dramatically increased from 30.5% two years ago), followed by commercial insurance and uninsured which both represent 16% of the client population. Primary and dental care clients are substantially different when it comes to payors. Commercial insurance is the most common payor for these services with just under 69% of all clients represented in this category, the next closest payor is MC+ with 12.76%.

See regional breakdown of payors at a glance in the charts below (beginning on the next page):



Description and Analysis of Compass Health Regions

Similarly to the health indicators and sociodemographic profile of Compass regions, this section presents an analysis of the Department of Mental Health (DMH) Service Areas using health outcome indicators from the Compass Health Network regions. These indicators assess length of life, quality of life, health risks, and social determinants of health. The tables on page 34-37 present all selected indicators averaged or tabulated across the DMH Service Areas (i.e., county level data are the individual unit of analysis). The goals here are to identify greater relative needs by service area and to inform potential targeted interventions to address those needs.

Statistical Analysis Overview

A one-way analysis of variance (ANOVA) was conducted to compare service areas. However, no significant differences were detected, likely due to:

- High variability within service areas
- Unequal sample sizes reducing statistical power
- Data inconsistencies (missing values, extreme outliers)
- Assumption violations affecting ANOVA reliability

To address these limitations, the Kruskal-Wallis test (a non-parametric alternative) was applied but similarly found no significant differences. A final analysis using the Mann-Whitney U test for paired comparisons revealed significant differences between specific service areas.

The following list depicts how each out county Compass serves is represented by its respective DMH region.

DMH Region	Compass Counties
2-3-4-5	Jackson
7	Cass, Johnson, Lafayette
8B	Bates, Benton, Cedar, Henry, Hickory, St. Clair, Vernon
11	Camden, Cole, Laclede, Miller, Osage, Pulaski
12	Boone, Carroll, Chariton, Cooper, Howard, Moniteau, Morgan, Pettis, Randolph, Saline
13	Linn
15	Callaway, Montgomery
16	Franklin, Lincoln, St. Charles, Warren
17A	Crawford, Dent, Gasconade, Maries, Phelps
17B	Iron, St. Francois, Washington
22	Jefferson
23	St. Louis
24-25	St. Louis City

Health Indicators and Sociodemographic Profile of DMH Regions

	2-3-4-5	7	8B	11	12	13	15	16	17A	17B	22	23	24-25
Quality and Length of Life													
Years of potential life lost rate	10,326	8,332	10,468	8,813	8,700	8,370	9,507	8,477	12,137	13,491	9,663	9,071	14,717
Poor or fair health	18.0%	16.0%	21.0%	18.0%	18.0%	19.0%	18.0%	16.0%	20.0%	21.0%	16.0%	15.0%	20.0%
Poor physical health days	3.8	3.8	4.6	4.1	4.2	4.2	4.1	3.8	4.3	4.7	3.9	3.3	4.3
Poor mental health days	5.5	5.1	5.6	5.2	5.4	5.4	5.2	5.1	5.5	5.8	5.3	5.1	6.2
Low birth weight	10.0%	8.0%	7.0%	8.0%	8.0%	6.0%	7.0%	8.0%	9.0%	10.0%	8.0%	10.0%	13.0%
Health Behaviors													
Adult smoking	18.0%	20.0%	24.0%	21.0%	21.0%	22.0%	22.0%	18.0%	23.0%	26.0%	20.0%	16.0%	20.0%
Adult obesity	39.0%	38.0%	39.0%	38.0%	40.0%	38.0%	40.0%	40.0%	39.0%	42.0%	37.0%	34.0%	37.0%
Food environment index	7.6	7.7	6.8	7.3	7.6	7.3	7.7	8.4	7.4	6.4	7.9	8.5	7.5
Physical inactivity	24.0%	25.0%	30.0%	27.0%	27.0%	27.0%	28.0%	24.0%	29.0%	31.0%	25.0%	22.0%	27.0%
Access to exercise opportunity	92.0%	56.0%	46.0%	56.0%	56.0%	66.0%	51.0%	71.0%	57.0%	69.0%	73.0%	95.0%	98.0%
Excessive drinking	20.0%	18.0%	15.0%	17.0%	17.0%	16.0%	17.0%	19.0%	16.0%	16.0%	18.0%	19.0%	19.0%
Chlamidya Infection Rate	879.4	407.5	213.4	371.0	311.5	253.3	336.0	245.8	192.3	214.7	252.0	620.0	1246.1
Teen births	25	18	29	22	21	20	23	17	24	33	16	13	29
Clinical Care Factors and Availability													
Uninsured	13%	11%	15%	12%	14%	13%	13%	10%	15%	14%	10%	8%	13%
Primary care physicians	1185:1	3671:1	4326:1	2619:1	4413:1	2961:1	4167:1	7225:1	7435:1	4755:1	3927:1	823:1	1033:1

	2-3-4-5	7	8B	11	12	13	15	16	17A	17B	22	23	24-25
Dentists	1065:1	2464:1	4081:1	2606:1	3359:1	3940:1	4733:1	3462:1	4288:1	3207:1	2364:1	1119:1	1500:1
Mental health providers	339:1	660:1	1501:1	2853:1	1251:1	2955:1	1694:1	960:1	1588:1	739:1	960:1	277:1	187:1
Preventable hospital stays	3,588	3,185	2,116	101	3,045	2,323	2,593	2,892	3,546	3,349	3,238	2,989	4,050
Mammography screening	49%	44%	37%	46%	42%	38%	43%	46%	41%	36%	47%	52%	38%
Flu vaccinations	50%	40%	28%	40%	43%	39%	44%	49%	35%	35%	51%	57%	46%
Social & Economic Factors													
High school graduation	92%	93%	88%	91%	89%	90%	89%	91%	88%	85%	91%	94%	90%
Unemployment	2.9%	2.6%	2.8%	2.5%	2.4%	2.9%	2.4%	2.4%	2.6%	3.5%	2.4%	2.4%	3.1%
Children in poverty	20%	12%	25%	16%	18%	19%	17%	10%	20%	25%	10%	14%	33%
Children w single parents	32%	19%	19%	18%	19%	16%	21%	19%	19%	26%	23%	29%	47%
Social associations	10.8	10.9	12.7	12.0	12.7	16.9	7.6	9.0	13.5	11.7	7.5	10.2	14.3
Injury deaths	110	81	110	92	77	94	93	106	116	117	129	104	184
Severe housing problems	15%	11%	13%	10%	10%	8%	9%	11%	12%	12%	10%	13%	19%
Other Health and QOL Indicators													
Frequent physical distress	12%	12%	14%	13%	13%	13%	13%	12%	14%	15%	12%	10%	13%
Frequent mental distress	18%	17%	19%	18%	18%	18%	18%	17%	19%	20%	17%	15%	18%
Diabetes prevalence	11%	10%	11%	10%	10%	10%	10%	9%	10%	11%	9%	9%	13%
HIV prevalence	494	87	124	81	139		153	86	129	137	101	346	1074
Food insecurity	12%	11%	15%	12%	12%	13%	12%	10%	14%	16%	10%	9%	14%

	2-3-4-5	7	8B	11	12	13	15	16	17A	17B	22	23	24-25
Limited access to healthy food	8%	9%	9%	10%	7%	8%	7%	4%	5%	9%	8%	5%	4%
Drug Overdose mortality	27	14	24	26	15		21	36	54	51	49	38	93
Motor vehicle crash death rate	14	16	27	18	19	18	22	18	23	25	18	11	17
Insufficient sleep	39%	32%	35%	33%	34%	33%	34%	34%	35%	35%	35%	31%	36%
Clinical Care													
Uninsured adults	16%	13%	17%	14%	16%	15%	15%	12%	17%	17%	12%	9%	15%
Uninsured children	7%	6%	8%	7%	8%	8%	7%	6%	9%	7%	5%	4%	4%
Social & Economic Factors													
Disconnected youth	7%	5%	23%	13%	18%			10%			5%	6%	9%
Median household income	$62,509	$69,449	$49,919	$63,381	$57,297	$52,831	$64,468	$79,243	$54,865	$46,846	$78,297	$79,609	$52,278
Homicides	22	4	10	5	5		3	4	11	6	4	16	49
Suicides	21	21	26	21	21	28	26	20	23	22	25	14	13
Firearm fatalities	34	18	23	21	17	32	20	15	21	23	19	24	56
Demographics													
Population	716,531	197,723	111,297	249,793	358,426	11,820	56,232	620,097	105,638	99,824	229,336	990,414	286,578
% below 18 years of age	22.9%	22.6%	21.3%	21.9%	22.4%	23.6%	21.1%	23.1%	21.2%	21.5%	22.4%	21.7%	18.0%
% 65 and older	16.1%	16.9%	25.1%	19.1%	19.5%	21.3%	19.2%	17.4%	21.1%	19.3%	16.8%	19.3%	15.7%
% Non-Hispanic Black	22.7%	3.8%	0.9%	4.2%	4.2%	1.1%	3.2%	2.8%	1.1%	2.8%	1.3%	25.0%	43.3%
% Amer Indian and Alaska Native	0.7%	0.7%	0.9%	0.7%	0.7%	0.4%	0.5%	0.4%	0.8%	0.7%	0.3%	0.2%	0.3%

	2-3-4-5	7	8B	11	12	13	15	16	17A	17B	22	23	24-25
% Asian	2.0%	1.1%	0.5%	1.1%	1.1%	0.2%	0.7%	1.2%	1.1%	0.3%	0.9%	5.0%	3.7%
% Native Hawaiian/Other Pacific Islander	0.3%	0.2%	0.1%	0.2%	0.3%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
% Hispanic	10.1%	4.6%	2.7%	4.1%	4.4%	3.1%	2.3%	3.1%	2.4%	2.1%	2.4%	3.3%	4.5%
% Non-Hispanic white	61.4%	87.4%	93.1%	87.8%	87.4%	93.8%	91.3%	90.7%	92.9%	92.6%	93.4%	64.3%	45.8%
% Not proficient in English	1.61%	0.44%	0.29%	0.41%	0.88%	0.18%	0.10%	0.22%	0.26%	0.12%	0.30%	1.02%	1.45%
% Females	51.35%	49.72%	49.87%	48.46%	49.32%	50.85%	48.75%	49.77%	49.19%	48.37%	49.85%	52.07%	51.47%
% Rural	4.3%	50.6%	88.0%	61.2%	70.8%	67.4%	80.1%	51.6%	82.9%	80.3%	34.8%	1.4%	0.0%

Narrative Summary of Regional Differences Across All Health and Demographic Indicators

The statistical analysis identified significant regional differences across numerous health and demographic indicators, highlighting disparities in outcomes, behaviors, and access to resources. Below is a detailed summary for all significant indicators:

1. Service Area 8B as an Outlier

Service Area 8B (Bates, Benton, Cedar, Henry, Hickory, St. Clair, Vernon Counties) showed significantly worse outcomes across multiple indicators, including:

- High mortality (years of potential life lost)
- Poor physical and mental health
- High smoking, excessive drinking, and physical inactivity rates
- High teen birth rate and child poverty
- Low access to healthcare and education

Further investigation is needed to determine causal factors and develop tailored interventions.

2. Health and Socioeconomic Disparities Across Service Areas

- **Years of Potential Life Lost:** Service Area 12 had significantly better outcomes than 17A and 17B.
- **Self-Reported Poor Health:** Service Area 16 reported better overall health than 12 and 17A.
- **Physical and Mental Health:** Service Area 7 experienced fewer physically unhealthy days than 12 and 17A.
- **Low Birth Weight:** Higher in 17B compared to 11, 12, and 16.
- **Food Environment:** Service Area 16 had better access to healthy food than 7, 12, 17A, and 17B.
- **Physical Inactivity:** Higher in 17A compared to 16.
- **Excessive Drinking:** More prevalent in 11, 12, and 17A than in 16.
- **Uninsured Rates:** Higher in 7 and 16 compared to 17A.
- **Vaccination Rates:** Higher in 12 and 16 than in 17A.
- **Educational Attainment:** Lower in 8B and 17A than in 7.
- **Unemployment Rates:** Higher in 17B compared to 12.
- **Child Poverty:** Higher in 12, 17A, and 17B compared to 7, 16, and 17.
- **Single-Parent Households:** Higher in 17B than in 7, 11, 12, and 16.
- **Injury Death Rate:** Elevated in 11, 12, 16, 17A, and 17B.
- **Social Association Rate:** Lower in 15 compared to 12.

Recommendations and Strategies

Based on the key findings there are specific strategies that could help address the disparities observed across the DMH Service Areas. Some of these are initiatives and approaches Compass could undertake on its own, but most would require multi-sector collaborative approaches to implement effectively**.**

1. Addressing Disparities in Service Area 8B

- **Expand Healthcare Access:** Mobile clinics, telehealth, and improved insurance outreach.
- **Behavioral Health Initiatives:** Mental health and substance use disorder treatment.
- **Nutrition and Fitness Programs:** Farmers' markets, mobile food pantries, and increased exercise opportunities.

2. Reducing Years of Potential Life Lost (YPLL)

- **Injury Prevention:** Traffic safety, substance abuse interventions, and workplace safety programs.
- **Chronic Disease Management:** Diabetes, hypertension, and heart disease prevention.
- **Suicide Prevention:** Crisis hotlines and community mental health training.

3. Improving Overall Health Outcomes

- **Health Education:** Smoking cessation, nutrition, and stress management programs.
- **Preventive Care Access:** Strengthen partnerships with local health departments.
- **Workplace Wellness Programs:** Incentives for employers to promote health initiatives.

4. Addressing Food Insecurity

- **Enhance Food Assistance:** Expand SNAP/WIC eligibility and accessibility.
- **School Meal Programs:** Improve nutrition education and food quality.
- **Grocery Store Incentives:** Encourage fresh produce availability in underserved areas.

5. Promoting Physical Activity

- **Infrastructure Investments:** Walking trails, bike paths, and community exercise spaces.
- **Community-Based Fitness Programs:** Free/low-cost exercise initiatives.
- **Youth Engagement:** More after-school physical activity programs.

6. Reducing Excessive Alcohol Consumption

- **Prevention and Education:** Expand outreach on alcohol misuse.
- **Policy Enforcement:** Strengthen responsible alcohol sales regulations.
- **Substance Use Treatment:** Increase rehabilitation services.

7. Expanding Healthcare Access

- **Insurance Outreach:** Improve Medicaid enrollment efforts.
- **Rural Health Expansion:** Incentives for healthcare providers in underserved regions.
- **Transportation Solutions:** Address barriers to accessing medical facilities.

8. Supporting Education and Workforce Development

- **High School Completion Support:** GED programs and dropout prevention initiatives.
- **Job Training & Placement:** Collaborate with employers for workforce development.
- **Early Childhood Education:** Increase funding for early learning initiatives.

9. Reducing Child Poverty and Strengthening Families

- **Childcare Assistance:** Expand access to affordable childcare services.
- **Family Support Services:** Parenting education and financial literacy programs.
- **Affordable Housing Initiatives:** Rental assistance and shelter support programs.

10. Strengthening Community Engagement

- **Civic Participation Programs:** Encourage neighborhood organizations and volunteerism.
- **Culturally Relevant Outreach:** Develop initiatives tailored to diverse populations.
- **Broadband Expansion:** Improve digital access for healthcare, education, and employment.

Conclusion

The findings highlight significant disparities across DMH Service Areas, particularly in Service Area 8B, emphasizing the need for targeted interventions. Addressing healthcare access, food security, education, and behavioral health will require coordinated efforts among healthcare providers, government agencies, non-profits, and businesses. Future research should focus on identifying specific barriers within each service area and tracking the effectiveness of intervention programs over time. A multi-sector approach, leveraging federal and state funding, is essential to reducing disparities and improving community well-being across all service areas

Needs Identified by Compass Health Leadership

Compass Health staff members, primarily Executives, Senior Managers, and Directors, were asked in October and November to complete a survey to identify unmet service needs across the organization and to recommend actions to meet current and emerging needs. The 52 respondents were representative of every region within Compass including Royal Oaks Hospital.

1. Current State of Health in the Community

- **General Health**:
  - Many regions report good access to services, but there are gaps, especially in behavioral health.
  - The merger with Comtrea has improved service availability in Jefferson County.
  - Some areas, like the Western region, face challenges with emergency services and transportation.
- **Behavioral Health**:
  - Behavioral health is a significant need across all regions, with long waitlists and a shortage of providers.
  - The pandemic has exacerbated the need for behavioral health services.
  - Some regions, like Jefferson County, have seen improvements in access due to new facilities and open access sites.
- **Primary Care**:
  - Primary care is generally available, but there are shortages in rural areas.
  - Some regions, like the Western region, report difficulties in finding providers who accept certain insurances.
  - The merger with Comtrea has improved primary care access in Jefferson County.
- **Oral Health**:
  - Dental services are improving, but there are still gaps, especially for Medicaid patients.
  - Some regions, like the Western region, report a lack of dental providers, particularly for adults.
  - New dental clinics have been opened in Jefferson County, but demand remains high.

2. Underserved or Unserved Populations

- **Uninsured/Underinsured**: Many regions report that uninsured and underinsured individuals struggle to access services.
- **Rural Populations**: Rural areas often lack access to primary care, behavioral health, and dental services.
- **Homeless Population**: The homeless population is consistently mentioned as underserved, particularly in terms of housing and behavioral health services.

- **Children and Adolescents**: There is a need for more behavioral health services for children, particularly in rural areas.
- **Substance Use Disorder (SUD)**: Individuals with SUD often lack access to adequate treatment and housing.
- **Developmentally Disabled**: This population is underserved, particularly in terms of behavioral health and dental services.

3. What Can Compass Do More or Better?

- **Improve Communication**: Many interviewees suggested improving internal and external communication to better serve clients and coordinate care.
- **Expand Services**: There is a need to expand behavioral health, primary care, and dental services, particularly in rural areas.
- **Increase Access**: Suggestions include improving transportation services, offering more open access sites, and reducing wait times.
- **Enhance Integration**: Better integration of services (e.g., behavioral health, primary care, dental) is needed to provide holistic care.
- **Address Stigma**: Efforts to reduce stigma around mental health and substance use disorders are needed, particularly in rural communities.
- **Focus on Staff Training**: More training for staff, particularly in trauma-informed care and engaging underserved populations, is recommended.

4. Additional Notes or Comments

- **Positive Feedback**: Many interviewees praised Compass for its growth, service expansion, and positive community impact.
- **Challenges**: Some noted challenges with staff retention, communication, and coordination between departments.
- **Community Perception**: While Compass is generally well-regarded, some regions report that the community is unaware of the full range of services offered.
- **Innovation**: Several interviewees highlighted the need for innovative solutions, such as mobile units and telehealth, to reach underserved populations.

Thematic Analysis of These Interviews

1. Current State of Health in the Community

Theme 1: Behavioral Health is a Critical Need

- Behavioral health is consistently identified as the area with the most significant gaps, particularly post-pandemic. Long waitlists and provider shortages are common across regions.
- *"Behavioral health is our largest need with the most gaps currently while we are relatively good at meeting the needs in dental and primary."*

Theme 2: Rural Areas Face Significant Challenges

- Rural populations often lack access to primary care, behavioral health, and dental services. Transportation is a recurring issue.
- *"Rural populations in my area are very underserved in all forms of healthcare because of transportation, distance, and lack of quality telehealth options."*

Theme 3: Dental Services are Improving but Gaps Remain

- While dental services have seen growth, particularly in Jefferson County, there are still gaps, especially for Medicaid patients and adults.
- *"Dental is not there yet, but we are getting it very soon. There are already a few dentists in the area. There is some trouble for people who want dental services that accept Medicaid."*

2. Underserved or Unserved Populations

Theme 1: Homeless Population is Underserved

- The homeless population is consistently mentioned as underserved, particularly in terms of housing and behavioral health services.
- *"The unhoused population is still underserved, but compared to six months ago, so many departments have stepped up and the issues are being tackled."*

Theme 2: Children and Adolescents Need More Support

- There is a significant need for more behavioral health services for children, particularly in rural areas.
- *"Young children under four, we need more clinicians who are trained for behavioral health services that children of that age need."*

Theme 3: Substance Use Disorder (SUD) Population is Underserved

- Individuals with SUD often lack access to adequate treatment and housing.
- *"People struggling with SUD often lack the services and housing needed."*

3. What Can Compass Do More or Better?

Theme 1: Improve Communication and Integration	**Theme 2**: Expand Services and Access	**Theme 3**: Address Stigma and Increase Awareness
• Many interviewees suggested improving internal and external communication to better serve clients and coordinate care. • *"Communication about everything that Compass is and does needs to be improved; Communication between departments could be improved; Being more proactive to reduce communication issues."*	• There is a need to expand behavioral health, primary care, and dental services, particularly in rural areas. • *"Continue to expand dental and primary care. Expand services around Tipton and 50 highway."*	• Efforts to reduce stigma around mental health and substance use disorders are needed, particularly in rural communities. • *"I think there is a lot of stigma because everyone knows everyone's business in a small town. These are 'pull yourself up by your bootstraps' people."*

4. Additional Notes or Comments

Theme 1: Positive Growth and Community Impact	**Theme 2**: Challenges with Staff Retention and Coordination	**Theme 3**: Need for Innovation
• Many interviewees praised Compass for its growth, service expansion, and positive community impact. • *"Compass has a very strong presence in the community in this region. It is very involved in systems of care, schools and resource boards."*	• Some noted challenges with staff retention, communication, and coordination between departments. • *"Our systems are set up to flow seamlessly together and sometimes that is lacking. Referral programs, our EHR systems are disconnected."*	• Several interviewees highlighted the need for innovative solutions, such as mobile units and telehealth, to reach underserved populations. • *"We should expand into the southeastern part of the state down Interstate 55."*

Summary of Interview Findings by Region

ADAPT Region

- **Current State of Health in the ADAPT Region**
  - General Health: Compass is well-respected in the community and recognized for providing an abundance of services. The organization is seen as trying to improve the St. Louis region.
  - Behavioral Health: The region is well-covered with a variety of behavioral health services, but there is a potential need for more outreach, as those who need services the most are not always accessing them.
  - Primary Care: There is an abundance of primary care providers, but some concerns exist about the quality of care. Wait times can range from one to two weeks, and there is a need for more education and public awareness on the importance of preventive primary care.
  - Oral Health: The availability of oral care is described as "abysmal," particularly for Medicaid patients. Many individuals have to travel outside of St. Louis to receive dental services.
- **Underserved or Unserved Populations**
  - Unhoused Population: While not entirely unserved, there is a lack of resources for the unhoused population, which continues to grow.
  - Medicaid Patients: Individuals who rely on Medicaid face significant barriers in accessing dental care, often having to travel long distances for services.
- **What Can Compass Do More or Better?**
  - Focus on Staff Retention: Improving retention strategies is crucial, as continuity of staff impacts how clients receive services and their perception of the organization.
  - Technical Support for Staff: Ensure that staff have the necessary tools, such as laptops and cellphones with hotspots, to perform their roles effectively.
  - Outreach and Education: Increase outreach efforts to ensure that those who need services the most are aware of and can access them. Public education on the importance of preventive care is also needed.
- **Additional Notes or Comments**
  - Positive Perception of Compass: Leadership expressed a very positive view of Compass, noting that the organization is well-regarded and impactful across the state. The strong leadership, outreach efforts, and the mission-driven approach of Compass was among the highlighted features.
  - Challenges with Continuity of Care: There is a need to focus on staff retention and technical support to ensure that clients receive consistent and high-quality care.
- **Exemplar Quotes**
  - On Compass's Reputation: "Compass as a whole is extremely well respected in this region. It is considered a very reputable organization that provides an abundance of services across a lot of different regions across the state. Compass is well regarded as extremely well organized and impactful organization."
  - On Staff Retention: "Continuity of staff impacts how clients receive services and how they view the company, so it is important to take a closer look at retention strategies."
  - On Compass's Mission and Leadership: "From an outside organization coming into Compass, I have been impressed with a lot of things, the organization structure, the outreach, the leadership, the services offered to the community. I have been really impressed with the goals, mission, and drive of Compass."

Central Region

- **Current State of Health**:
  - Behavioral health is the largest need, with significant gaps in services.
  - Primary care is generally available, but there are shortages in rural areas.
  - Dental services are improving, but there is still a need for more providers, especially for Medicaid patients.
- **Underserved Populations**:
  - Uninsured/underinsured individuals.
  - Rural populations, particularly those with transportation issues.
  - Homeless population and individuals with substance use disorders (SUD).
- **What Compass Can Do Better**:
  - Improve technology for patient access and communication.
  - Expand dental and primary care services, particularly in rural areas.
  - Address stigma around mental health and substance use.
- **Exemplar Quote**: *"We are averaging 2500 or 2600 patients walking into open access every month."*

Jefferson County

- **Current State of Health**:
  - The merger with Comtrea has significantly improved access to services.
  - Behavioral health services are improving, but there is still a need for more providers.
  - Dental services have seen growth, but demand remains high.
- **Underserved Populations**:
  - Homeless population.
  - Individuals with transportation issues.
  - Uninsured and underinsured individuals.
- **What Compass Can Do Better**:
  - Increase communication to the community about available services.
  - Expand behavioral health and dental services.
  - Improve transportation services for patients.
- **Exemplar Quote**: *"I think there is still a perception that certain people can't get services at Compass, like those uninsured individuals."*

Eastern Region

- **Current State of Health**:
  - Behavioral health services are robust, but there is a need for more SUD services.
  - Primary care is available, but there are challenges with provider shortages.
  - Dental services are saturated, but there are gaps for Medicaid patients.
- **Underserved Populations**:
  - Homeless population.
  - Spanish-speaking Hispanic and Latino communities.
  - Individuals with SUD.
- **What Compass Can Do Better**:
  - Improve communication between departments.
  - Expand SUD services and detox options.
  - Increase outreach to underserved populations.
- **Exemplar Quote**: *"I love the fact that we are almost everywhere."*

Western Region

- **Current State of Health**:
  - Behavioral health services are available but underutilized.
  - Primary care is lacking in rural areas, with many patients traveling for services.
  - Dental services are limited, particularly for adults and Medicaid patients.
- **Underserved Populations**:
  - Homeless population.
  - Rural communities, particularly those with transportation issues.
  - Children and adolescents in need of behavioral health services.
- **What Compass Can Do Better**:
  - Improve transportation services.
  - Expand dental and primary care services.
  - Increase visibility and reduce stigma in smaller towns.
- **Exemplar Quote**: *"I think there is a lot of stigma because everyone knows everyone's business in a small town. These are 'pull yourself up by your bootstraps' people."*

Southern Region

- **Current State of Health**:
  - Behavioral health services are lacking, particularly for Medicaid patients.
  - Primary care is limited, with many patients traveling for services.
  - Dental services are growing, but there is still a need for more providers.
- **Underserved Populations**:
  - Homeless population.
  - Youth and individuals with autism.
  - Incarcerated individuals.
- **What Compass Can Do Better**:
  - Increase training for staff to improve awareness of available services.
  - Expand services for youth and individuals with autism.
  - Improve integration of services.
- **Exemplar Quote**: *"I love that we have more people out there but I think we miss a lot of opportunities because our own team struggles to represent the breadth of what we are in the community."*

Royal Oaks

- **Current State of Health**:
  - Behavioral health services are well-regarded, but there is a need for more inpatient services.
  - Primary care is available, but there are gaps in rural areas.
  - Dental services are saturated, but there is a need for more Medicaid providers.
- **Underserved Populations**:
  - Individuals with SUD.
  - Homeless population.
  - Children and adolescents in need of behavioral health services.
- **What Compass Can Do Better**:
  - Improve marketing of integrated care.
  - Expand inpatient and crisis services.
  - Increase collaboration with other providers.
- **Exemplar Quote**: *"I would like to see a combination of Royal Oaks and Southwest put together more collaboratively."*

Regional Summaries

ADAPT	Expand dental services, improve quality of care for primary care services, and increase outreach for behavioral health services.
Central	Focus on expanding behavioral health and dental services, particularly in rural areas. Improve technology and communication to enhance patient access.
Jefferson County	Continue to build on the success of the Comtrea merger by expanding behavioral health and dental services. Increase community awareness of available services.
Eastern	Enhance SUD services and detox options. Improve communication between departments and increase outreach to underserved populations.
Western	Address transportation barriers and expand dental and primary care services. Reduce stigma and increase visibility in smaller towns.
Southern	Expand services for youth and individuals with autism. Improve staff training and service integration.
Royal Oaks	Focus on expanding inpatient and crisis services. Improve collaboration with other providers and market integrated care.

Summary: The interviews reveal that while Compass Health Network has made significant strides in improving access to healthcare services, particularly in behavioral health and dental care, there are still notable gaps, especially in rural areas and for underserved populations like the homeless and those with substance use disorders. Key areas for improvement include enhancing communication, expanding services, and addressing stigma. The organization is well-regarded in the community, but there is a need for continued innovation and staff training to meet the growing and evolving needs of the populations served.

Community Stakeholder and Partners Input

Following a process of nomination and identification of key community stakeholders and leaders representing the Compass Health Network service area, in depth interviews were conducted with such leaders. The focus of the interviews was to better understand their interface with Compass, their general perceptions of Compass in the community, their perspectives on the state of health and healthcare in their region, any unserved or underserved populations of which they were aware, and their thoughts on what Compass Health Network should do more or better. All interviews were transcribed and subjected to content analysis to identify key themes related to the needs assessment.

Missouri Division of Behavioral Health (DBH)

In August and September 2024, structured interviews were conducted with 17 Division of Behavioral Health (DBH) leaders as part of a needs assessment for Compass Health Network. The Division of Behavioral Health is a division within the state's Department of Mental Health (DMH). The interviews explored the strengths, challenges, and opportunities within the community's behavioral health services, focusing on Compass's role. This summary reflects the insights gathered from these interviews and outlines key themes, priorities, and potential action items for Compass Health Network moving forward.

Strengths of Compass Health Network:

Compass Health Network was repeatedly recognized for its strong leadership, innovative approaches, and evidence-based practices. Several leaders were highlighted for dedication and effectiveness and as exemplars in the state who are often consulted by the department for purposes of problem-solving. **Peer support programs**, **Crisis Access Points (CAP) or Behavioral Health Crisis Centers (BHCC)**, and **housing initiatives** were identified as key strengths, with Compass lauded for being proactive in adopting new initiatives and providing integrated care.

Unmet Needs in the Community:

The primary unmet need identified was **affordable housing**, especially for individuals with serious mental illness (SMI) and substance use disorders (SUD). There is a critical shortage of **clustered apartments** and **step-down units** that provide stable housing environments. Gaps in **youth services**, particularly for those with intellectual and developmental disabilities (IDD), were also noted. **Access to psychiatric care** remains a challenge, with long waiting times being a significant barrier to timely treatment. The need for better integration between **physical health and behavioral health services** was also highlighted.

Underserved Populations:

- **Unhoused individuals** with SMI and SUD
- **Youth and transitional-age individuals**, especially those aging out of foster care
- **Rural populations**, facing transportation challenges and limited access to services
- **Communities** in St. Louis, where distrust in healthcare systems hinders access to care
- **Individuals with co-occurring mental health and IDD**

Areas for Improvement:

- **Communication and coordination** with community partners and internally with staff, particularly in growing regions like Jefferson County.
- **Access to care**, with suggestions to streamline intake processes and reduce the burden of lengthy assessments.
- **Staff training**, particularly around issues like forensic populations, co-occurring IDD and mental health, and legalized cannabis effects.
- **High quality care**, focusing on building trust in communities and strengthening staff.
- **Youth services** and early intervention for psychosis and aggressive behaviors were emphasized as critical gaps.

Key Priorities:

1. **Expanding housing solutions**: Focus on increasing housing options for vulnerable populations, including developing more clustered apartments and step-down units.
2. **Improving youth and transition-age services**: Create targeted programs for early intervention and transitional care, especially for those with IDD.
3. **Reducing waiting times for psychiatric care**: Streamline intake processes and explore telehealth options to meet demand.
4. **Enhancing communication**: Strengthen outreach and internal communication to ensure seamless coordination across teams and with partners.
5. **Focusing on competent care**: Engage communities through tailored services and by building trust via community outreach.

Long-Term Plans:

- **Invest in workforce development and retention** to address turnover and train staff for specialized care.
- **Expand prevention services**, particularly for substance use, and focus on secondary and tertiary prevention.
- **Modernize IT and billing systems** to enhance operational efficiency and improve service delivery.
- **Develop stronger partnerships** with schools, law enforcement, and community organizations to support at-risk populations.

Ideas for Exploration in DBH Interviews:

- Treatment family home(s) for youth.
- Changes in the law that would better protect mothers seeking/receiving treatment.
- Medicaid change to allow those detained in county jails to continue or initiate receipt of Medicaid services.

From the perspective of DBH, Compass Health Network is a recognized leader in behavioral health, but there are opportunities for improvement in housing, psychiatric care access, and services for youth and underserved populations. Addressing these areas will ensure Compass continues to meet the evolving needs of the communities it serves while maintaining its leadership in providing innovative, integrated care.

Overall Thematic Analysis of DBH Interviews

1. Noted Strengths of the Organization

- **Leadership and Staff:**
  - Proactive leadership, problem-solving, and advocacy. Seen as a leader who pushes boundaries and keeps the organization at the forefront of behavioral health.
  - Frequently mentioned for their exceptional knowledge and responsiveness, particularly in handling complex billing issues.
  - Highlighted for responsiveness and problem-solving in the St. Louis region.
  - Frequently mentioned for work in crisis services, particularly the 988 program, and hands-on involvement in legislative efforts.
  - Recognized for leadership in healthcare home programs, helping to integrate care for clients across various services.
  - Praised for being innovative and thinking "outside the box" when solving financial and administrative issues.
  - Compass is lauded for its commitment to hiring and training peer specialists, who provide valuable support and engagement to clients.
- **Programs and Services:**
  - **Crisis Access Points (CAP) or Behavioral Health Crisis Centers (BHCC):** Notably in Rolla, Compass's 24/7 crisis centers are considered highly effective and innovative in responding to community needs.
  - **Individual Placement and Support (IPS):** The supported employment program is recognized for its high fidelity to the model and effectiveness in helping clients find and maintain employment.
  - **Housing Initiatives:** Compass has made significant strides in developing housing options, including clustered apartments for people with serious mental illness (SMI).
  - **Evidence-Based Practices:** Compass is seen as an early adopter of innovative, evidence-based practices, such as peer support, integrated care, and high-fidelity evidence-based models.
  - **Proactive Leadership:** Compass is often the first organization to step up and adopt new initiatives, ensuring clients benefit from the latest practices and resources.

2. Unmet Health and Behavioral Health Needs in the Community

- **Housing:** There is a critical shortage of affordable housing, particularly for individuals with SMI and substance use disorders (SUD). Many interviewees noted that unhoused individuals with mental illness are the most underserved group. More clustered apartments and step-down units are needed to provide stable living environments.
- **Integrated Care:** While Compass excels in providing integrated care, there are still gaps in the seamless coordination of physical health and behavioral health services. Specifically, there is a need for better care for individuals with chronic health issues (e.g., diabetes, hypertension) who also have mental health needs.
- **Youth Services:** Intermediate services for youth, especially those with co-occurring intellectual/developmental disabilities (IDD) and mental health issues, are lacking. Early

intervention services and intensive care options for young people are difficult to access. Many interviewees noted the gap in services for those transitioning from youth to adulthood, particularly those aging out of foster care.

- **Access to Psychiatric Care:** Lengthy waiting periods to see psychiatrists or psychiatric nurse practitioners (up to 60-90 days) are a significant barrier to timely care, especially for individuals recently discharged from incarceration or hospitalization.
- **Maternal Health:** Mothers with SUD face unique barriers to accessing care due to fears of losing custody of their children. There is a critical need for specialized services that address these fears and support maternal health in the community.

3. Underserved Populations Mentioned or Alluded To

- **Unhoused Individuals:** Repeatedly highlighted as one of the most underserved populations. Individuals with SMI and SUD living on the streets need more outreach and housing-first solutions.
- **Youth and Transitional-Age Populations:** Youth with aggressive behavior, intellectual disabilities, and those transitioning out of foster care are underserved. There is a lack of appropriate intermediate and intensive care options for them, as well as step-down services from hospitalization.
- **Rural Populations:** Rural areas, especially in southern Missouri, face challenges related to transportation, limiting access to care for individuals who live far from mental health facilities.
- **Communities in St. Louis:** There is a significant level of distrust in healthcare and mental health systems among some residents in the St. Louis area. Interviewees stressed the importance of competent care and stronger engagement with the community.
- **Individuals with Co-occurring Mental Health and Developmental Disabilities:** These individuals are often not eligible for Medicaid waivers and require higher levels of care than are currently available.
- **Pregnant Women and Mothers with SUD:** At-risk mothers, in particular, are often reluctant to seek care due to fears of losing custody of their children. There is a critical need for services that address this population's unique needs.

4. Things Compass Needs to Do More or Better

- **Communication and Coordination:** Many interviewees highlighted gaps in communication, particularly within the rapidly growing regions like Jefferson County. Compass needs to improve outreach to community partners, increase communication with staff about organizational changes, and streamline the first point of contact for clients.
- **Access to Care:** The lengthy intake assessments required by accreditation bodies are seen as a barrier to care. Compass should explore breaking these assessments into more manageable steps to avoid overwhelming clients and staff.
- **Staff Training:** Interviewees called for more staff training, particularly on specialized issues like the effects of legalized cannabis, forensic populations, and co-occurring mental health and developmental disabilities. Better training will help staff feel more confident and competent in addressing these complex cases.
- **High Quality Care:** Compass needs to improve its efforts to build trust within the community, particularly in St. Louis. Having a more robust staff, engaging more with community events, and offering services in a tailored manner were suggested.

- **Youth Services and Early Intervention:** Compass is encouraged to focus more on early intervention for psychosis and other mental health issues among youth, especially those in transitional phases like aging out of foster care. Building stronger partnerships with schools and law enforcement can also improve outcomes for this group.
- **Prevention Services:** Several interviewees noted that prevention efforts, particularly in substance use, are under-prioritized. Compass could play a bigger role in prevention by expanding its prevention programs, especially in secondary and tertiary prevention.

5. Miscellaneous Feedback Provided by Interviewees

- **Reputation and Humility:** While Compass is recognized as a leader in behavioral health in Missouri, some interviewees mentioned that there can be a perception of a lack of humility. Encouraging a culture of continual learning and reflection might help balance the organization's leadership position with an openness to new learning and collaboration.
- **Partnerships with Community Organizations:** Some interviewees from community organizations mentioned challenges in building partnerships with Compass, noting that Compass can be seen as difficult to collaborate with at times. Fostering stronger community partnerships, particularly in recovery services, could address these concerns.
- **Workforce Development:** Several interviewees highlighted workforce challenges, particularly in retaining younger staff and filling vacancies. Compass is encouraged to focus on developing the next generation of behavioral health workers, including offering more training and professional development opportunities to ensure staff are equipped to meet the growing demand for services.
- **Social Determinants of Health:** There is a growing recognition that social determinants of health (e.g., housing, transportation, food security) play a critical role in behavioral health outcomes. Compass is encouraged to collaborate more closely with external partners to address these issues holistically.

Overall, Compass Health Network is viewed by DBH leaders as a highly effective, innovative leader in behavioral health services across Missouri. The organization's strengths lie in its leadership, evidence-based practices, peer support programs, housing initiatives, and crisis services. However, there are significant gaps in care for underserved populations, particularly the unhoused, youth with developmental disabilities, and individuals in rural areas. Compass is encouraged to improve its communication, staff training, access to psychiatric services, and community partnerships while continuing to build on its successes in providing high-quality, integrated care.

Potential Key Priorities from DBH Findings

Based on the thematic analysis of the interview findings, **key priorities** might be considered or pursued by Compass:

1. Expand Housing Solutions

- **Unmet Need:** Housing was the most frequently mentioned need, particularly for people with serious mental illness (SMI), substance use disorders (SUD), and co-occurring intellectual and developmental disabilities (IDD). The lack of affordable, low-barrier housing options is leaving vulnerable populations unhoused.
- **Priority:** Expand housing programs, such as clustered apartments and step-down units, to provide stable living environments for clients. Additionally, ensure a continuum of care that addresses both housing and mental health needs.

2. Address Youth and Transition-Age Services

- **Unmet Need:** There is a significant gap in services for youth and transitional-age populations, particularly those with behavioral health and IDD, and those aging out of foster care. These individuals often lack access to intermediate, intensive, and specialized care.
- **Priority:** Develop targeted services for youth, including early intervention programs for psychosis, aggressive behavior, and transitional care for young adults aging out of foster care. Build partnerships with schools and law enforcement to identify at-risk youth earlier.

3. Improve Access to Psychiatric Care

- **Unmet Need:** Long waiting times for psychiatric services, especially for those recently released from jail or hospital, are a major barrier to timely care.
- **Priority:** Reduce waiting times for psychiatric appointments by streamlining intake processes and triaging clients more effectively. Explore ways to address the burden of lengthy intake assessments to make them less cumbersome for clients and staff.

4. Enhance Communication and Engagement

- **Unmet Need:** There are communication gaps between Compass and its community partners, particularly in regions with rapid growth, like Jefferson County. Internal communication about organizational changes and service availability also needs improvement.
- **Priority:** Strengthen outreach and communication with community stakeholders, ensuring they are aware of available services. Internally, improve communication to ensure staff and clients receive timely information about services, programs, and procedures.

5. Strengthen Competent Care

- **Unmet Need:** Distrust in healthcare systems, particularly among parts of the community in St. Louis, is a barrier to accessing care.
- **Priority:** Expand competent care initiatives by increasing staff effectiveness, improving community engagement, and tailoring services to better meet the needs of communities. Use trusted community figures to build stronger relationships and trust.

6. Enhance Staff Training and Development

- **Unmet Need:** There are gaps in staff knowledge, particularly regarding forensic populations, co-occurring mental health and IDD, and the effects of legalized cannabis on mental health.

- **Priority:** Provide additional training for staff on specialized issues, including forensic mental health, cannabis-related disorders, and integrated care for individuals with IDD. Focus on developing and retaining younger staff members to meet growing service demand.

7. Focus on Prevention Services

- **Unmet Need:** Prevention, particularly substance use prevention, is underfunded and under-prioritized. There is a need for more secondary and tertiary prevention programs.
- **Priority:** Increase efforts in prevention by expanding programming for substance use prevention and addressing social determinants of health. Secure funding and resources to support these initiatives.

8. Improve Care for Complex and Hard-to-Treat Populations

- **Unmet Need:** Individuals with complex needs, such as those with SMI, forensic populations, and those recently discharged from hospitals, often do not have the services they need.
- **Priority:** Focus on developing step-down units, intermediate care solutions, and more specialized services for high-need populations, including forensic patients and those discharged from hospitals.

9. Build Stronger Partnerships and Collaborations

- **Unmet Need:** Some community organizations and recovery services reported difficulty partnering with Compass, citing concerns about communication and collaboration.
- **Priority:** Foster stronger partnerships with community organizations, particularly in recovery services, to ensure seamless care and support. Work with schools, law enforcement, and community coalitions to build a more robust support system for clients.

10. Optimize Integrated Care and Holistic Health Approaches

- **Unmet Need:** Despite strong integrated care efforts, there is room to improve coordination between behavioral health and physical health services, especially for individuals with chronic conditions.
- **Priority:** Enhance the integration of behavioral health and primary care services by improving coordination among providers. Develop programs that address both physical and mental health needs, particularly for individuals with chronic conditions like diabetes or hypertension.

Compass Health Network's key priorities should focus on expanding housing solutions, improving youth and psychiatric services, enhancing communication and competent care, investing in staff training, increasing prevention efforts, and developing services for complex populations. These priorities will help address the significant unmet needs identified in the community and position Compass to continue its leadership in behavioral health care in Missouri.

Important But Less Dominant Themes from Interviews

There are several **less dominant needs** mentioned in the interviews that may not have been emphasized as heavily but still provide important insights for Compass Health Network's strategic planning. Here are some of the **specific needs or concerns** that were mentioned more subtly but are still valuable:

1. Transportation

- **Issue:** Several interviewees noted that **lack of transportation** is a significant barrier, particularly in **rural areas** like Jefferson County. This issue prevents many clients from accessing services, especially those with limited financial resources.
- **Action:** Address transportation needs through partnerships with local organizations or by developing transportation services for clients in rural and underserved areas.

2. Dental Care

- **Issue: Access to dental care** was noted as a recurring unmet need, particularly for those with mental health or SUD issues. Dental care is often not integrated into traditional behavioral health services but is crucial for the overall well-being of clients.
- **Action:** Explore partnerships with dental providers or integrate dental services into behavioral health programs, particularly in rural or underserved regions.

3. Forensic Populations and Legal Barriers

- **Issue:** There were several references to **forensic populations**, particularly individuals who are involved with the criminal justice system but are detained rather than incarcerated. This group often loses **Medicaid benefits** due to their legal status, which creates barriers to accessing mental health care.
- **Action:** Explore ways to provide care to forensic populations and address the legal complexities that lead to Medicaid coverage loss for detained individuals.

4. Turnover and Staff Retention

- **Issue:** Staff turnover, particularly in key areas like Jefferson County, was mentioned as a concern. Turnover affects the continuity of care and can result in inconsistent services for clients, particularly those in vulnerable populations.
- **Action:** Focus on **staff retention** strategies, including professional development, better support for frontline workers, and ensuring manageable caseloads. Address turnover in key regions to maintain service quality and continuity.

5. Crisis Diversion and Intermediate Care for Children

- **Issue:** Multiple interviewees mentioned the need for **crisis diversion units** or **intermediate care options** for children, particularly those with behavioral health crises that could lead to hospitalization. A **step-down unit** or stabilization service could prevent hospitalization or provide transitional care before permanent solutions are found.
- **Action:** Explore the development of **stabilization units** or other intermediate care solutions for children, particularly those with behavioral health crises.

6. Early Childhood Intervention

- **Issue:** While less frequently mentioned, there was discussion around early intervention for children, especially those under five years old. **Autism and developmental disabilities** were particularly noted as areas needing earlier intervention to prevent longer-term issues.
- **Action:** Focus on **early intervention programs** for children with autism or developmental disabilities. Develop partnerships with schools and early childhood education providers to ensure early identification and treatment.

7. Client and Family Education

- **Issue:** Several interviewees noted that **family education and support**, particularly for parents of children with behavioral health issues or autism, is lacking. Parents often feel they do not receive enough guidance on how to navigate systems or support their children.
- **Action:** Provide **parent training programs** and educational resources to help families better understand behavioral health systems and support their children's development. This can help reduce parental frustration and enhance care outcomes.

8. Underserved Older Adults and End-of-Life Care

- **Issue:** There was some mention of a lack of services for **older adults** and **end-of-life care** for those with behavioral health needs. As this population grows, so does the need for integrated behavioral health and primary care solutions tailored to older adults.
- **Action:** Consider expanding services for older adults, including end-of-life care that integrates mental health and medical services. Develop programming that addresses the unique needs of aging populations with mental health or substance use disorders.

9. Streamlining Billing and IT Systems

- **Issue:** Some interviewees raised concerns about **outdated billing systems** and challenges with IT infrastructure (at DBH, not within the Compass system). Managed care and Medicaid billing processes were mentioned as areas that could be improved.
- **Action:** DBH needs to modernize billing systems and IT infrastructure to ensure smoother operations and better service delivery. The implied action item for Compass is to continue to be open and vocal to help them better address concerns about outdated systems that may delay or complicate service access.

10. Children Stuck in Hospitals

- **Issue:** A specific issue was raised about **children stuck in hospitals**, particularly those in foster care or with aggressive behaviors. These children may face long hospital stays due to a lack of appropriate placements or intermediate care.
- **Action:** Develop programs or partnerships that address the needs of **children in extended hospital stays**, ensuring that they have access to behavioral health services and appropriate placements post-discharge.

11. Autism and Functional Assessments

- **Issue:** There were concerns about the growing population of children with **autism** and the need for better **functional assessments**. Interviewees highlighted that autism is being treated more like a mental illness, requiring new approaches to care and assessment.
- **Action:** Enhance **autism services** by ensuring that functional assessments are completed early and that staff have the training necessary to address autism-related behavioral health challenges.

12. Substance Use Reporting and Fear of Custody Loss

- **Issue:** Several interviewees noted that **pregnant women and mothers** are often reluctant to seek help for substance use issues due to fear of losing custody of their children. This fear is a significant barrier to care for this population.
- **Action:** Implement **non-punitive approaches** to substance use treatment for pregnant women and mothers, focusing on supportive care that minimizes the fear of losing custody. Develop clear communication strategies that reassure mothers that seeking help is in their own and their children's best interest.

These less dominant but still important needs—transportation, dental care, services for forensic populations, turnover, family education, and autism assessments—provide additional dimensions to Compass's strategic priorities. Addressing these areas will help ensure that Compass continues to provide comprehensive, client-centered care across all populations, even in areas that may not have been highlighted as critical in the immediate analysis. By considering these secondary needs alongside the more dominant ones, Compass can round out its service offerings and better meet the full spectrum of community needs.

Ideas for Exploration Suggested in DBH Interviews

In the course of the interviews, things were sometimes mentioned that might be considered "wishlist" items, or things not necessarily the responsibility of Compass or something needing improvement in the organization, per se. Some notable ideas for exploration were:

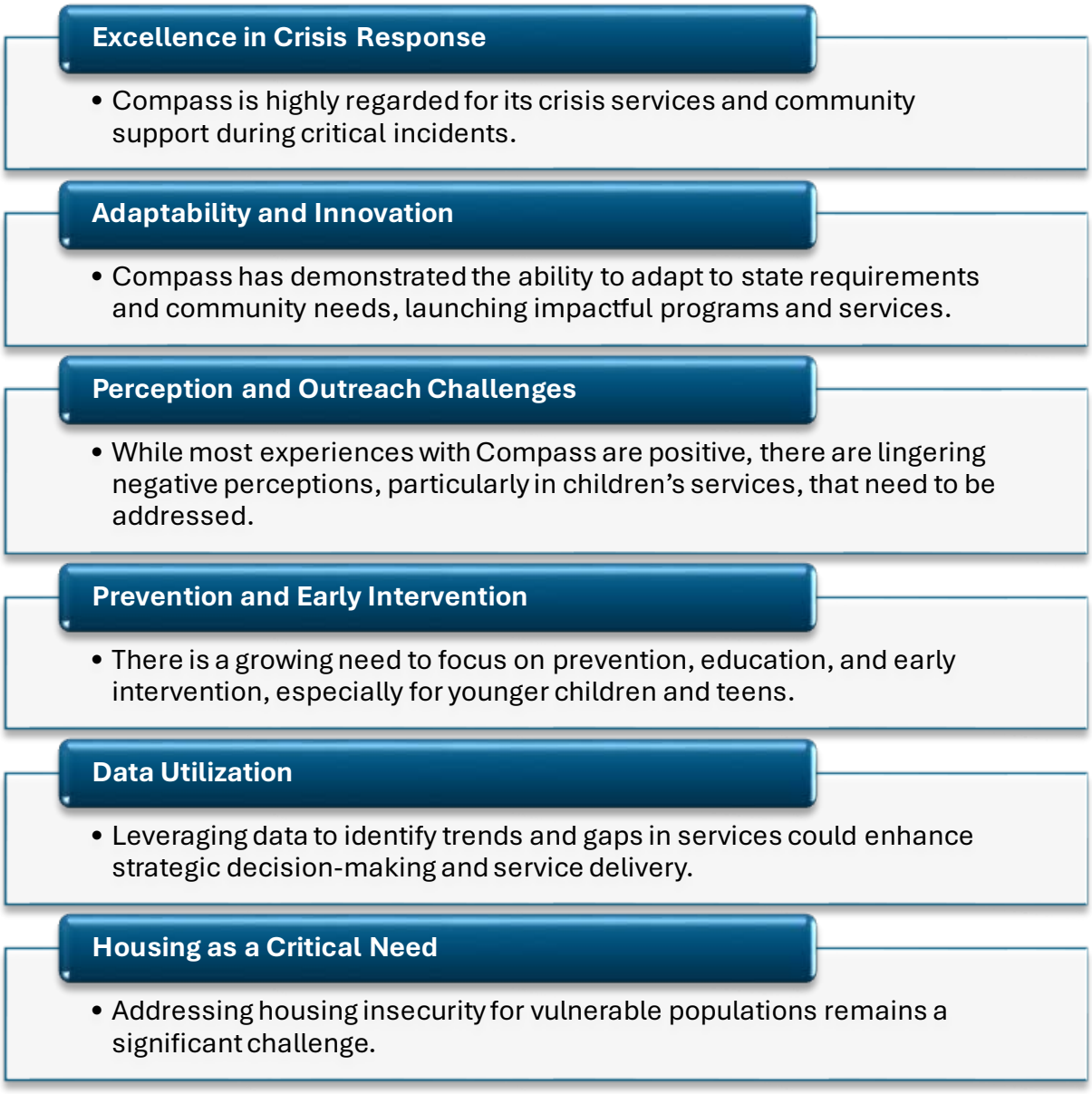
- Put forth the idea for a treatment family home for youth. This is interesting, challenging, and perhaps not on Compass's radar screen at present; yet, it could directly and indirectly impact several themes of need identified in this process.
- Advocated for changes in the law that would better protect mothers seeking/receiving treatment, particularly so that entry into treatment and/or positive drug test during treatment does not trigger a Children's Division referral (which represents a major barrier to care).
- Suggested a Medicaid change to allow those detained in county jails to continue or initiate receipt of Medicaid services. This deserves specific mention as it represents a worthy advocacy goal in order to reduce and eliminate unnecessary barriers to care, which are already many for incarcerated or justice-involved individuals.

Missouri Behavioral Health Council (MBHC)

Key Findings

1. **Strengths of Compass Health Network:**
    - **Crisis Services:** Compass excels in crisis services, particularly Behavioral Health Crisis (BHC) services and Crisis Behavioral Health Liaisons (CBHLs). CBHLs are highly reliable and responsive, even during challenges at MBHC.
    - **Community Support:** Compass is recognized for its exceptional community support, especially in high-profile crisis situations (e.g., suicide deaths in Jefferson City). Leadership was specifically praised for her willingness to assist and provide support.
    - **Leadership and Expertise:** Leaders were commended for their strategic vision, operational expertise, and ability to execute complex initiatives effectively.
    - **Innovative Programs:** Compass has implemented notable initiatives such as Dahlia House, Southwest Missouri CPRC, and clustered apartments, which demonstrate adaptability and responsiveness to community needs.
2. **Opportunities for Improvement:**
    - **Children's Services:** While Compass is doing significant work in children's services, there are occasional negative perceptions due to past bad experiences. There was emphasis on the need to address these perceptions and improve outreach.
    - **Prevention and Early Intervention:** There is a need to expand prevention efforts, particularly in educating communities about mental health, normalizing emotional struggles, and reducing the stigma around seeking help. The alarming rise in suicide attempts and completions among younger children was highlighted, suggesting a need for earlier intervention.
    - **Data-Driven Insights:** A leader suggested analyzing data on intensive services (e.g., CPRC services) to identify patterns and gaps in care, particularly post-COVID, where the mental health landscape for children has significantly changed.
    - **Teen Peer Programs:** Developing or expanding peer support programs for teens could help address mental health challenges and suicidality among younger populations.
    - **Housing for Underserved Populations:** Homeless and unhoused populations, particularly those with mental health and substance use challenges, remain underserved. More housing options and innovative solutions are needed.

Themes



Implications for Strategic Planning

1. **Enhance Children's Services:**
   - Address negative perceptions through improved communication, outreach, and service delivery.
   - Expand prevention and early intervention programs, focusing on younger children and teens.
   - Develop or expand peer support programs for adolescents to address mental health challenges and suicidality.

2. **Strengthen Prevention Efforts:**
    - Launch community education campaigns to normalize mental health struggles and reduce stigma.
    - Partner with schools and community organizations to provide mental health education and resources.
3. **Leverage Data for Decision-Making:**
    - Conduct a thorough analysis of intensive services (e.g., CPRC) to identify patterns, gaps, and opportunities for improvement.
    - Use data to inform strategic planning and resource allocation, particularly in underserved areas.
4. **Expand Housing Solutions:**
    - Explore innovative housing models and partnerships to address the needs of homeless and unhoused populations with mental health and substance use challenges.
    - Advocate for state and federal funding to support housing initiatives.
5. **Celebrate and Communicate Successes:**
    - Increase visibility of Compass's impactful programs and initiatives (e.g., Dahlia House, clustered apartments) to build community trust and recognition.
    - Highlight leadership expertise and operational successes to reinforce Compass's reputation as a leader in behavioral health.
6. **Foster Collaboration:**
    - Strengthen partnerships with state agencies, schools, and community organizations to address challenges and expand service reach.
    - Continue leveraging the expertise of leaders to drive innovation and operational excellence.

Conclusion: MBHC's feedback underscores Compass Health Network's strengths in crisis response, community support, and innovative programming. However, there are clear opportunities to enhance children's services, expand prevention efforts, and address housing insecurity for underserved populations. By leveraging data, fostering collaboration, and celebrating successes, Compass can continue to adapt and thrive in a rapidly evolving behavioral health landscape. Strategic planning should prioritize early intervention, community education, and innovative solutions to meet the growing and changing needs of the populations served.

Missouri Hospital Association (MHA)

Key Findings and Themes

1. Strengths of Compass Health Network

- **Professionalism and Commitment to Quality Healthcare:** Both interviewees expressed highly favorable impressions of Compass Health Network. Executive leadership was noted for its evident commitment to health and serving vulnerable populations. Compass was also praised for being innovative, collaborative, and mindful of existing players in the healthcare landscape.
- **Collaborative Leadership:** Leadership was described as strong and fostering collaboration and creative problem-solving, particularly in addressing children's behavioral health issues.
- **Crisis Care Excellence:** An interviewee shared a positive anecdote about a high school student who received compassionate and effective care at a Compass crisis center, underscoring the organization's ability to deliver impactful services.

2. Opportunities for Improvement

- **Behavioral Health Services:** Both interviewees identified behavioral health as a critical area of concern. One emphasized the need for earlier intervention and more community-based services to prevent crises that lead to emergency room visits. The other called for a complete rebuild of Missouri's behavioral health system, citing gaps due to deinstitutionalization and inadequate investment.
- **School-Based Services:** While school-based behavioral health services were acknowledged as a logical solution, barriers such as parental consent and post-pandemic challenges were discussed. The need for better access to care during evenings and weekends to reduce ER utilization was also highlighted.
- **Telehealth Utilization:** Missouri's telehealth policy was praised but disappointment was that post-pandemic adoption has waned was expressed. It was suggested to leverage telehealth to overcome transportation barriers and improve access to care.
- **Maternal and Child Health:** A significant need for better integration of care for young mothers and babies was identified, particularly in addressing barriers to care and improving outcomes for this vulnerable population.

3. Unserved and Underserved Populations

- **Children and Families in Crisis:** The struggles of families with children in foster care or those experiencing behavioral health crises was emphasized, noting that these populations often lack access to timely and appropriate care.
- **Moms and Babies:** The need for comprehensive care for young mothers and babies was highlighted, pointing to poor statistics and outcomes in this area. It was suggested that Compass could play a key role in addressing these gaps.

4. Strategic Implications

- **Collaboration and Partnerships:** Both interviewees stressed the importance of collaboration in addressing issues. Compass's existing partnerships and collaborative approach were seen as strengths that should be leveraged further.

- **Policy Advocacy:** Compass could play a key role in advocating for policy changes to improve behavioral health services, particularly for children and vulnerable populations. A specific need was noted for a statewide effort to rebuild the behavioral health system with support from the new governor.
- **Innovative Service Delivery:** Expanding school-based services, increasing evening and weekend clinic hours, and promoting telehealth were identified as potential strategies to improve access and reduce reliance on emergency rooms.
- **Focus on Maternal and Child Health:** Compass could enhance its impact by developing targeted programs to support young mothers and babies, addressing barriers to care, and improving health outcomes for this population.

Strategic Recommendations for Compass Health Network

Enhance Behavioral Health Services

- Invest in early intervention programs and community-based services to prevent crises.
- Expand school-based behavioral health services while addressing barriers such as parental consent.

Improve Access to Care

- Increase clinic hours during evenings and weekends to reduce ER utilization.
- Promote telehealth services to overcome transportation barriers and improve access.

Strengthen Maternal and Child Health Programs

- Develop targeted initiatives to support young mothers and babies, addressing barriers to care and improving outcomes.

Advocate for Change

- Collaborate with MHA and other stakeholders to advocate for policy changes and increased investment in Missouri's behavioral health system.

Leverage Partnerships

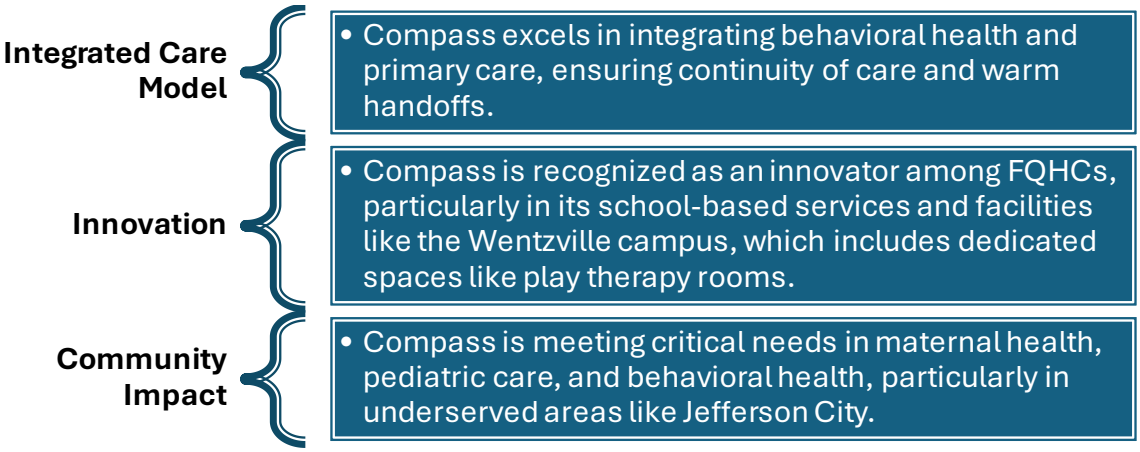
- Continue to build on existing collaborations and partnerships to address challenges and improve service delivery.

Missouri Primary Care Association (MPCA)

Key Findings

1. **Needs Compass is Meeting:**
    - **Maternal and Pediatric Health:** Compass is addressing critical gaps in maternal and pediatric healthcare, particularly through the Women and Children's Center in Columbia. The Worley location, taken over from Family Care, is also meeting significant demand.
    - **Behavioral Health:** Compass is making strides in reducing stigma around behavioral health, especially for children. Compass is noted as a key resource for pediatric behavioral health in Jefferson City and Central Missouri where such services are scarce.
2. **Challenges and Opportunities:**
    - **Workforce Shortages:** There is a critical shortage of providers, particularly in women's health and behavioral health. For example, a part-time 72-year-old provider serves as the only women's health provider across seven counties in southeast Missouri.
    - **Wait Times for Behavioral Health:** Long wait times for behavioral health services are a widespread issue, compounded by difficulties in retaining providers.
    - **Reproductive Health Needs:** Missouri faces significant challenges in maternal mortality and reproductive health. Compass has an opportunity to expand outreach and education, particularly in underserved communities and among women of color, who often distrust healthcare systems.
    - **Outreach and Marketing:** Compass's outreach efforts, particularly in education and community engagement, are underutilized. Reporting on outreach activities (e.g., flyers, social media posts, community events) is notably low given the organization's size and reach.
3. **Political and Funding Landscape:**
    - The new state administration under Governor Kehoe is supportive of Federally Qualified Health Centers (FQHCs), but budget constraints are expected in the coming years. Workforce development is a priority for the administration, aligning with Compass's needs.
    - Conservative political dynamics may continue to create challenges for reproductive health initiatives. Compass is well-positioned to serve as an alternative to Planned Parenthood, but proactive advocacy and storytelling will be essential.

Strengths



Opportunities

1. **Expand Outreach Efforts:**
   - Increase community engagement and education, particularly in hard-to-reach populations.
   - Leverage CMS Navigator grants and other funding to grow outreach staff and activities.
   - Improve reporting and visibility of outreach efforts (e.g., social media, flyers, community events).
2. **Address Workforce Shortages:**
   - Focus on recruiting and retaining providers in high-demand areas like women's health and behavioral health.
   - Explore partnerships with educational institutions and state workforce initiatives.
3. **Advocacy and Storytelling:**
   - Use data and compelling narratives to advocate for funding and policy support.
   - Position Compass as a leader in addressing Missouri's maternal mortality crisis and behavioral health needs.
4. **Marketing and Visibility:**
   - Ramp up marketing efforts to increase awareness of Compass's services and impact.
   - Ensure Compass's contact information is prominently displayed on resources like the "find local help" page.

Implications for Strategic Planning

1. **Prioritize Outreach and Education:** Develop a comprehensive outreach strategy to engage underserved populations and improve health literacy.
2. **Invest in Workforce Development:** Partner with state initiatives and educational programs to recruit and retain providers in high-demand specialties.
3. **Expand Reproductive Health Services:** Focus on reducing maternal mortality and improving access to reproductive health services through targeted programs and partnerships.
4. **Enhance Advocacy Efforts:** Use data and storytelling to advocate for funding and policy changes that support Compass's mission.
5. **Strengthen Marketing and Reporting:** Increase visibility through marketing campaigns and improve reporting on outreach activities to demonstrate impact.

Conclusion: Compass Health Network is making significant strides in addressing critical healthcare needs, particularly in maternal health, pediatric care, and behavioral health. However, challenges related to workforce shortages, outreach, and political dynamics require strategic attention. By expanding outreach, investing in workforce development, and enhancing advocacy efforts, Compass can further solidify its role as a leader in community-based healthcare and continue to improve health outcomes across Missouri.

Regional Community Leaders

ADAPT Region

Common Themes:

1. **Complex Client Needs**: Many clients have co-occurring mental health and substance use disorders, and a significant portion are unhoused.
2. **Service Gaps**: Long wait times for services and the need for mental health peer respite services.
3. **Unserved Populations**: Unhoused individuals with mental health and substance use disorders, especially those using K2 (synthetic marijuana).
4. **Hopelessness**: Clients often feel hopeless due to barriers and lack of access to care.

Prioritized Issues:

1. **Reduce Wait Times**: Address the gap between intake and service delivery.
2. **Expand Peer Respite Services**: Provide more mental health peer respite services for individuals who do not require hospitalization.
3. **Increase Outreach to Unhoused Populations**: Develop targeted outreach programs for unhoused individuals with mental health and substance use disorders.
4. **Improve Staffing Consistency**: Address staffing turnover to ensure consistent care for clients.

Central Region

Common Themes:

1. **Behavioral Health Needs**: Mental health is a top priority, especially for pregnant and postpartum mothers, teachers, and students.
2. **Access Barriers**: Transportation and long wait times are significant barriers to accessing care.
3. **School-Based Services**: There is a strong need for more school-based mental health services and support for teachers.
4. **Dental Care**: Limited access to dental care, especially for low-income individuals.

Prioritized Issues:

1. **Expand School-Based Services**: Increase mental health services in schools and provide more support for teachers.
2. **Address Transportation Barriers**: Partner with local transit authorities to improve access to care.
3. **Improve Dental Access**: Expand dental services, especially for adults and Medicaid patients.
4. **Enhance Communication**: Improve communication about available services, especially crisis centers and open access.

Eastern Region

Common Themes:

1. **Jail Diversion**: The jail has become a de facto mental health facility, with a significant portion of inmates on psychotropic medications.
2. **Therapy Access**: Difficulty accessing therapy for individuals in skilled nursing facilities.
3. **Service Navigation**: Clients and advocates find it challenging to navigate Compass services due to complexity and lack of clear communication.
4. **Home-Based Assessments**: Need for home-based assessments to improve access for clients.

Prioritized Issues:

1. **Expand Jail Diversion Programs**: Provide more mental health and substance use treatment units in jails.
2. **Increase Therapy Services**: Improve access to therapy for individuals in skilled nursing facilities.
3. **Simplify Service Navigation**: Streamline the process for accessing Compass services and improve communication.
4. **Provide Home-Based Assessments**: Offer home-based assessments to reduce barriers for clients.

Jefferson County Region

Common Themes:

1. **Behavioral Health Progress**: Significant strides have been made, but more work is needed, especially in schools.
2. **Transportation Barriers**: Transportation remains a major barrier to accessing care.
3. **Parenting Support**: Need for more parenting help and modeling for families.
4. **Dental Care**: Limited access to dental care, especially for low-income individuals.

Prioritized Issues:

1. **Increase School-Based Services**: Provide more mental health services in schools and support for teachers.
2. **Address Transportation Barriers**: Partner with local transit authorities to improve access to care.
3. **Expand Parenting Support**: Offer more parenting classes and support for families.
4. **Improve Dental Access**: Expand dental services, especially for adults and Medicaid patients.

Southern Region

Common Themes:

1. **Behavioral Health Crisis**: Significant need for more behavioral health services, especially for youth and individuals with substance use disorders.
2. **Jail Navigator Programs**: Expansion of jail navigator programs is needed to help with transitions back to the community.
3. **Substance Use Treatment**: Lack of treatment options for non-opioid substance use disorders.
4. **Collaboration with Law Enforcement**: Need for better coordination with law enforcement to address mental health crises.

Prioritized Issues:

1. **Expand Jail Navigator Programs**: Provide more support for individuals transitioning back to the community.
2. **Increase Substance Use Treatment**: Expand treatment options for non-opioid substance use disorders.
3. **Enhance Collaboration with Law Enforcement**: Improve coordination with law enforcement to address mental health crises.
4. **Provide More Inpatient Beds**: Increase the number of inpatient beds for behavioral health.

Western Region

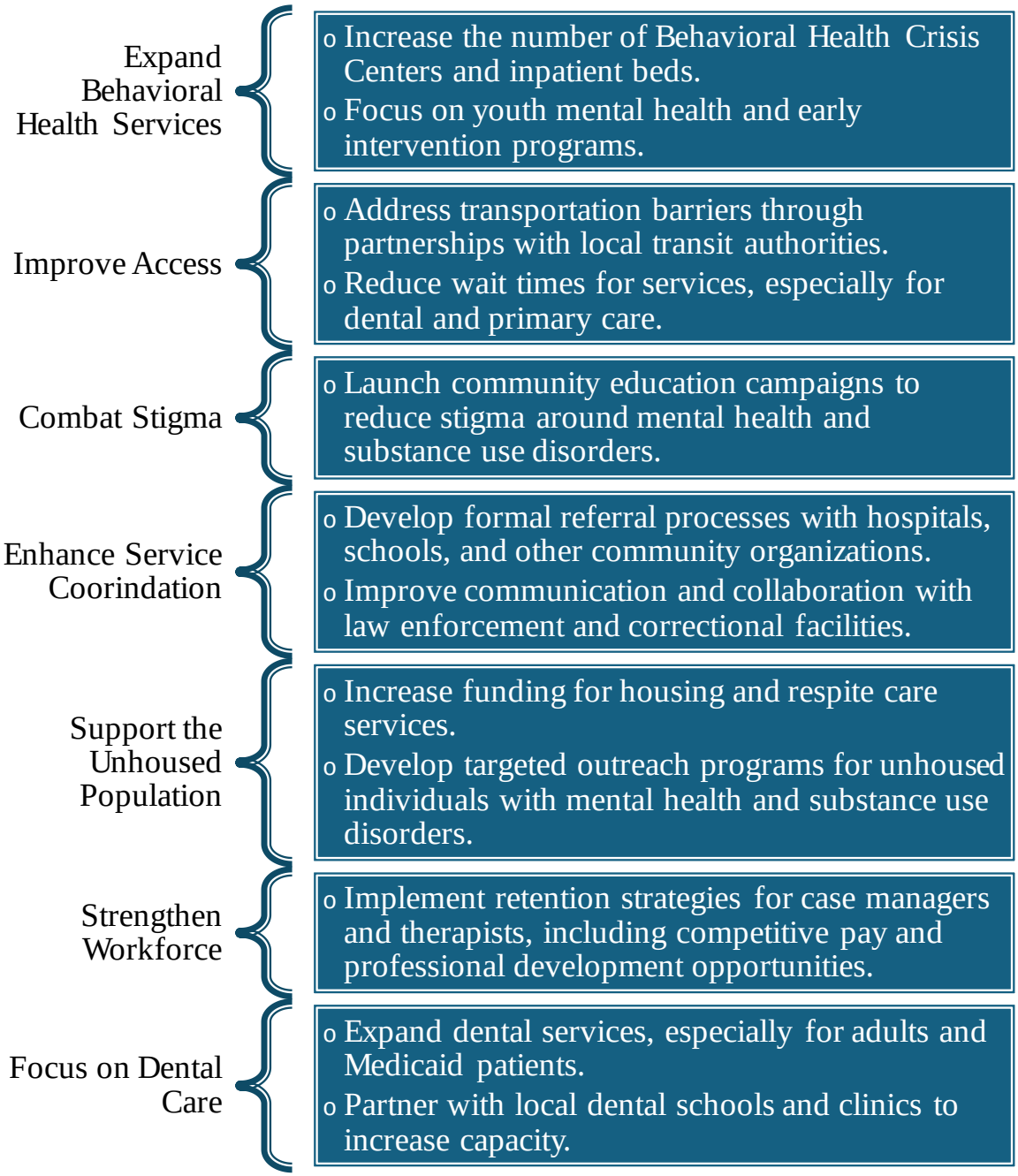
Common Themes:

1. **Youth Mental Health**: Significant need for more mental health services for youth, especially post-pandemic.
2. **Homelessness**: Growing need for services for homeless individuals, including mental health and substance use treatment.
3. **Dental Care**: Limited access to dental care, especially for low-income individuals.
4. **Parenting Support**: Need for more parenting support and resilience-building programs.

Prioritized Issues:

1. **Expand Youth Mental Health Services**: Provide more school-based mental health services and early intervention programs.
2. **Address Homelessness**: Increase housing and respite care services for homeless individuals.
3. **Improve Dental Access**: Expand dental services, especially for adults and Medicaid patients.
4. **Provide Parenting Support**: Offer more parenting classes and support for families.

Potential Cross-Regional Strategic Priorities from These Findings



Needs Identified by Clients

Focus Group Findings

Six groups of Compass Health Network customers with serious mental illness were targeted for interviews/surveys in December 2024 as part of the needs assessment process. The groups, served by Compass at its Wellness Centers in Raymore (Cass County; Western Region), Eldon (Miller County; Central Region), Rolla (Phelps County; Southern Region), Festus (Jefferson County), St. Peters (St. Charles County; Eastern Region), and ADAPT (St. Louis City) were assessed using a questionnaire adapted from the focus group script used in the previous 2023 needs assessment process. It was streamlined significantly to focus on the theme of healthcare needs and suggestions for improvement; i.e., gaps in healthcare services, examples of unmet healthcare desires or needs, and possible solutions or alternatives presented by participants as ways to improve individual or community health or healthcare services. A total of 54 customers (8 from Raymore, 9 from Eldon, 13 from Rolla, 12 from Festus, 8 from St. Peters, and 4 from ADAPT) provided responses, with roughly equivalent proportions of those identifying as males and females. The results, derived through iterative content analysis by independent raters, are described below.

Raymore Wellbeing Center (December 11, 2024)

1. Quality of Life

- **Theme**: Mixed satisfaction with quality of life, with community and wellness resources positively impacting perceptions.
  - *"The Wellbeing center helps relieve stress, and I like spending time with the people here more than they like their animals."*
  - *"Dying of cancer… I feel like the only one who is dealing with problems because everyone is different, except here."*

2. Health Challenges

- **Theme**: Chronic illnesses, mental health struggles, and limited resources for healthy living.
  - *"I have diabetes and the knowledge to eat healthily, but not the funds to do so."*

3. Unmet Needs

- **Theme**: Transportation, clothing, and improved facilities were major concerns.
  - *"Using the IHS to call disability transportation service is very expensive, and they can be rude."*
  - *"We need better clothing for the seasons and help cleaning."*

4. Social Connection

- **Theme**: Overwhelming loneliness despite physical proximity to others.
  - *"I feel very lonely… all the time."*
  - *"I am afraid to call the crisis line because they might admit me."*

Raymore Summary:

Participants reported mixed quality-of-life scores, emphasizing the importance of community support but citing financial and housing struggles. Health challenges included chronic conditions and mental health issues. Improved transportation, enhanced staff interactions, and access to healthy food were identified as critical needs.

Eldon Clubhouse (December 12, 2024)

1. Quality of Life

- **Theme**: Improved quality of life linked to recovery support and crafts-based activities.
  - *"My life is a 3, but when I am here, it's a 7 or 8. Quality of life improves immediately."*

2. Transportation Challenges

- **Theme**: Difficulties in accessing reliable transportation to medical appointments and other needs.
  - *"Now I am on a special list because MTM missed me twice."*
  - *"Employees use personal vehicles and the Compass van to transfer clients, but it's not enough."*

3. Facility Improvements

- **Theme**: Requests for better-equipped kitchens and more entertainment options.
  - *"We are learning to bake from scratch, so we need more counter space and a better microwave."*

4. Social and Emotional Connection

- **Theme**: Balancing loneliness with Compass as a community anchor.
  - *"Compass Health is my friend. If I could get a better home, it would be even better."*

Eldon Summary:

Quality of life was rated higher here, with participants attributing improvements to recovery support and personal growth activities. Transportation and housing remained significant concerns. The group highlighted the importance of expanded facilities for hygiene and exercise.

Rolla Wellbeing Center (December 16, 2024)

1. Quality of Life

- **Theme**: Strong sense of improvement from the center's support but lingering social challenges.
  - *"Being here with everybody has been a help to me. When I include the wellbeing center, my quality of life rises to an 8 or 7."*

2. Health Challenges

- **Theme**: Weight management, diabetes, and medication side effects.

- *"Frustrations with weight loss, especially with medications prescribed that cause weight gain."*

3. Facility Requests

- **Theme**: Need for practical life skills training and improved resources.
  - *"The kitchen has an instant pot, but not everyone has that at home. We need to learn transferable skills."*

4. Transportation Barriers

- **Theme**: Difficulty getting to specialized doctors and appointments.
  - *"Medicaid transportation is not reliable; sometimes they don't pick you up at all."*

Rolla Summary:

Participants acknowledged the center's role in meeting basic needs and improving their social lives. Transportation challenges were prevalent. Requests included enhanced one-on-one support, technology access, and a larger kitchen for life skills training.

Festus Wellbeing Center (December 17, 2024)

1. Quality of Life

- **Theme**: Gratitude for support and housing assistance but significant housing insecurity.
  - *"My CSS helping me find an apartment to subsidize would help me get to a 10."*
  - *"I live in a residential home. It's okay, but I'd like to be on my own."*

2. Unmet Needs

- **Theme**: Emphasis on housing support and extended operating hours for the center.
  - *"We need a department for housing support. The list I have has numbers that don't answer or don't meet the criteria."*
  - *"Most reported they would utilize the center during evening hours."*

3. Health Challenges

- **Theme**: Barriers to accessing specialized care and maintaining healthy living habits.
  - *"Needs a podiatrist… hard to clip nails and maintain foot health."*

4. Social Connections

- **Theme**: Mixed satisfaction with social opportunities.
  - *"Half of the group would like more social connections and to talk about their problems more openly."*

Festus Summary:

Housing insecurity and transportation were prominent issues. The center's supportive environment was praised, with participants advocating for partnerships to address unmet needs like housing, transportation, and nighttime programs.

St. Peters Headway Center (December 18, 2024)

1. Quality of Life

- **Theme**: High appreciation for the center but concerns about isolation and limited transportation.
  - *"I live on the other side of the river, don't know too many people or my way around. I need a friend."*

2. Transportation

- **Theme**: A pervasive barrier to independence and accessing opportunities.
  - *"Medicaid transportation will get me to the doctor but won't pick me back up."*

3. Social Needs

- **Theme**: Struggles with social skills and forming deeper relationships.
  - *"Love and intimacy… I don't want to be lonely."*

4. Health Challenges

- **Theme**: Navigating healthcare systems with limited resources and knowledge.
  - *"I have multiple doctors, appointments, and medications that don't always react well together."*

St. Peters Headway Center Summary:

While many expressed gratitude for the center's services, transportation and social isolation were recurring themes. Participants highlighted the need for better insurance coverage, job support, and expanded programming for physical and behavioral health needs.

St. Louis ADAPT Center (December 18, 2024)

1. Quality of Life

- **Theme**: Desire for more autonomy and dissatisfaction with constraints.
  - *"Even if we work, they take 40% of it. It's not enough money at all."*

2. Health Challenges

- **Theme**: Frustration with misdiagnosis and insufficient medical attention.
  - *"Doctors should listen to us more, give us more than five minutes of their time."*

3. Unmet Needs

- **Theme**: Greater food variety and opportunities for self-expression.
  - *"We need more healthy foods; we eat the same things over and over."*

4. Social Connection

- **Theme**: Limited access to broader community connections.
  - *"I write poetry and would like to connect with the poetry world."*

St. Louis ADAPT Center Summary:

Participants in this smaller group emphasized challenges, such as inadequate government benefits and healthcare access. They praised the Wellness Center for its education programs and support but highlighted unmet needs in transportation, technology access, and healthy food.

Qualitative Analysis Across All Focus Groups

1. Quality of Life

- Common Themes: Ratings varied widely (from 2/10 to 20/10). Positive factors included strong community support, personal growth opportunities, and family connections. Negative factors were often related to financial instability, housing challenges, and limited social connections.
- Notable Observations: Many participants noted a significant improvement in quality of life linked to the Wellbeing Centers, emphasizing a sense of belonging and safety.

2. **Health Challenges**

- Common Issues: Chronic illnesses (e.g., diabetes, arthritis, cancer), mental health conditions (e.g., bipolar disorder, schizophrenia, PTSD), and dental care were frequently mentioned. Several participants cited challenges in accessing healthcare and maintaining a healthy diet due to financial limitations.
- Emerging Needs: More accessible health and dental services, specialized care like podiatry, and dietary support.

3. **Unmet Needs**

- Recurring Requests: Improved transportation, more one-on-one staff time, expanded facilities for hygiene and cooking, and access to affordable healthy food. Several groups also noted the need for better technological support and skill-building opportunities.
- Barriers: Financial constraints, inefficiencies, and gaps in social services.

4. **Loneliness and Social Connection**

- Key Insights: Loneliness was pervasive, even among those engaged in community activities. Coping mechanisms included spending time at Wellbeing Centers, social media, and faith-based connections.
- Suggestions: Programs to build deeper social connections and support groups tailored to specific challenges.

5. **Transportation**

- Critical Barrier: Inadequate and unreliable transportation hindered access to healthcare, social opportunities, and essential services. Many participants proposed collaboration with local organizations to expand transport options.

6**. Social Media**

- Varying Experiences: Some participants found social media useful for maintaining connections, while others cited its negative impacts, including drama and unhealthy comparisons.

Cross-Focus Group Themes and Recommendations

Consistent Themes:

1. **Transportation**: Universally recognized as a significant barrier to accessing essential services and social opportunities.
2. **Social Isolation**: Loneliness persisted despite engagement in activities; deeper connections and tailored support are needed.
3. **Financial Constraints**: Limited income impacted access to healthy food, housing, and healthcare.
4. **Health and Wellness**: Chronic illnesses and mental health conditions were common. Dental care and weight management emerged as unmet needs.
5. **Wellness Centers as Safe Havens**: Participants consistently valued the centers as places of belonging, growth, and support.

Emergent Themes:

1. **Desire for Tailored Support**: Many participants sought more personalized attention from staff, including one-on-one counseling.
2. **Technology as a Tool**: Requests for better access to computers and digital literacy training were common.
3. **Integrated Services**: Suggestions included collaborations with local nonprofits to enhance transportation and housing options.

Recommendations:

- **Transportation Solutions**: Collaborate with local organizations to expand affordable and reliable transportation options.
- **Enhanced Social Programs**: Develop initiatives to foster deeper connections and reduce loneliness.
- **Facility Improvements**: Expand kitchen and hygiene facilities to support life skills training.
- **Health Initiatives**: Increase access to affordable dental care, healthy food, and weight management programs.
- **Staff Training and Resources**: Provide staff with resources to offer more personalized support.

Summary of Focus Group Themes and Findings

Overall Trends

Mean Ratings: The average quality of life rating across all groups was approximately 7.5, indicating moderately high satisfaction overall. However, this average masks significant variability within and between groups.

Range of Ratings: Ratings ranged from 3 to an exceptionally high 20, with some groups reporting extreme lows linked to personal hardships and barriers, and others reflecting a strong sense of community or personal progress.

Group Comparisons

Raymore Wellbeing Center

Average Rating: 7.5

Unique Observations: This group exhibited the widest range of ratings (from 3 to 20), suggesting highly varied personal circumstances. A standout comment was the 20/10 rating, attributed to a participant's gratitude for personal aspects like companionship from pets.

Challenges: Several participants noted hardships, such as a lack of privacy, financial struggles, and mental health difficulties, pulling the average rating downward.

Eldon Clubhouse

Average Rating: 7.56

Consistency: Most participants reported ratings in the 7–9 range, reflecting a generally positive view of their quality of life.

Key Influences: Positive community engagement and recovery-focused activities significantly enhanced participants' well-being, although transportation challenges and housing issues were noted.

Rolla Wellbeing Center

Average Rating: 7.63

High Ratings: Several participants expressed satisfaction with the support and skills they gained at the center, with comments like "Being here with everybody has been a help to me."

Barriers: Despite the high average, social isolation and health-related frustrations (e.g., medication side effects, weight management) persisted.

Festus Wellbeing Center

Average Rating: 6.83

Lower Average: This group had the second-lowest average rating, with some participants citing significant housing insecurity and transportation issues.

Key Needs: Many participants sought housing support and extended operating hours at the center to improve their circumstances.

St. Peters Headway Center

Average Rating: 7.4

Transportation-Driven Frustrations: The limited access to reliable transportation was a recurring theme, directly impacting quality-of-life ratings.

Positive Remarks: Participants appreciated the sense of safety and support provided by the center, with one person remarking, "Thank God for Headway and the Wellbeing Center."

St. Louis ADAPT Center

Average Rating: 6.88

Significant Barriers: Financial instability, dissatisfaction with medical attention, and challenges (e.g., benefit reductions) negatively impacted ratings. Comments like "Doctors should listen to us more and give us more than five minutes of their time" were reflective of broader frustrations.

Community Value: Participants consistently highlighted the center's role in improving their sense of connection and providing structured support.

Shared Strengths:

Across all groups, participants consistently valued the Wellbeing Centers for providing a sense of belonging, community, and safety. Many participants noted significant improvements in their quality of life when actively engaged in center activities, with multiple ratings rising by several points when considering the centers' impact.

Group-Specific Differences:

Groups like Rolla and Eldon had higher average ratings due to strong community engagement and satisfaction with center programs.

Festus and St. Louis ADAPT groups reported lower averages, driven by barriers like housing insecurity, transportation, and dissatisfaction with medical support.

Extreme Ratings:

The 20/10 rating at Raymore Wellbeing Center was an outlier but highlights the deep gratitude participants feel for specific aspects of their lives, such as access to care or companionship.

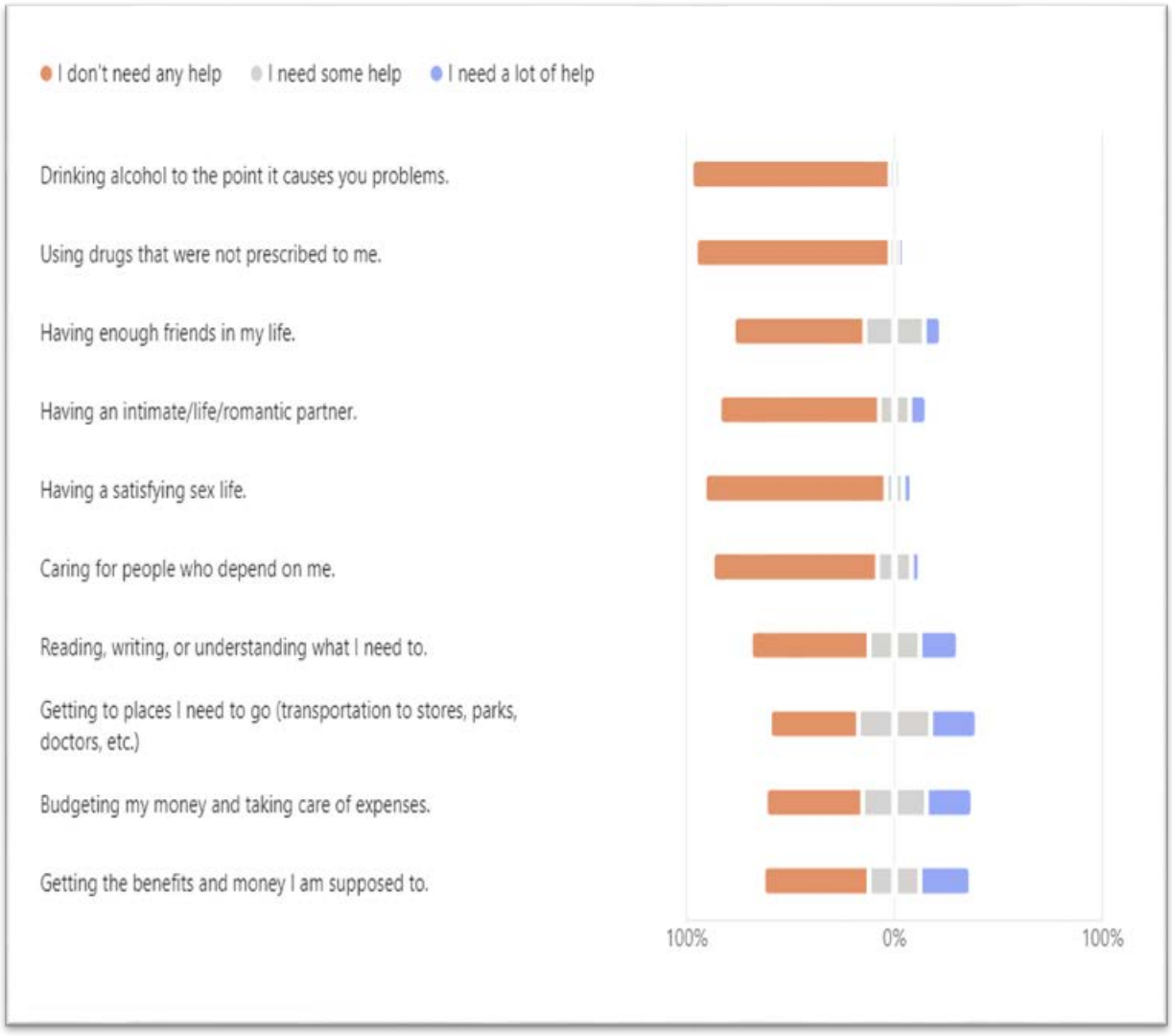
Conclusion

While overall ratings suggest moderate satisfaction, the significant variability points to persistent structural challenges (e.g., housing, transportation) and the critical role of Wellbeing Centers in mitigating these barriers. Continued investment in targeted interventions—particularly in areas with lower averages—can further improve the quality of life for participants.

Structured Needs Assessment of Customers with SMI

The following data was collected using an online platform known as Microsoft Forms. Some results also include printed off surveys that were filled out by respondents and then keyed in by a member of the research team. The form collected no identifying information. The results are, therefore, anonymous. A link to the survey was also posted on a private Facebook page for certain wellbeing centers. These pages are only available for previous and current wellbeing center clients.

The results of the survey include 49 respondents, each of whom was able to not answer any questions which made them uncomfortable or that they could not understand. Most of the respondents answered each question with only a few who skipped any questions. Only one question was skipped by more than one client, and it was not answered by two respondents. The question skipped by two respondents asked about needing help with thoughts about harming oneself. With a response rate of 99.42% we conclude that this survey was understood and did not cause significant distress in respondents.



Of the 21 topics asked about in the survey, 4 stand out as areas the clients needed more help than others. Those topics include in no particular order:

- Reading, writing, and understanding what they need to
- Getting to places they need to go (i.e. transportation)
- Budgeting and expenses
- Accessing and utilizing benefits

There were also 4 topics that had the least need reported by respondents. Those topics include, again in no particular order:

- Thoughts of harming oneself
- Thoughts of harming others
- Drinking too much alcohol
- Using drugs not prescribed/misuse of prescribed medication

Prioritized Population Health Needs and Disparities for Compass Regions as Identified in Regional Community Health Needs Assessments

The information in this section was gathered from the most recent available community health needs assessments conducted (as required by the Affordable Care Act) by regional non-profit hospitals, whose service areas fully or partially overlap Compass Health Network regions (i.e., if there are any overlapping counties). In addition to a compendium of the prioritized health needs in each region, any health disparities discovered in the community health needs assessment process are also provided below. The method used was as follows: (1) Extract up to the top five prioritized health needs from each CHNA, (2) Compile these needs, in order, for each Compass region, and (3) Identify and list up to the top five health needs that occurred most frequently in that master list for each region. Below is a list of the CHNAs included in our analysis, followed by a summary of the prioritized needs and health disparities populations by region.

ADAPT Region (St. Louis City)

Community health needs assessments from the following hospitals, health systems, or collaboratives overlapping with the ADAPT Region are included here:

- City of St. Louis Department of Health 2022

Central Region (Audrain, Boone, Callaway, Chariton, Cole, Cooper, Howard, Linn, Miller, Moniteau, Montgomery, Osage, Randolph Counties)

Community health needs assessments from the following hospitals, health systems, or collaboratives overlapping with the Central Region are included here:

- Pike County Memorial Hospital 2022
- Columbia/Boone County Public Health and Human Services 2023
- SSM Health St. Mary's Hospital – Jefferson City 2021
- General John J. Pershing Memorial Hospital 2022
- Cole County Health Department 2023
- Hannibal Regional Hospital 2022
- Lake Regional Health System 2021
- Audrain-Montgomery Community Health Assessment Partnership (AMCHAP) 2018
- Boone Hospital Center 2022

Eastern Region (Lincoln, St. Charles, St. Louis, Warren Counties)

Community health needs assessments from the following hospitals, health systems, or collaboratives overlapping with the Eastern Region are included here:

- Barnes-Jewish St. Peters Hospital 2022
- SSM Health St. Joseph Hospital 2021
- Mercy Hospital Lincoln/Lincoln County Health Department 2022

- St. Louis County Department of Public Health 2022

Jefferson County

Community health needs assessments from the following hospitals, health systems, or collaboratives overlapping with the Jefferson County Region are included here:

- Mercy Hospital Jefferson County 2022

Southern Region (Camden, Crawford, Dent, Franklin, Gasconade, Iron, Laclede, Maries, Phelps, Pulaski, St. Francois, Washington Counties)

Community health needs assessments from the following hospitals, health systems, or collaboratives overlapping with the Southern Region are included here:

- Missouri Baptist Sullivan Hospital 2022
- Salem Memorial District Hospital 2022
- Mercy Hospital Washington 2022
- Parkland Health Center 2022
- Phelps Health 2022
- Economic Security Corporation of Southwest Area 2021
- Washington County Rural Health Network 2019
- Ozarks Healthcare 2022
- Lake Regional Health System 2022
- Mercy Hospital Lebanon 2022

Western Region (Bates, Benton, Carroll, Cass, Cedar, Henry, Hickory, Jackson, Johnson, Lafayette, Morgan, Pettis, St. Clair, Saline, Vernon Counties)

Community health needs assessments from the following hospitals, health systems, or collaboratives overlapping with the Western Region are included here:

- Bates County Memorial Hospital 2022
- Bothwell Regional Health Center 2022
- Carrol County Memorial Hospital and Carroll County Health Department 2022
- Cass Regional Medical Center 2022
- Fitzgibbon Hospital 2022
- Golden Valley Memorial Healthcare/Compass Health Network & Henry County Health Center 2022
- Lake Regional Health System 2021
- Western Missouri Medical Center 2022
- Cedar County Memorial Hospital 2023
- Citizens Memorial Hospital 2022
- Missouri Baptist Sullivan Hospital 2022
- Lafayette County Health Department 2024
- St. Luke’s Hospital of Kansas City 2023

Summary and Cross-Cutting Themes from Regional CHNAs

In the Central region, access to healthcare remains a primary concern, particularly for uninsured and underinsured populations. Limited transportation infrastructure exacerbates these challenges, making it difficult for residents to access preventive care and specialist services. Chronic diseases, including obesity and heart disease, are prevalent and contribute to rising healthcare costs and diminished quality of life. Economic instability and limited social support systems further impact overall well-being. To address these challenges, investments in transportation services can improve healthcare access. The expansion of Federally Qualified Health Centers (FQHCs) and mobile clinics can bring essential medical care to underserved populations. Strengthening partnerships between healthcare providers and local community organizations can enhance service availability. Targeted chronic disease prevention programs, including nutrition and exercise education, can help reduce the burden of illness. Additionally, workforce development and job training programs can support economic stability and improve access to healthcare resources.

The Southern region has a high prevalence of chronic diseases such as diabetes, hypertension, and obesity. Limited access to fresh and nutritious food, compounded by economic instability, has contributed to worsening health outcomes. Mental health concerns, including depression and substance abuse, are also prominent, with a lack of accessible mental health services exacerbating the crisis. Transportation and financial barriers further limit access to care for vulnerable populations. Implementing nutrition education programs and community gardens can improve food security and encourage healthier eating habits. Expanding access to preventive screenings and chronic disease management programs can enhance early detection and treatment efforts. Promoting physical activity through community-based wellness initiatives and infrastructure improvements can help mitigate obesity and related conditions. The expansion of mental health services, including telehealth and integrated behavioral health programs, can provide critical support to those in need. Addressing transportation barriers through improved public transit and local ride assistance programs can ensure that healthcare services reach the most vulnerable populations.

The Eastern region struggles with housing instability and social determinants of health, affecting overall well-being. The lack of affordable housing options contributes to stress and exacerbates chronic health conditions. Additionally, economic differences create barriers to healthcare access. Mental health and substance abuse continue to be critical issues, with many individuals unable to receive timely care due to provider shortages and financial constraints. Strengthening affordable housing programs and rental assistance initiatives can provide stability and reduce health risks associated with inadequate housing. Workforce development programs can enhance economic stability and create new employment opportunities. Expanding public transportation options can improve healthcare access and enable residents to attend necessary medical appointments. Enhancing mental health services by increasing provider availability and community outreach efforts can address gaps in care. Substance abuse remains a pressing concern, and harm reduction strategies combined with rehabilitation programs can support long-term recovery and prevent further health complications.

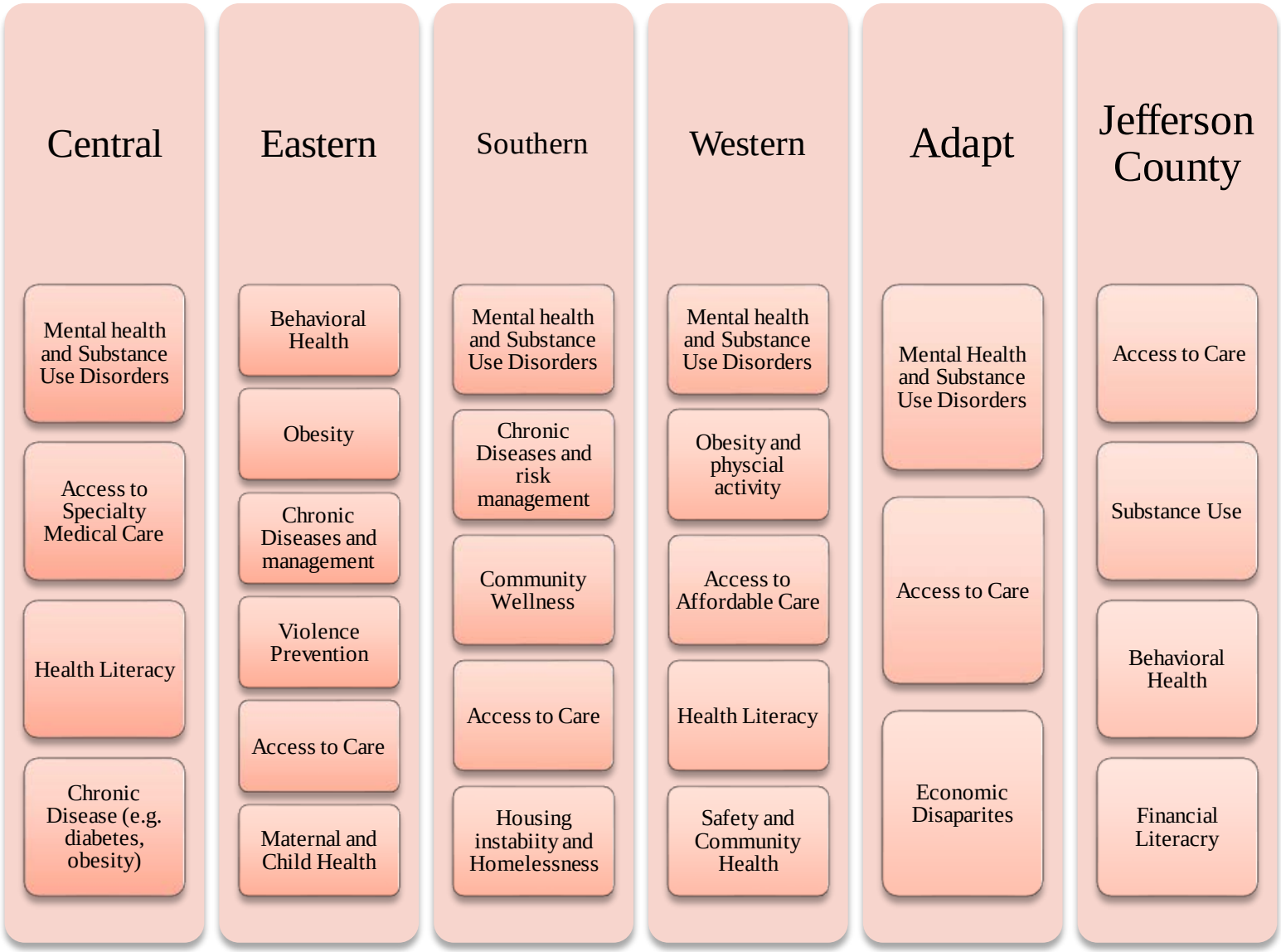
The Western region faces unique healthcare access challenges, particularly in underserved rural areas. Healthcare provider shortages, coupled with transportation difficulties, leave many residents without essential medical care. Chronic diseases such as obesity and diabetes remain prevalent, while economic hardships contribute to food insecurity and limited healthcare access. Mental health concerns, including high rates of depression and substance abuse, further complicate overall health outcomes. Recruiting and retaining healthcare professionals through loan forgiveness and possible incentive programs may help alleviate provider shortages. Expanding rural health networks and telemedicine services can ensure residents receive timely and specialized care; this will also help tackle issues with access to care in underserved communities. Community outreach efforts should be enhanced to connect residents with available resources and support services. Strengthening chronic disease prevention initiatives focused on nutrition and physical activity can lead to better health outcomes. Improving access to mental health services, including substance abuse treatment programs, is crucial for addressing the growing need for behavioral health support.

Jefferson County faces challenges with mental health, substance use, healthcare access, and financial literacy, impacting overall well-being. Limited behavioral health services and provider shortages hinder timely care, while rising substance use disorders strain emergency services. Economic instability and financial literacy gaps further restrict healthcare access. Expanding mental health and substance use programs, increasing mobile clinics and telehealth services, and strengthening transportation assistance can improve care accessibility. Investing in financial literacy education and workforce development can enhance economic stability and empower residents to navigate healthcare resources effectively.

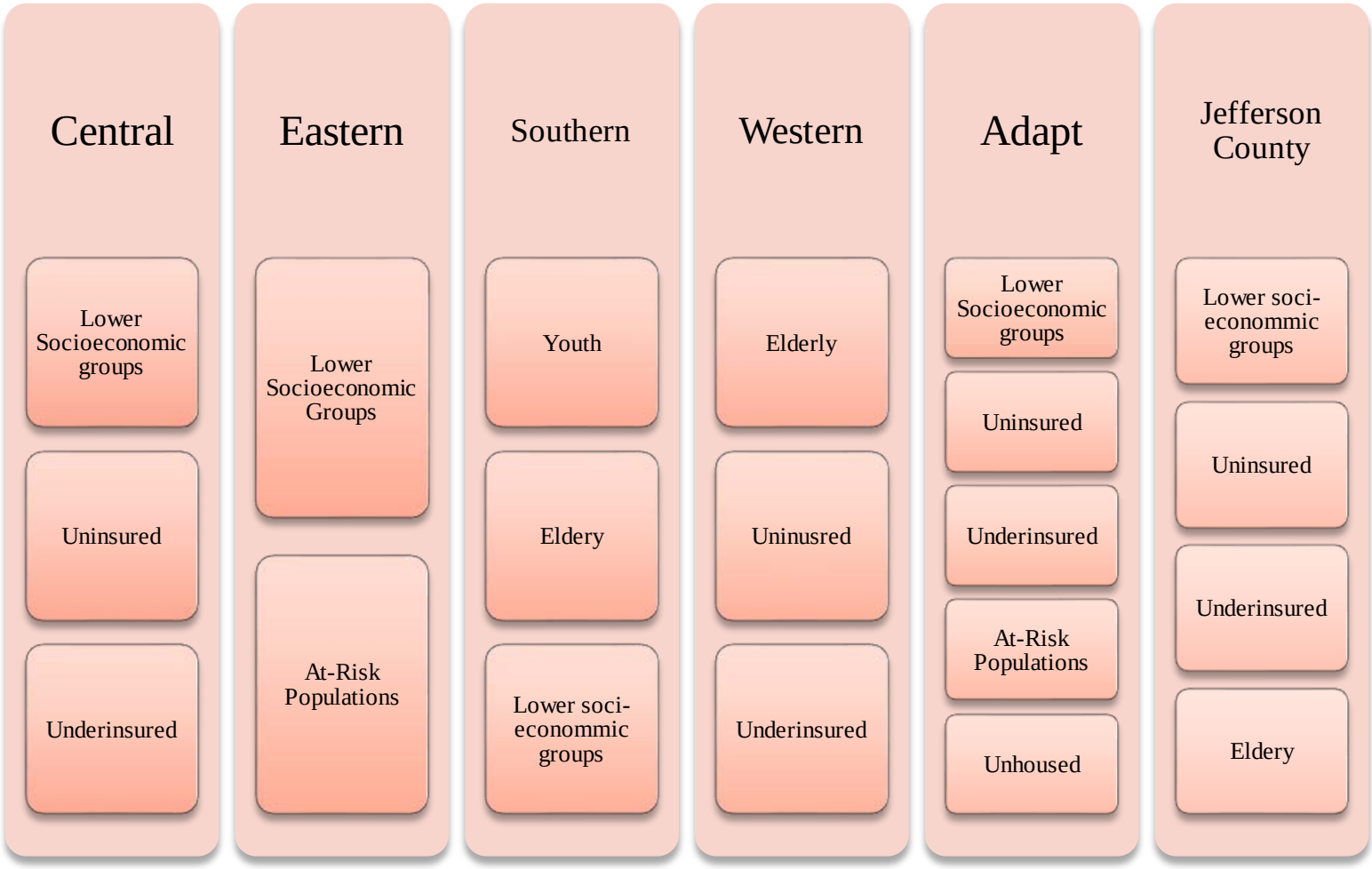
The ADAPT service area faces significant health challenges related to mental health, substance use, healthcare access, and economic variability, all of which impact overall well-being. High rates of mental health disorders and substance use, particularly opioid and alcohol misuse, continue to strain healthcare and emergency services. Provider shortages, financial constraints, and transportation barriers further limit access to care, disproportionately affecting underserved communities.

Expanding mental health and substance use programs, increasing mobile clinics, Federally Qualified Health Centers (FQHCs), and telehealth services, and strengthening transportation and housing assistance can improve access to care. Investing in workforce development, financial literacy education, and affordable housing initiatives can promote economic stability and improve overall health outcomes for vulnerable populations across the region.

Prioritized Health Summarized from Regional CHNAs



Summary of Health Disparities Identified in Regional CHNAs



Addressing these regional health disparities requires a tailored approach that considers local challenges and resources. By fostering collaboration between healthcare providers, policymakers, and community organizations, each region can implement targeted strategies to improve health outcomes and reduce these differences. Long-term investments in healthcare infrastructure, workforce development, and social services will be critical to sustaining these improvements and promoting overall community well-being.

Conclusion: Prioritized Needs to Guide Strategic Planning

This chapter synthesizes the findings from the comprehensive needs assessment conducted across Compass Health Network's service areas. The assessment utilized a variety of methodologies, including quantitative data analysis, qualitative interviews, focus groups, and stakeholder input, to identify and prioritize the most pressing health and behavioral health needs. The following sections discuss synthesis of qualitative and qualitative data, identify the most pressing health and behavioral health needs, categorize these needs into overarching themes, prioritize them based on their prevalence and impact, and provide actionable recommendations for addressing them.

I. ***Synthesizing Qualitative and Quantitative Findings***: differences in needs emerging from the qualitative (Compass Health Leadership, Stakeholder Interviews, etc.) versus the quantitative data (Sociodemographic and Health Status Overview, etc.):

Qualitative Data (Interviews, Surveys):

- **Focus:** Provides insights into the perceived needs and challenges from the perspective of Compass Health staff, primarily executives, senior managers, and directors, and community stakeholders.
- **Themes:**
    - **Access to Services:** Highlights gaps in access, particularly in behavioral health, dental services (especially for Medicaid patients), and primary care in rural areas.
    - **Provider Shortages:** Emphasizes shortages of behavioral health and dental providers.
    - **Impact of External Factors:** Acknowledges the pandemic's impact on increasing the need for behavioral health services.
    - **Insurance Acceptance:** Notes difficulties in finding providers who accept certain insurances in some regions (e.g., Western region).
    - **Specific Populations:** Identifies uninsured/underinsured individuals and rural populations as underserved.
- **Strengths:** Offers nuanced understanding of local challenges and service gaps from the viewpoint of those working within the Compass Health system.
- **Limitations:** Subjective perceptions; may not fully capture the breadth or depth of community needs as objectively measured.

Quantitative Data (Sociodemographic and Health Status Overview):

- **Focus:** Presents an objective, data-driven analysis of sociodemographic factors, health status, health outcomes, and health risk factors across Compass Health service areas.
- **Themes:**
    - **Regional Disparities:** Identifies significant regional differences in health outcomes (mortality rates, YPLL, low birthweight), health behaviors (smoking, excessive drinking, physical inactivity), access to resources (food environment, healthcare access, insurance), and sociodemographic factors (education, poverty, unemployment).
    - **Specific Areas of Concern:** Highlights specific concerns in regions like ADAPT and Southern, which consistently perform worse across multiple indicators.

    - **Disparities in Health Outcomes:** Showcases differences in rates of chronic diseases, mental health issues, substance use, and other health-related indicators.
- **Strengths:** Provides statistical evidence of health disparities and needs, allowing for targeted interventions based on objective data.
- **Limitations:** May not capture the underlying reasons or contextual factors driving the identified disparities; lacks the nuanced perspective of individual experiences.

Key Differences and Overlapping Themes:

- **Regional Disparities:** Both qualitative and quantitative data identify regional disparities. The quantitative data provides specific metrics to highlight these disparities (e.g., higher mortality rates in the Southern region), while the qualitative data offers insights into the challenges contributing to these disparities (e.g., transportation issues in the Western region).
- **Behavioral Health:** Both sources emphasize behavioral health as a significant need. The qualitative data highlights long waitlists and provider shortages, while the quantitative data shows higher rates of mentally unhealthy days in certain regions.
- **Access to Care:** Both sources identify access to care as a major challenge for uninsured/underinsured individuals and those in rural areas. The quantitative data supports this by showing higher uninsurance rates in specific regions.
- **Underserved Populations:** Both the qualitative and quantitative data sources point to the same underserved populations. Qualitative insights highlight specific access barriers, while the quantitative data demonstrates the impact of these barriers on health outcomes.

The two types of data complement each other, providing a more comprehensive understanding of the health and behavioral health needs within the Compass Health service areas. Integrating these findings can inform targeted interventions and resource allocation to address the identified disparities and improve health outcomes for the populations served.

II. ***Most Pressing Needs Identified***: Based on all findings, here are some of the most pressing health and behavioral health needs identified within the Compass Health service areas:

1. Behavioral Health:

- **High Need Across All Regions:** Long waitlists and a shortage of providers are consistently reported.
- **Exacerbation Due to Pandemic:** The pandemic has significantly increased the demand for behavioral health services.
- **Mental Health Challenges:** The ADAPT region reports significantly higher rates of mentally unhealthy days, indicating a need for targeted mental health interventions.

2. Disparities Across Regions:

- **ADAPT and Southern Regions:** These regions consistently show worse outcomes across multiple indicators, suggesting a need for concentrated health and social service interventions. This includes higher rates of:
    - Premature mortality
    - Smoking
    - Chlamydia
    - Teen Births

    - Uninsurance
    - Children in Single-Parent Households
    - Injury Death Rate
    - Severe Housing Problems
- **Eastern Region:** Generally reports better health outcomes compared to Southern and Western regions, but disparities still exist.

3. Access to Care:

- **Uninsured/Underinsured:** Difficulty accessing services is a common issue for this population across many regions.
- **Rural Areas:** Lack of access to primary care is a significant challenge.
- **Insurance Acceptance:** Difficulty finding providers who accept certain insurances, particularly in the Western region.

4. Specific Health Concerns:

- **Mortality Rates:** Higher mortality rates in the Central and Southern regions compared to the Eastern region.
- **Years of Potential Life Lost (YPLL):** The ADAPT region experiences significantly higher rates of premature mortality.
- **Low Birthweight:** The Eastern region reports lower percentages of low birthweight infants compared to Southern regions, reflecting variables in maternal and child health.
- **Substance Use:** Higher rates of excessive drinking observed in the ADAPT region.
- **Oral Health:** Gaps in dental services, especially for Medicaid patients, and a lack of dental providers in some regions like the Western region.

5. Sociodemographic Factors:

- **Poverty:** Higher child poverty rates in Southern regions.
- **Education:** Lower educational attainment in the ADAPT and Southern regions.
- **Unemployment:** Higher unemployment rates in the Southern region.

In summary, the most pressing needs are in behavioral health, addressing regional disparities (particularly in the ADAPT and Southern regions), improving access to care for vulnerable populations, and tackling specific health concerns influenced by sociodemographic factors.

III. ***Categorization of Needs***

Based on the analysis presented in the preceding sections, the identified needs can be broadly categorized into the following areas:

1. **Behavioral Health:** This encompasses mental health, substance use disorders, and related support services.
2. **Physical Health:** This includes primary care access, chronic disease management, oral health, and preventative services.
3. **Socioeconomic Factors:** This includes poverty, housing instability, food insecurity, lack of transportation, and unemployment, all of which significantly impact health outcomes.
4. **Healthcare Access:** This includes insurance coverage, availability of services, and high quality competency of care.

5. **Public Health:** This includes health education, prevention programs, and addressing health risk behaviors.

IV. *Prioritization Methodology*

The prioritization of needs is based on the following criteria:

1. **Prevalence and Impact:** The number of individuals affected by the need and the severity of its impact on their health and well-being.
2. **Disparities:** The extent to which the need disproportionately affects specific populations or geographic regions.
3. **Alignment with Compass Health's Mission and Capacity:** The degree to which addressing the need aligns with Compass Health's mission, strategic priorities, and existing resources.
4. **Feasibility:** The availability of evidence-based interventions and the potential for successful implementation within the Compass Health service area.
5. **Stakeholder Input:** Consideration of the perspectives and priorities of Compass Health leadership, community partners, and clients.

V. *Prioritized Needs and Potentially Actionable Recommendations*

Based on the above criteria, the following health and behavioral health needs are prioritized for action:

Tier 1: Critical and Immediate Needs

1. **Expanding Access to Mental Health and Substance Use Services**
    - **Rationale:** The data consistently indicates a significant need for increased mental health services across all regions, especially in ADAPT, with long waitlists, a shortage of providers, and high rates of mentally unhealthy days. Substance abuse, particularly opioid and alcohol misuse, is a growing concern.
    - **Actionable Steps:**
        - Increase provider capacity by recruiting and retaining more mental health professionals through competitive compensation and supportive work environments.
        - Expand tele-behavioral health services to increase access in underserved areas.
        - Develop more crisis diversion units and intermediate care options for youth and adults to prevent hospitalizations and provide timely care.
        - Implement evidence-based mental health programs in schools and community centers, focusing on early intervention and prevention.
        - Enhance crisis intervention services and mobile outreach teams to respond to mental health emergencies.
2. **Affordable Housing Solutions**
    - **Rationale:** High rates of poverty, housing instability, and food insecurity, particularly in the Southern and ADAPT regions, significantly impact health outcomes. Affordable housing is a critical need, especially for individuals with serious mental illness (SMI) and substance use disorders (SUD).
    - **Actionable Steps:**
        - Partner with local housing authorities and nonprofits to develop housing-first programs that provide stable living environments for individuals with SMI and SUD.
        - Create more step-down units and clustered apartments to provide transitional housing for individuals moving from hospitals or crisis centers.
        - Advocate for policies that address poverty, housing affordability, and food security.

3. **Transportation Solutions**
    - **Rationale:** Lack of reliable transportation is a pervasive issue, particularly in rural regions, preventing individuals from accessing necessary healthcare services.
    - **Actionable Steps:**
        - Collaborate with local transit authorities and ride-sharing services to provide affordable and reliable transportation options for healthcare appointments.
        - Expand mobile clinic services to bring healthcare directly to underserved rural and urban areas.
4. **Chronic Disease Prevention and Management**
    - **Rationale:** Chronic conditions such as diabetes, hypertension, and obesity are prevalent across all regions. There is a need for more preventive care, chronic disease management programs, and education on healthy lifestyles.
    - **Actionable Steps:**
        - Implement community-based wellness initiatives focused on nutrition, physical activity, and chronic disease management.
        - Use telehealth to provide ongoing support and monitoring for individuals with chronic conditions, reducing the need for in-person visits.

Tier 2: High-Priority Needs

1. **Youth and Transitional-Age Services**
    - **Rationale:** There is a growing need for mental health services for children and adolescents, particularly in the wake of the COVID-19 pandemic. Youth aging out of foster care or transitioning to adulthood face significant gaps in services.
    - **Actionable Steps:**
        - Expand early intervention programs, school-based mental health services, and transitional care for youth aging out of foster care.
        - Provide training for teachers to identify and support students with mental health needs.
2. **Dental Care Access**
    - **Rationale:** Access to dental services, particularly for Medicaid patients, is a significant unmet need. Many regions report a lack of dental providers, especially for adults.
    - **Actionable Steps:**
        - Continue to expand dental services, especially for underserved populations.
        - Recruit and retain dental providers who accept Medicaid.
        - Implement oral health education programs in schools and community settings.
3. **High Quality Care**
    - **Rationale:** There is a need for more and better care, particularly for parts of St. Louis, where distrust in healthcare systems is a barrier to access.
    - **Actionable Steps:**
        - Enhance competency training for staff and engage in community outreach to build trust with underserved populations.
        - Actively recruit and retain a workforce that reflects the communities served by Compass Health Network.
4. **Telehealth Expansion**
    - **Rationale:** While telehealth has potential, its adoption has waned post-pandemic, and there is a need to expand and promote its use to overcome geographic and transportation barriers.
    - **Actionable Steps:**
        - Promote and expand telehealth services to overcome geographic and transportation barriers, particularly in rural areas.

Tier 3: Important but Less Immediate Needs

1. **Food Security Initiatives**
    - **Rationale:** Limited access to healthy and affordable food is a significant issue, particularly in rural and low-income areas. This contributes to chronic health conditions like obesity and diabetes.
    - **Actionable Steps:**
        - Develop community gardens, nutrition education programs, and partnerships with local food banks to address food insecurity.
2. **Economic Stability Programs**
    - **Rationale:** High rates of unemployment, poverty, and income differences are prevalent, particularly in Southern and ADAPT regions. Economic instability limits access to healthcare and contributes to poor health outcomes.
    - **Actionable Steps:**
        - Invest in workforce development, job training, and financial literacy programs to improve economic stability and healthcare access.
3. **Staff Training and Retention**
    - **Rationale:** There is a need for additional training for staff on specialized issues (e.g., forensic populations, co-occurring disorders) and strategies to reduce turnover.
    - **Actionable Steps:**
        - Provide additional training for staff on specialized issues and implement strategies to reduce turnover.
4. **Prevention Services**
    - **Rationale:** There is a need to expand prevention efforts, particularly for substance use, and focus on secondary and tertiary prevention programs.
    - **Actionable Steps:**
        - Expand prevention efforts, particularly for substance use, and focus on secondary and tertiary prevention programs.

Conclusion

This prioritized list of needs provides a potential data-based roadmap for Compass Health to focus its resources and efforts on addressing the most pressing health and behavioral health challenges within its service area. By implementing the actionable steps outlined above, Compass Health can make a significant impact on the health and well-being of the communities it serves. The focus should be on expanding access to care, addressing social determinants of health, and ensuring that available services are of high quality. Long-term investments in healthcare infrastructure, workforce development, and community partnerships will be essential to sustaining these improvements and promoting overall community well-being.

Appendices

Appendix A: Data Dictionary and Data Sources for Indicators

Measure	Data Elements	Description
Geographic identifiers	**FIPS**	Federal Information Processing Standard
	State	
	County	
Premature Death	Unreliable	Value reported but considered unreliable since based on counts of twenty or less.
	Deaths	Number of deaths <75
	Years of Potential Life Lost Rate	Age-adjusted YPLL rate per 100,000
Poor or Fair Health	**% Fair or Poor Health**	Percentage of adults that report fair or poor health
Poor Physical Health Days	**Average Number of Physically Unhealthy Days**	Average number of reported physically unhealthy days per month
Poor Mental Health Days	**Average Number of Mentally Unhealthy Days**	Average number of reported mentally unhealthy days per month
Low Birthweight	Unreliable	Value reported but considered unreliable since based on counts of twenty or less.
	% Low Birthweight	Percentage of births with low birthweight (<2500g)
Adult Smoking	**% Adults Reporting Currently Smoking**	Percentage of adults that reported currently smoking
Adult Obesity	**% Adults with Obesity**	Percentage of adults that report BMI >= 30
Food Environment Index	**Food Environment Index**	Indicator of access to healthy foods - 0 is worst, 10 is best
Physical Inactivity	**% Physically Inactive**	Percentage of adults that report no leisure-time physical activity
Access to Exercise Opportunities	**% With Access to Exercise Opportunities**	Percentage of the population with access to places for physical activity
Excessive Drinking	**% Excessive Drinking**	Percentage of adults that report excessive drinking
Sexually Transmitted Infections	# Chlamydia Cases	Number of chlamydia cases
	Chlamydia Rate	Chlamydia cases per 100,000 population

Teen Births	**Teen Birth Rate**	Births per 1,000 females ages 15-19
Uninsured	# Uninsured	Number of people under age 65 without insurance
	% Uninsured	Percentage of people under age 65 without insurance
Primary Care Physicians	# Primary Care Physicians	Number of primary care physicians (PCP) in patient care
	Primary Care Physicians Rate	Primary Care Physicians per 100,000 population
	Primary Care Physicians Ratio	Population to Primary Care Physicians ratio
Dentists	# Dentists	Number of dentists
	Dentist Rate	dentists per 100,000 population
	Dentist Ratio	Population to dentists ratio
Mental Health Providers	# Mental Health Providers	Number of mental health providers (MHP)
	Mental Health Provider Rate	Mental Health Providers per 100,000 population
	Mental Health Provider Ratio	Population to Mental Health Providers ratio
Preventable Hospital Stays	**Preventable Hospitalization Rate**	Discharges for Ambulatory Care Sensitive Conditions per 100,000 Medicare Enrollees
Mammography Screening	**% with Annual Mammogram**	Percentage of female Medicare enrollees having an annual mammogram (age 65-74)
Flu Vaccinations	**% Vaccinated**	Percentage of annual Medicare enrollees having an annual flu vaccination
High School Completion	# Completed High School	Adults age 25 and over with a high school diploma or equivalent
	Population	Adults age 25 and over
	% Completed High School	Percentage of adults age 25 and over with a high school diploma or equivalent
Unemployment	# Unemployed	Number of people ages 16+ unemployed and looking for work
	Labor Force	Size of the labor force
	% Unemployed	Percentage of population ages 16+ unemployed and looking for work
Children in Poverty	**% Children in Poverty**	Percentage of children (under age 18) living in poverty
Income Inequality	80th Percentile Income	80th percentile of median household income
	20th Percentile Income	20th percentile of median household income
	Income Ratio	Ratio of household income at the 80th percentile to income at the 20th percentile

Children in Single-Parent Households	# Children in Single-Parent Households	Number of children that live in single-parent households
	# Children in Households	Number of children in households
	% Children in Single-Parent Households	Percentage of children that live in single-parent households
Social Associations	# Associations	Number of associations
	Social Association Rate	Associations per 10,000 population
Injury Deaths	# Injury Deaths	Number of injury deaths
	Injury Death Rate	Injury mortality rate per 100,000
Severe Housing Problems	**% Severe Housing Problems**	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities
	Severe Housing Cost Burden	Percentage of households with high housing costs
	Overcrowding	Percentage of households with overcrowding
	Inadequate Facilities	Percentage of households with lack of kitchen or plumbing facilities

Focus Area	Measure	Description	Source	Year(s)
HEALTH OUTCOMES				
Quality of Life	Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
	Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
	Diabetes Prevalence	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).	Behavioral Risk Factor Surveillance System	2021
	HIV Prevalence+	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2021
HEALTH FACTORS				
HEALTH BEHAVIORS				
Diet and Exercise	Food Insecurity	Percentage of population who lack adequate access to food.	Map the Meal Gap	2021
	Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	USDA Food Environment Atlas	2019
Alcohol and Drug Use	Drug Overdose Deaths*	Number of drug poisoning deaths per 100,000 population.	National Center for Health Statistics - Mortality Files; Census	2019-2021

			Population Estimates Program	
Other Health Behaviors	Insufficient Sleep	Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted).	Behavioral Risk Factor Surveillance System	2020
CLINICAL CARE				
Access to Care	Uninsured Adults	Percentage of adults under age 65 without health insurance.	Small Area Health Insurance Estimates	2021
	Uninsured Children	Percentage of children under age 19 without health insurance.	Small Area Health Insurance Estimates	2021
	Other Primary Care Providers	Ratio of population to primary care providers other than physicians.	CMS, National Provider Identification	2023
SOCIAL & ECONOMIC FACTORS				
Education	High School Graduation+	Percentage of ninth-grade cohort that graduates in four years.	EDFacts	2020-2021
	Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	American Community Survey, 5-year estimates	2018-2022
Income	Median Household Income*	The income where half of households in a county earn more and half of households earn less.	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates	2022 & 2018-2022
Family and Social Support	Residential Segregation - Black/White	Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents.	American Community Survey, 5-year estimates	2018-2022
Community Safety	Homicides*	Number of deaths due to homicide per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2015-2021
	Suicides*	Number of deaths due to suicide per 100,000 population (age-adjusted).	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2017-2021
	Firearm Fatalities*	Number of deaths due to firearms per 100,000 population.	National Center for Health Statistics - Mortality Files; Census Population Estimates Program	2017-2021
DEMOGRAPHICS				
All	Population	Resident population.	Census Population Estimates Program	2022
	% Below 18 Years of Age	Percentage of population below 18 years of age.	Census Population Estimates Program	2022
	% 65 and Older	Percentage of population ages 65 and older.	Census Population Estimates Program	2022

	% Non-Hispanic Black	Percentage of population identifying as non-Hispanic Black or African American.	Census Population Estimates Program	2022
	% American Indian or Alaska Native	Percentage of population identifying as American Indian or Alaska Native.	Census Population Estimates Program	2022
	% Asian	Percentage of population identifying as Asian.	Census Population Estimates Program	2022
	% Native Hawaiian or Other Pacific Islander	Percentage of population identifying as Native Hawaiian or Other Pacific Islander.	Census Population Estimates Program	2022
	% Hispanic	Percentage of population identifying as Hispanic.	Census Population Estimates Program	2022
	% Non-Hispanic White	Percentage of population identifying as non-Hispanic white.	Census Population Estimates Program	2022
	% Not Proficient in English	Percentage of population aged 5 and over who reported speaking English less than well.	American Community Survey, 5-year estimates	2018-2022
	% Female	Percentage of population identifying as female.	Census Population Estimates Program	2022
	% Rural	Percentage of population living in a census-defined rural area.	Decennial Census Demographic and Housing Characteristics File	2020

Appendix B: Regional Stakeholder Interviewee List

Eastern Region

Position	County
Department of Corrections	St. Charles
Health Department	Warren
The Community and Children's Resource Board	St. Charles
Public Administrator	St. Charles
Chairmen and Resident	St. Charles
Former Senator and Chair of Public Service Commission	St. Charles
Public Administrator	Lincoln
The Community and Children's Resource Board	St. Charles

Jefferson County Region

Position	County
Superintendent	Jefferson
Mercy Jefferson	Jefferson
Mercy Jefferson	Jefferson

Central Region

Position	County
County Commissioner	Boone
County Commissioner	Boone
United Way of Central Missouri	Cole
Community Health Center of Central Missouri	Cole
Health Department	Randolph
Columbia Public Schools Health Services	Boone
Community Services Department	Boone
Missouri Representative	Cole
Health Department	Osage
Missouri Senator	Linn

Southern Region

Position	County
Missouri House of Representatives	Phelps
Sheriff's Department	Phelps

Crisis Intervention Team	Maries
Healthy Dent County	Dent
Franklin County Resource Board	Franklin
Health Department	Dent
Mercy Washington Supervisor	Franklin
Probation and Parole Supervisor	Crawford
Phelps Health	Phelps
Four Rivers Community Health Center	Phelps

Western Region

Position	**County**
Gaurdian ad Litem	Lafayette
Previous Superintendent	Cass-Raymore
Healthy Nevada	Vernon
Juvenile Officer	Lafayette
Mental Health Coordinator	Pettis
Senator	several
Public Administrator	Lafayette
Cass County Coalition	Cass-Raymore

ADAPT Region

Position	**County**
St. Louis Empowerment Center	St. Louis City
STL Public Library	St. Louis City
St. Francis Xavier Church	St. Louis City

Appendix C: CHNA Table

County	Year	Region	Vulnerable Population(s)	Vulnerable population #2	Health Needs 1	Health Needs 2	Health Needs 3	Health Needs 4	Health Needs 5	Hospital System/ Writer of CHNA
St. Louis City	2022	ADAPT	Black/ African American residents	People with substance use disorder	Behavioral Health	Violence prevention	Intersection of Health and Economic Mobility	Maternal and Child Health	Chronic diseases	City of St. Louis Department of Health/ St. Louis County Department of Public Health
Audrain	2022	Central	Lower socio-economic groups		Mental health	Substance abuse	Obesity/nutrition	Access to care		Pike County Memorial Hospital
Boone	2023	Central	Lower socio-economic groups		Mental health	Healthy Behaviors	Substance abuse	Affordable Housing	Barriers to Care	Columbia/Boone County Public Health and Human Services
Callaway	2021	Central	Lower socio-economic groups	Uninsured/ undersinsured	Mental health	Specialty medical care	Health literacy			SSM Health St. Mary's Hospital – Jefferson City
Chariton	2022	Central	Elderly/Older adults	Youth	Chronic diseases	Access to care	Childhood/Adult Obesity			General John J. Pershing Memorial Hospital
Cole	2023	Central	Lower socio-economic groups/Women	Uninsured/ undersinsured	Mental and Maternal Health	Chronic Disease	Access to Care			Cole County Health Department
Cooper	2017	Central								
Lewis	2022	Central	Uninsured/Underinsured		Mental health	Available workforce	Substance abuse	Child care	Chronic diseases	Hannibal Regional Hospital
Marion	2022	Central	Uninsured/Underinsured		Mental health	Available workforce	Substance abuse	Child care	Chronic diseases	Hannibal Regional Hospital
Miller	2021	Central	Uninsured		Mental health	Access to care	Ability to pay and/or lack of insurance			Lake Regional Health System
Moniteau	2021	Central	Lower socio-economic groups	Uninsured/ undersinsured	Mental health	Specialty medical care	Health literacy			SSM Health St. Mary's Hospital – Jefferson City
Monroe	2022	Central	Uninsured/Underinsured		Mental health	Available workforce	Substance abuse	Child care	Chronic diseases	Hannibal Regional Hospital
Montgomery	2018	Central			Mental health/Substance abuse	Access to care	Chronic diseases	Health Literacy		Audrain-Montgomery Community Health Assessment Partnership (AMCHAP)
Osage	2021	Central	Lower socio-economic groups	Uninsured/ undersinsured	Mental health	Specialty medical care	Health literacy			SSM Health St. Mary's Hospital – Jefferson City

Pike	2022	Central	Lower socio-economic groups		Mental health	Substance abuse	Obesity/nutrition	Access to care		Pike County Memorial Hospital
Ralls	2022	Central	Uninsured/Underinsured		Mental health	Available workforce	Substance abuse	Child care	Chronic diseases	Hannibal Regional Hospital
Shelby	2022	Central	Uninsured/Underinsured		Mental health	Available workforce	Substance abuse	Child care	Chronic diseases	Hannibal Regional Hospital
Linn	2022	Central	Elderly/Older adults	Youth	Chronic diseases	Access to care	Childhood/Adult Obesity			General John J. Pershing Memorial Hospital
Central Region	2021	Central	Lower socio-economic groups	Uninsured/ undersinsured	Mental health/Substance abuse	Access to Specialty Care	Health literacy			SSM Health St. Mary's Hospital - Jefferson City
Howard	2022	Central	Lower socio-economic groups	ED Utilizers	Diabetes	Heart and vascular disease	Skin cancer			Boone Hospital Center
Randolph	2022	Central	Elderly/Older adults	Youth	Chronic diseases	Access to care	Childhood/Adult Obesity			General John J. Pershing Memorial Hospital
Lincoln	2022	Eastern	Uninsured	Lower socio-economic groups	Behavioral Health	Housing Instability	Transportation			Mercy Hospital Lincoln/Lincoln County Health Department
St. Charles	2022	Eastern	Lower socio-economic groups	Homeless/Unhoused	Mental health	Heart and vascular disease				BJH-St. Peters
Warren	2021	Eastern	Lower socio-economic groups	Disabled persons	Behavioral Health	Chronic diseases	Obesity			SSM Health St. Joesph Hospital
Eastern Region	2021	Eastern	Lower socio-economic groups		Obesity	Chronic diseases	Behavioral health	Access to care		SSM Health St. Joseph Hospital
St. Louis	2022	Eastern	Black/ African American residents	People with substance use disorder	Behavioral Health	Violence prevention	Intersection of Health and Economic Mobility	Maternal and Child Health	Chronic diseases	City of St. Louis Department of Health/St. Louis County Department of Public Health
Jefferson	2022	Jefferson County			Access to care	Substance abuse	Behavioral health	Financial literacy		Mercy Hospital Jefferson
Crawford	2022	Southern	Lower socio-economic groups		Heart Health	Diabetes				Missouri Baptist Sullivan Hospital
Dent	2022	Southern	Lower socio-economic groups	Elderly groups	Affordable health care	Substance abuse	Obesity (Nutrition / Exercise	Lack of Dental care		Salem Memorial District Hospital
Franklin	2022	Southern	Homeless	Lower socio-economic groups	Housing instability	Obesity	Mental health/ SUD			Mercy Hospital Washington

Gasconade	2022	Southern	Homeless	Lower socio-economic groups	Housing instability	Obesity	Mental health/ SUD		Mercy Hospital Washington
Iron	2022	Southern	Lower socio-economic groups	Homeless/Unhoused	Mental health	Substance abuse			Parkland Health Center
Maries	2022	Southern	Elderly	Lower socio-economic groups	Community wellness	Access to care			Phelps Health
McDonald	2021	Southern	Lower socio-economic groups		Safe environment	Employment opportunities	Affordable housing	Health Literacy	Economic Security Corporation of Southwest Area
Phelps	2022	Southern	Elderly	Lower socio-economic groups	Community wellness	Access to care			Phelps Health
Pulaski	2022	Southern	Lower socio-economic groups		Community wellness	Access to care			Phelps Health
St. Francois	2022	Southern	Lower socio-economic groups	Homeless/Unhoused	Mental health	Substance abuse			Parkland Health Center
Washington	2019	Southern			Substance abuse	Mental health	Chronic diseases		Washington County Rural Health Network
Southern Region	2022	Southern	Youth		Mental health/Substance abuse	Chronic diseases	Heart Health	Access to care	Ozarks Healthcare
Camden	2022	Southern	Uninsured	Lower socio-economic groups	Mental health	Access to care	Ability to pay and/or lack of insurance		Lake Regional Health System
Laclede	2022	Southern	Uninsured/Underinsured	Lower socio-economic groups	Heart Health	Mental health	Substance abuse		Mercy Hospital Lebanon
Bates	2022	Western			Substance abuse	Mental health	Obesity/nutrition		Bates County Memorial Hospital/VVV Consultants LLC
Benton	2022	Western	Elderly	Uninsured	Substance abuse	Psychiatric IP Beds	Nursing Home (Available / Quality)		Golden Valley Memorial Healthcare/Compass Health Network & Henry County Health Center
Carroll	2024	Western	Youth	Lower socio-economic groups	SDOH	Mental health & substance abuse	Chronic diseases & Obesity		Carroll County Memorial Hospital and Carroll County Health Department

Cass	2022	Western	Elderly		Mental health	Lack Leadership "Community Health as a Priority	Obesity (Nutrition / Exercise		Cass Regional Medical Center/VVV Consultants LLC
Cedar	2023	Western	Elderly/Older adults	Uninsured/undersinsured	Mental health	Substance abuse	Child care		CCMH/VVV Consultants LLC
Henry	2022	Western	Elderly	Uninsured	Substance abuse	Psychiatric IP Beds	Nursing Home (Available / Quality)		Golden Valley Memorial Healthcare/Compass Health Network & Henry County Health Center
Hickory	2022	Western	Elderly/Older adults	Uninsured/ undersinsured	Smoking Cessation	Substance abuse	Adult obesity/physical inactivity	Availability of mental health providers	Citizens Memorial Hospital
Johnson	2022	Western	Uninsured/Underinsured		Mental health/Substance abuse	Affordable care	Chronic diseases		Western Missouri Medical Center/Quality Works
Morgan	2021	Western	Uninsured		Mental health	Access to care	Ability to pay and/or lack of insurance		Lake Regional Health System
Pettis	2022	Western	Underinsured		Mental health	Substance abuse	Obesity		Bothwell Regional Health Center
Polk	2022	Western	Elderly/Older adults		Smoking Cessation	Substance abuse	Adult obesity/physical inactivity	Availability of mental health providers	Citizens Memorial Hospital
Saline	2022	Western	Elderly	Lower socio-economic groups	Health literacy	Health advocacy	Preventative care and wellness		Fitzgibbon Hospital
St. Clair	2022	Western	Lower socio-economic groups		Heart Health	Diabetes			MBSH
Vernon	2023	Western			Mental health	Substance abuse	Child care		CCMH/VVV Consultants LLC
Jackson	2023	Western	Elderly	Lower socio-economic groups	Access to care	Mental health	SDOH		St. Lukes Hospital KCMO
Western Region	2022	Western	Elderly/Older adults	Uninsured/ undersinsured	Mental health/Substance abuse	Access to care	Obesity	Health Literacy	Western Missouri Medical Center
Lafayette	2024	Western	Women	Children/Youth	Women's Health	Access to care	Safety		Lafayette County Health Department

Appendix D: CHNA Requirements Crosswalk

Requirement agency	Topic	Specifics
SAMHSA	Description of Agency	A description of the physical boundaries and size of the service area, including identification of sites where services are delivered by the CCBHC, including through DCOs
	MH & SUD Prevalence	Information about the prevalence of mental health and substance use conditions and related needs in the service area, such as rates of suicide and overdose
	Social Determinants of Health	Economic factors and social determinants of health affecting the population's access to health services, such as percentage of the population with incomes below the poverty level, access to transportation, nutrition, and stable housing.
	Cultures and Languages	Cultures and languages of the populations residing in the service area
	Underserved populations	The identification of the underserved population(s) within the service area
	Staffing plans	A description of how the staffing plan does and/or will address findings
	Plan to update CHNA every 3 years	
	Input should come from the following entities if they are in the CCBHC service area	People with lived experience of mental and substance use conditions and individuals who have received/are receiving services from the clinic conducting the needs assessment
		Health centers (including FQHCs in the service area)
		Local health departments
		Inpatient psychiatric facilities, inpatient acute care hospitals, and hospital outpatient clinics
		One or more Department of Veterans Affairs facilities
		Representatives from local K-12 school systems
		Crisis response partners such as hospital emergency departments, emergency responders, crisis stabilization settings, crisis call centers and warmlines

	CCBHCs must engage also with other community partners, especially those who also work with people receiving services from the CCBHC and populations that historically are not engaging with health services, such as:	Organizations operated by people with lived experience of mental health and substance use conditions
		Other mental health and SUD treatment providers in the community
		Residential programs
		Juvenile justice agencies and facilities
		Criminal justice agencies and facilities
		Indian Health Service or other tribal programs such as Indian Health Service youth regional treatment centers as applicable
		Child welfare agencies and state licensed and nationally accredited child placing agencies for therapeutic foster care service
		Crisis response partners such as hospital emergency departments, crisis stabilization settings, crisis call centers and warmlines
		Specialty providers of medications for treatment of opioid and alcohol use disorders
		Peer-run and operated service providers
		Homeless shelters and housing agencies
		Employment services systems
		Services for older adults, such as Area Agencies on Aging
		Aging and Disability Resource Centers
		Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs)
	Needs Assessment Steering Committee	Have a needs assessment team to steer the process from beginning to end and ensure there are sufficient resources to complete all activities and put findings into practice.
HRSA	Conduct needs assessment every 3 years	
	Access to care and health care utilization	
	Top causes of morbidity and mortality	

	Unique health care needs or characteristics	
	The health center must assess the unmet need for health services in the catchment or proposed catchment area of the center based on the population served, or proposed to be served, utilizing, but not limited to, the following factors	Available health resources in relation to the size of the area and its population, including appropriate ratios of primary care physicians in general or family practice, internal medicine, pediatrics, or obstetrics and gynecology to its population
		Health indices for the population of the area, such as infant mortality rate
		Economic factors affecting the population's access to health services, such as percentage of the population with incomes below the poverty level
		Demographic factors affecting the population's need and demand for health services, such as percentage of the population age 65 and over
IRS	Every 3 years	
	Report details	Definition of community served
		Demographics of community
		Existing health care facilities and resources within the community that are available to respond to the health needs of the community
		How data was obtained
		The health needs of the community
		Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
		The process for identifying and prioritizing community health needs and services to meet the community health needs
		The process for consulting with persons representing the community's interests
		Information gaps that limit the hospital facility's ability to assess all of the community's health needs
	Input	Input from persons who represent the community served including those with special knowledge of or expertise in public health

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