

# 2025-2028 Community Health Needs Assessment and Improvement Plan





Where we've been, where we are today, and where we're going...

## A Message from Bob Cannon, President, BJC HealthCare, and David A. Braasch, President, Alton Memorial Hospital

At BJC HealthCare, our mission to improve the health and well-being of the communities we serve has guided us for decades. Community health improvement is not simply work we do—it is woven into our identity. As part of the health system's pillar of stewardship, community engagement is central to how we care for and invest in our region.

This report includes our 2025 Community Health Needs Assessment (CHNA) and the resulting 2026–2028 Community Health Improvement Plan (CHIP) for Alton Memorial Hospital, both of which reflect our ongoing commitment to understanding and addressing the unique health needs of the communities we serve.

We know that improving community health is not something we do alone. Collaboration is at the heart of this work. We are deeply grateful to the public health departments, community organizations, other health systems, health care providers, and countless dedicated community members who share our commitment to building a healthier future. Their insights, experiences, and leadership help shape our understanding of the challenges our neighbors face and the opportunities we have to improve health together.

For Alton Memorial Hospital, we are committing to focused efforts around mental health, obesity and maintaining health weight. These priorities were carefully determined through conversations with community members and leaders across the region, as well as a community health needs survey, public health data, and hospital data. Taken together, they reflect our shared vision for meaningful, measurable improvements in community health.

This report outlines the process we used to engage with the community and provides a roadmap for action. It is not a comprehensive list of every initiative underway, but rather a blueprint that demonstrates how we continually assess community needs, set priorities, and work collaboratively to address them.

At BJC HealthCare, we are proud to stand alongside our community in this important work. Together, we can continue to create healthier, stronger communities for generations to come.

Sincerely,



**Bob Cannon**  
President, BJC HealthCare



**David A. Braasch**  
President, Alton Memorial Hospital

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# About BJC HealthCare

BJC Health System is one of the largest nonprofit health care organizations in the United States. It is also the largest in the state of Missouri. BJC Health System serves communities in Missouri, southern Illinois, eastern Kansas, and throughout the Midwest. BJC HealthCare is the East Region of BJC Health System.

BJC HealthCare provides **high-quality and compassionate health care** and health services. BJC HealthCare includes 14 award-winning hospitals and other types of health care locations. Across these locations, BJC HealthCare offers a wide range of health services and care from professionals with expertise in their fields.



## Purpose

BJC HealthCare is dedicated to improving the health and well-being of the diverse communities we serve through an unwavering commitment to excellence in medicine and a spirit of curiosity that drives innovation and exceptional care.

## About the Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP)

All nonprofit hospitals, including all BJC HealthCare hospitals, are required to complete a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community of focus. While BJC hospitals serve lots of communities, for our CHNA we define our community as the county in which the hospital sits.

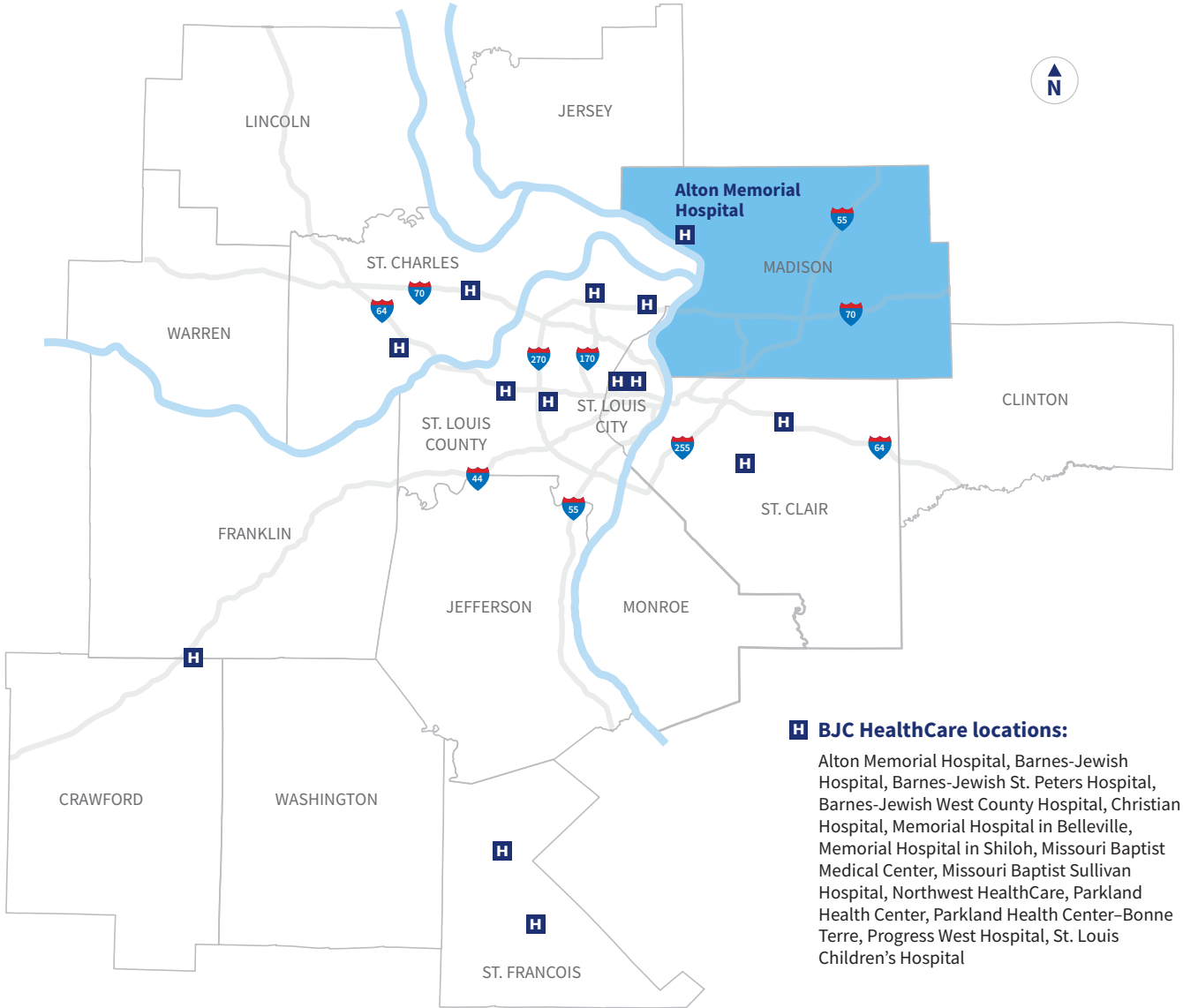
When their CHNAs are complete, hospitals create Community Health Improvement Plans (CHIPs). These plans set specific goals and actions to improve health needs in the community. In this report, we will share how we learned about health needs in the Alton Memorial Hospital community and chose which health needs to work on. Then, we will talk about our goals and plans for building a healthier community.

# Alton Memorial Hospital and the Community We Serve

The Alton Memorial Hospital Community Health Needs Assessment is focused on **Madison County, Illinois**.

Alton Memorial Hospital is a full-service acute care hospital with inpatient and outpatient services. Alton Memorial cares for Alton, Illinois, and the surrounding communities in a five-county area.

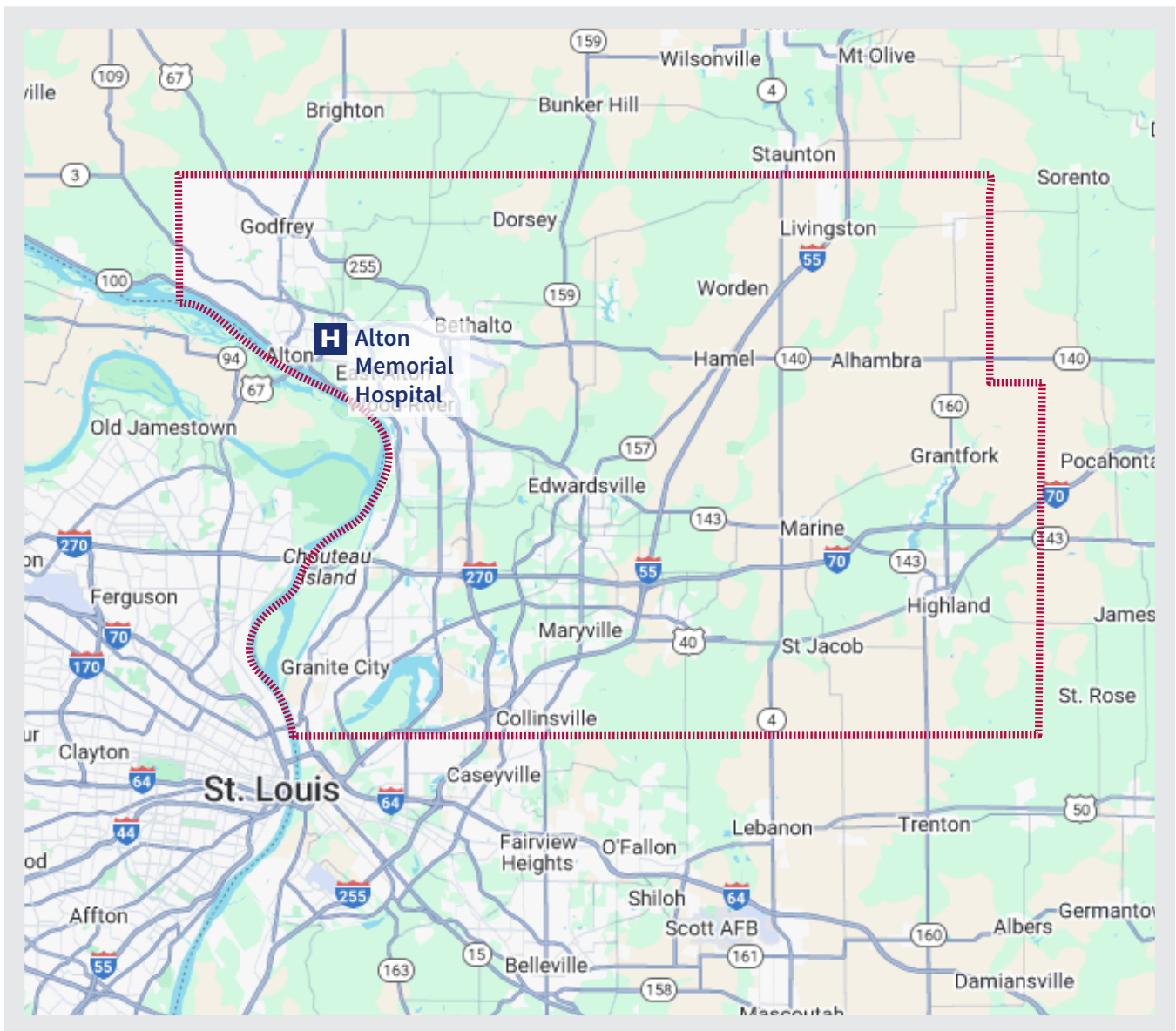
**Alton Memorial Hospital** is part of the larger BJC service area, which includes health care locations across the St. Louis region.



Alton Memorial offers services including surgery, imaging, interventional and diagnostic heart services, Siteman Cancer Network cancer care, therapy, 24-hour emergency care, ambulance services, and more. Alton Memorial has the only hospital-based bariatric program in the Metro East, offering surgical weight-loss management to promote lifelong wellness.

Alton Memorial is a **training site** for family medicine residents through Southern Illinois University School of Medicine in Springfield, Illinois. It is also a student rotation location for nursing, pharmacy, and radiology through Southern Illinois University of Edwardsville, Lewis and Clark Community College, and Southwestern Illinois College.

### Alton Memorial Hospital Community Health Needs Assessment service area close-up



Over the years, Alton Memorial has given back to the community in many ways. In 2023, Alton Memorial provided **\$20.8 million** in community benefit. This total includes:

- \$8.5 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- \$5.9 million in **services that fill gaps** in health care access for the community
- \$4.3 million in **unreimbursed care** for people with Medicaid and Medicare
- \$1.8 million in **education and professional support** for current and future health professionals
- \$0.2 million in **programs that bring health resources and education** to the community



In the United States, health insurance pays for the cost of most health care. Medicare and Medicaid are one type of insurance. People with this insurance pay for their health care with these programs. Sometimes, Medicare and Medicaid do not cover the full cost of health care services. This unpaid amount is known as **unreimbursed care**.

Alton Memorial has dedicated staff who provide care for many community members. The team includes 897 employees and 449 physicians who practice at our hospital. In 2024, we cared for 7,083 inpatient admissions, 3,830 outpatient surgeries, and 28,975 Emergency Department visits. See more details in the graphic below.

## Alton Memorial Hospital by the Numbers



**897**

Total  
Employees



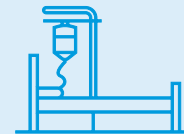
**449**

Physicians



**\$198.7**

Million  
Net Revenue  
(2023)



**158**

Staffed  
Beds



**7,083**

Inpatient  
Admissions



**3,830**

Outpatient  
Surgeries



**28,975**

Emergency  
Department  
Visits



**781**

Deliveries

About **265,000 people** call Madison County home.<sup>1</sup> The county is an urban area.<sup>1</sup> Most of the people who live in Madison County are white, and about one in five residents are older than 65 years.<sup>1</sup> The life expectancy for Madison County residents is about 75 years.<sup>2</sup> The life expectancy for all Illinois residents is about 78 years.<sup>2</sup>

Education, employment, and income are all important factors for health. For example, they can affect people's access to:

- Health care and insurance
- Healthy food
- Safe and healthy working conditions

About 4 in 10 Madison County households spend more than 30% of their income on housing costs like rent or mortgages.<sup>1</sup> When housing is expensive, it can be hard to meet other needs, like food or transportation.

In Madison County, **most residents have a high school degree.**<sup>1</sup> High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in Madison County is about \$75,000 per year.<sup>1</sup> This is lower than the median state household income.<sup>1</sup>

About one in seven children in Madison County live in poverty.<sup>1</sup> This is about the same as in Illinois.<sup>1</sup>

## Community Feature: Camp Dubois, Lewis and Clark Historic Site


Alton, Illinois, is home to the historic Camp River Dubois, located near the Mississippi River.<sup>3</sup> Meriwether Lewis, William Clark, and the Corps of Discovery stayed at the campsite through the winter of 1803 to May 1804, when they began their expedition to explore the Louisiana Purchase.<sup>3</sup> While at the site, the group prepared for their expedition by training and gathering necessary supplies.<sup>3,4</sup> Today, there is a reconstruction of the campsite that people can visit throughout the year.<sup>4</sup> At special events, there are also reenactors who show what life would have looked like then.<sup>4</sup> The visitor's center has a large exhibit area, theater, and gift shop.<sup>4</sup> There is also a replica of a 55-foot keelboat that shows how the Corps of Discovery packed the supplies needed for their journey.<sup>4</sup>




*Camp Dubois, Lewis and Clark Historic Site, Wood River, Illinois*

# Alton Memorial Hospital Community Characteristics

## Madison County

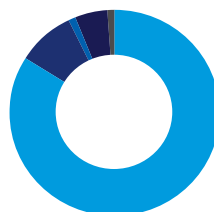


Population  
**264,631**



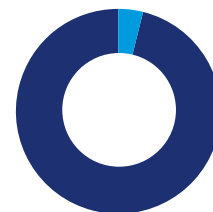
Land Area  
**740 sq. mi.**

## Race



**84%** White  
**9%** Black  
**1%** Asian  
**5%** 2 or more races  
**1%** Other\*

## Ethnicity



**4%** Hispanic/Latino  
**96%** Not Hispanic/Latino



Most people have at least a high school education

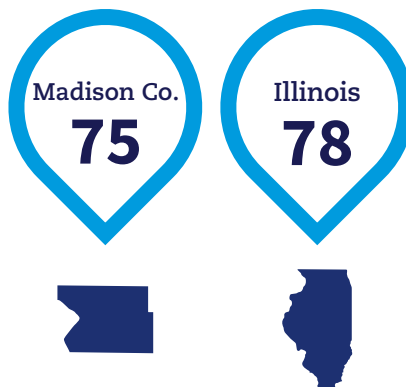



Madison Co.  
**94%**




Illinois  
**90%**


## Life Expectancy

The median household income in Madison County is lower than for the state of Illinois



Madison Co.  
**\$74,800**



Illinois  
**\$81,702**




Almost half of people spend more than 30% of their income on housing




Madison Co.  
**43%**




Illinois  
**44%**



Poverty rates among children in Madison County are about the same as in the state of Illinois

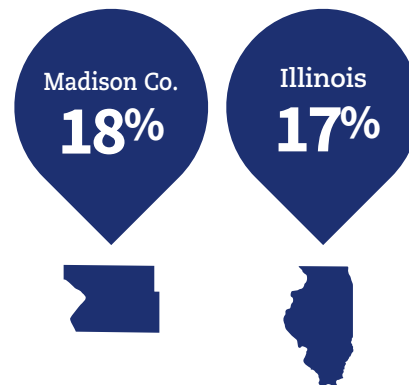


Madison Co.  
**14%**



Illinois  
**15%**

## People over 65



SOURCE: County Health Rankings,<sup>2</sup> U.S. Census Bureau<sup>1</sup>

\*Note: Other includes American Indian and Alaska Native people, Native Hawaiian and Pacific Islander people, and people of other races not included in the categories above.

At BJC HealthCare, we are committed to improving the health, well-being, and lives of the communities where we live and work. As part of this, we believe that the **experiences and voices of our community** must be at the center of all BJC Community Health Needs Assessments (CHNAs). Listening to and working with community members helps us make sure BJC CHNAs and Community Health Improvement Plans (CHIPs) reflect community members' experiences and meet community needs. Together, our community's CHNA and CHIP create a **roadmap for a healthier future.**



# Where We've Been...

In 2022, every BJC HealthCare East Region hospital completed a Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). Each hospital looked at its local community's **strengths, challenges, and opportunities**. Our region includes a wide geographic area. Every community we serve is unique. While some communities had similar health needs, our plans focused on local needs and resources.

We have worked hard to serve our communities and respond to the needs we found through the 2022 CHNA and CHIP. We looked at our progress toward the CHIP goals to help us understand what went well and what still needs work.

We made important progress across the region. These improvements came from the dedication of hospital teams and our collaborating organizations. Some successes include:

- **Having free health screenings** to find health concerns early and making follow-up appointments for those at high risk
- **Offering free education and counseling** for physical, mental, or behavioral health needs
- **Following up with program participants** to track progress, provide encouragement, and offer resources
- **Sharing self-care kits, test strips, and health information** at community events
- **Creating support groups** so that individuals facing similar health challenges can share experiences and learn coping skills
- **Working with community organizations** to share resources and create long-lasting solutions

These efforts reflect our commitment to improving community health. We want to put community members' needs first and create lasting change.



# Alton Memorial Hospital Community Health Needs and Goals from 2022–2025

In our last Community Health Needs Assessment at Alton Memorial Hospital, we learned that substance use and mental health were some of the top health concerns in Madison County. For each health need, we set a goal and made a plan to reach the goal.



## Substance Use

**Goal:** Reduce the number of drug-related and alcohol-related deaths in Madison County and surrounding counties.



## Mental Health

**Goal:** Address mental and behavioral health issues.

## Substance Use

### Our First Substance Use Strategy ►

We wanted to **help strengthen support for people with substance use disorder** by connecting them with certified peer recovery specialists. We reviewed how to use evidence-based practices to make sure patients have good outcomes. Then, we created the Alton Memorial Warm Handoff program to address the specific needs of people with substance use disorder.

In the Warm Handoff program, our certified peer recovery specialists use their lived experience and specialized training to support patients in developing coping strategies, engaging in treatment, and navigating barriers with recovery. The peer recovery specialists stayed in contact with patients for 90 days after their first visit and helped connect patients to treatment, community resources, and re-engagement when needed.

The Warm Handoff program team wanted to meet with patients returning to Alton Memorial Hospital for help with substance use disorders 90% of the time.

### Our Progress on Our First Substance Use Strategy ►

The Alton Memorial Warm Handoff program enrolled 758 patients. Of those 758 patients, 93 returned to the hospital for additional support and services. All 93 individuals met with a Warm Handoff team member and agreed to re-engage in treatment, resulting in a 100% re-engagement rate.

## Our Second Substance Use Strategy ►

We wanted to **connect more people who misuse substances to medication assisted recovery (MAR)**. Medication assisted recovery (MAR) combines medication and counseling to treat substance use disorder.<sup>5</sup> We offered MAR to patients when they came to the Emergency Department or were admitted to the hospital with substance use disorder.

Each patient would start medication to support their recovery. Each patient would be given a bridge prescription lasting until their scheduled follow-up appointment with a community provider. Bridge prescriptions make sure our patients receive enough medication to continue their treatment between visits. We wanted at least 80% of our patients who received MAR and a bridge prescription to attend their first appointment with their community treatment provider.

## Our Progress on Our Second Substance Use Strategy ►

285 patients consented to and received MAR. Of those 285 patients, 45 patients asked to taper off treatment during their hospital stay and did not have any plan to continue medication. Of the other 240 patients, 189 of them successfully attended their first appointment with their treatment provider, resulting in a 79% success rate.

## Our Third Substance Use Strategy ►

We also wanted to **reduce the number of people who die from substance use overdoses**. We gave out Naloxone, which is a medication that reverses opioid overdoses, to patients and visitors who were at risk for opioid overdose. We also gave Naloxone to people who may be able to assist someone after an overdose.

## Our Progress on Our Third Substance Use Strategy ►

There was a brief gap in distribution during program rollout while a process was established to meet regulatory requirements. Even with the slow start, in 2023 we identified 209 patients that had a high risk of opioid overdose. All 209 patients were offered Naloxone. 84% of the patients agreed to take home Naloxone.

In 2024, we expanded the program efforts. We identified 157 patients that had a high risk of an opioid overdose. We gave 98% of these patients Naloxone.

## Our Fourth Substance Use Strategy ►

To **reduce barriers in accessing community resources**, we used Alton Memorial's Mobile Health and Wellness vehicle to screen patients for different health factors. In addition to substance use, these included:

- Housing instability
- Depression
- Intimate partner violence
- Social connections
- Stress
- Physical activity
- Transportation
- Food insecurity
- Financial strain

Based on the results of the screening, the Mobile Health and Wellness staff provided harm reduction and focused on serving people who need the resources most, especially in places with many reported overdoses. Harm reduction aims to reduce the negative effects of behaviors or actions, instead of trying to stop them.<sup>6,7</sup>

## Our Progress on Our Fourth Substance Use Strategy ►

The Mobile Health and Wellness vehicle and the staff who run it were an important community resource, often collaborating with Southern Illinois School of Medicine residents and Dr. Christine Taylor. In 2023, the vehicle staff did 66 community outreach events. The Mobile Health and Wellness staff provided:

- 512 Naloxone kits
- 1,497 fentanyl test strips
- 706 xylazine test strips
- 121 medication waste bags
- 13 drug test administration kits
- 1 HIV test kit

The Mobile Health and Wellness staff went to 102 community outreach events in 2024. The vehicle staff provided:

- 869 Naloxone kits
- 1,122 fentanyl test strips
- 886 xylazine test strips
- 305 condoms
- 29 medication waste bags
- 44 drug test administration kits
- 15 HIV test kits

In addition to the harm reduction supplies provided in 2023 and 2024, the Mobile Health and Wellness staff provided important hygiene supplies like:

- Toothbrushes
- Shampoo
- Deodorant
- Feminine hygiene supplies
- Blood pressure monitors
- Glucose testing kits
- Wound care supplies

## Mental Health

### Our Strategy ►

We also wanted to address mental and behavioral health in Madison County and the surrounding areas.

We wanted to **connect patients to resources for mental and behavioral health**. We worked with community organizations that address mental and behavioral health to do so. These organizations included Gateway Regional Medical Center, Centerstone, and Touchette Hospital. We also connected patients to other external resources. We kept track of how many patients we referred to community organizations and how many organizations we worked with.

### Our Progress ►

We referred 540 patients to over 40 different behavioral health service providers.

# Where We Are Today...

## 2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of the Madison County community by doing a new Community Health Needs Assessment (CHNA). With the CHNA, we can make a plan with updated goals for improving community health. To understand Madison County's current needs, we used many **sources of information**. These included:



Community Survey



Community Information



Community Conversations



Hospital Service Information



Hospital Team Survey

This information helped us understand the strengths and challenges in our community. We used this information to find where to build more support and where to make changes to improve community health.

In this section, we will cover how we gathered information and what we learned from each source. You can find more details in the appendices.

Asking for and using community information is a matter of **trust and responsibility**. To protect the privacy of the people who participated, all information was kept confidential and secure. Names and other identifying information were removed from the health information. The information was only reviewed for large groups and not for individuals.

Improving the community's health takes collaboration. BJC HealthCare worked on the 2025 CHNA with many organizations. BJC HealthCare is part of the **St. Louis Regional Community Health Needs Assessment Collaborative**. This group includes other local hospital systems like SSM Health, Mercy, St. Luke's Hospital, and Shriners Children's. Together, the collaborative worked on a survey for the community about community health needs. The collaborative also co-hosted community leader and member conversations about community health needs. We used the same strategies across the entire region—from St. Louis, to Alton, to Sullivan, and beyond. The collaborative also worked with a local consulting group, Key Strategic Group (KSG), to **engage community leaders and members**. KSG is known for their skill in lifting up community voices to impact strategic work. BJC HealthCare collaborated with local health departments and community organizations to share the survey and co-host community conversations. By working together, we used community members' time wisely to make the biggest impact on community health.

## Community Survey

We invited **community members in Madison County** to fill out our survey and share their thoughts. They could take the survey in English or Spanish. This was the first time we have offered the survey in Spanish. BJC HealthCare employees who live in the county could take the survey, too. We asked about:

- **Health needs** of adults and children
- **Community resources** and strengths
- **Barriers** to health care

We collaborated with other hospitals to create and distribute the survey. By working together, we asked community members these questions once instead of multiple times.

We shared the survey online and in print. We used a QR code to share the survey more easily. Local community leaders and organizations helped us share the survey.

This included people from:

- Leaders and staff at local school districts and universities
- Public health and social service providers
- Other community support organizations

We also shared it at BJC hospitals, clinics, and community sites in Madison County. 241 community members completed the survey. See more details in Appendix B and Appendix C.

The top concerns among community members were mental health, obesity and maintaining healthy weight, heart conditions, and age-related illnesses. Specifically, mental health challenges like depression, anxiety, and alcohol use were concerns for the community.

We learned that costs, not enough services or providers, and health insurance not being accepted were serious challenges to getting care. The community needs more mental health and substance use services, affordable housing, and good paying jobs. See more details in the list on the right.



### COMMUNITY SURVEY

#### Top 5 Health Problems

1. Mental health
2. Obesity and maintaining healthy weight
3. Heart conditions (tie)
3. Age-related illnesses (tie)
4. Cancers

#### Top 6 Mental Health Concerns

1. Depression
2. Anxiety
3. Alcohol use
4. Drug use
5. Serious mental illnesses (tie)
5. Loneliness (tie)

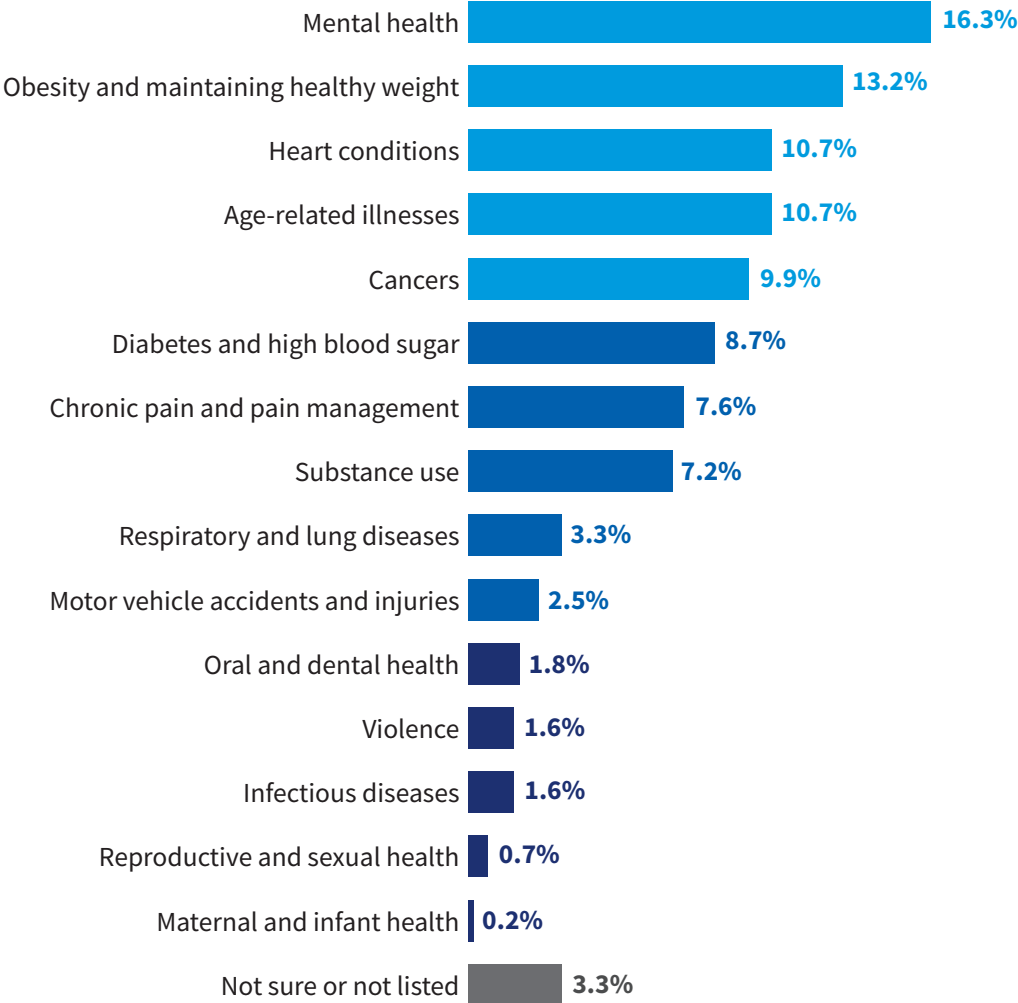
#### Top 5 Barriers to Care

1. Costs
2. Not enough services or providers
3. Health insurance is not accepted
4. Scheduling problems
5. No health insurance

#### Top 5 Community Resource Needs

1. Mental health and substance use services
2. Affordable housing
3. Good paying jobs
4. Aging services
5. Public transportation

Community members took the **Community Health Needs Assessment Survey** and identified the top three health problems affecting themselves and other adults in their communities. Here are the percentages of respondents who put each concern in their top three, ranked from **most concerning** to **moderately concerning** to **least concerning**.



## Community Information

We looked at community information for Madison County by using Conduent's [Healthy Communities Institute \(HCI\)](#) online tool. We use the HCI tool to explore **large amounts of information on community health**.

The HCI tool includes more than 100 social, economic, and health measurements. HCI has information from national and local sources, like the National Cancer Institute and the United States Census Bureau. The information from HCI is usually two to six years old because different information is collected at different times. It also takes time to get the data ready to be shared.

We looked at information about how common health issues like cancer, poor mental health, and high blood pressure are in our community. We also looked at information about community health outcomes, like the average number of days people reported experiencing poor mental health or the number of people killed by gun violence.

HCI also has information about **social determinants of health**. Social determinants of health are things that can make a community's health better or worse. Some examples of social determinants of health are education, strength of relationships, and access to healthy food. They can impact a community's ability to access health care or to live healthier lives.

We used HCI's Data Scoring Tool to compare Madison County with other communities, national goals from [Healthy People 2030](#), and past community health information.

The top health needs from HCI were heart disease and stroke, oral health, and cancer. The top social determinants of health needs were physical activity, nutrition and healthy eating, and community (like the use of public transportation and access to the internet). See more details in the list on the right.



## COMMUNITY INFORMATION

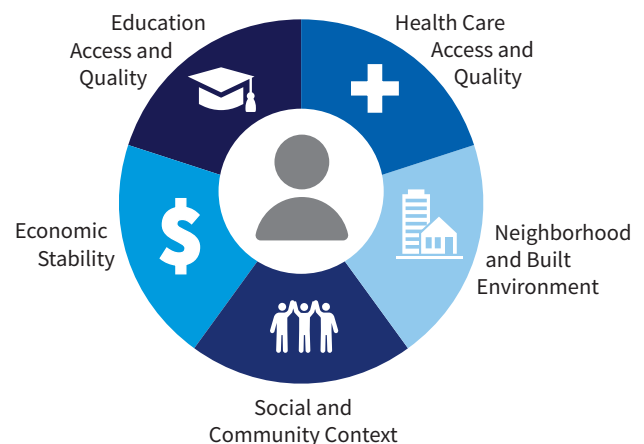
### Top 5 Health Problems

1. Heart disease and stroke
2. Oral health
3. Cancer
4. Respiratory diseases (tie)
4. Immunizations and infectious diseases (tie)

### Top 5 Most Needed Social Determinants of Health

1. Physical activity
2. Nutrition and healthy eating
3. Community
4. Economy
5. Environmental health

## Social Determinants of Health



## Community Conversations

Our community knows their own health needs best. We worked collaboratively to identify **key community leaders and organizations**. We invited community leaders to meet with us for conversations. We wanted to learn more about the community's health issues. We asked community leaders about the impact of these health issues, barriers to care, and ideas for addressing these issues. We also learned more about the community's challenges and strengths.

### Community Leaders

We invited many community leaders to meetings at Alton Works. These leaders included:

- Health care providers
- Local government officials
- Public health officials
- Fire department staff
- Staff from nonprofit organizations

We gave the leaders community health information to review. After reviewing the information, we talked about what it showed.

Community leaders were concerned about mental health, heart conditions, age-related illnesses, substance use, and maternal and infant health. They thought these health needs were the most important to focus on.

They also talked about needed community resources. The community leaders discussed mental health and substance use services, affordable housing, public transportation, and others. See more details in the list on the right.



**Dave Braasch, President of Alton Memorial Hospital, speaking at Community Leader Conversation at Alton Works, Alton, Illinois**



### COMMUNITY LEADER CONVERSATIONS

We met with **community leaders** to talk about their health needs.

#### Discussed Community Health Needs

- Mental health
- Heart conditions
- Age-related illnesses
- Substance use
- Maternal and infant health

#### Discussed Community Health Resources

- Mental health and substance use services
- Affordable housing
- Public transportation
- Affordable, healthy food
- Health care services
- Safe childcare
- Places to be physically active

## Community Members

After speaking with community leaders, we wanted to speak with community members. Community leaders served as links to community members. They engaged community members and helped co-host community conversations. See Appendix G for a list of organizations who participated in the conversations.

We spoke with community members at Senior Services Plus. We asked community members which health needs were the most important to them. Community members discussed mental health, age-related illnesses, oral and dental health, and violence.

We then asked community members which community resources were most needed. They discussed mental health and substance use services, affordable housing, aging services, and others. See more details in the list on the right.



**Senior Services Plus in Alton, Illinois, where conversations with community members took place**



## COMMUNITY MEMBER CONVERSATIONS

We met with **community members** to talk about their health needs.

### Discussed Community Health Needs

- Mental health
- Age-related illnesses
- Oral and dental health
- Violence

### Discussed Community Health Resources

- Mental health and substance use services
- Affordable housing
- Aging services
- Public transportation
- Affordable, healthy food
- Health care services
- Safe childcare
- Good schools
- Clean outdoor environment
- Safe community
- Places to be physically active

## Hospital Service Information

When patients receive care at a hospital, their care is billed to their insurance. This is known as a claim. We looked at the hospital claims data for Alton Memorial. We looked at all types of care, including same-day appointments, inpatient care, and Emergency Department visits.

We looked at this information at a group level. We wanted to see the most common reasons patients come to our hospital for care. For Alton Memorial, the most common reasons patients visit the hospital are for hypertension, diabetes, and substance use disorder. See more details in the list below.



### HOSPITAL SERVICE INFORMATION

#### Top 5 Health Conditions

1. Hypertension
2. Diabetes
3. Substance use disorder
4. Chronic kidney disease (tie)
4. Behavioral health disorder (tie)

## Hospital Team Survey

Alton Memorial has a Community Health Needs Assessment (CHNA) team made up of **people from many different roles in the hospital**. We wanted our team to include people with different perspectives, knowledge, and skills. Team members work in areas like:

- Medical care (like doctors and nurses)
- Social work
- Community health support
- Marketing and communications
- Patient experience
- Finance

The Alton Memorial CHNA team took a survey about local health needs. Team members were most concerned about mental health, substance use, and heart conditions. See more details in the list below.



### HOSPITAL TEAM SURVEY

#### Top 5 Community Health Needs

1. Mental health (tie)
1. Substance use (tie)
2. Heart conditions (tie)
2. Age-related illnesses (tie)
2. Diabetes and high blood sugar (tie)

#### Top 5 Most Needed Community Health Resources

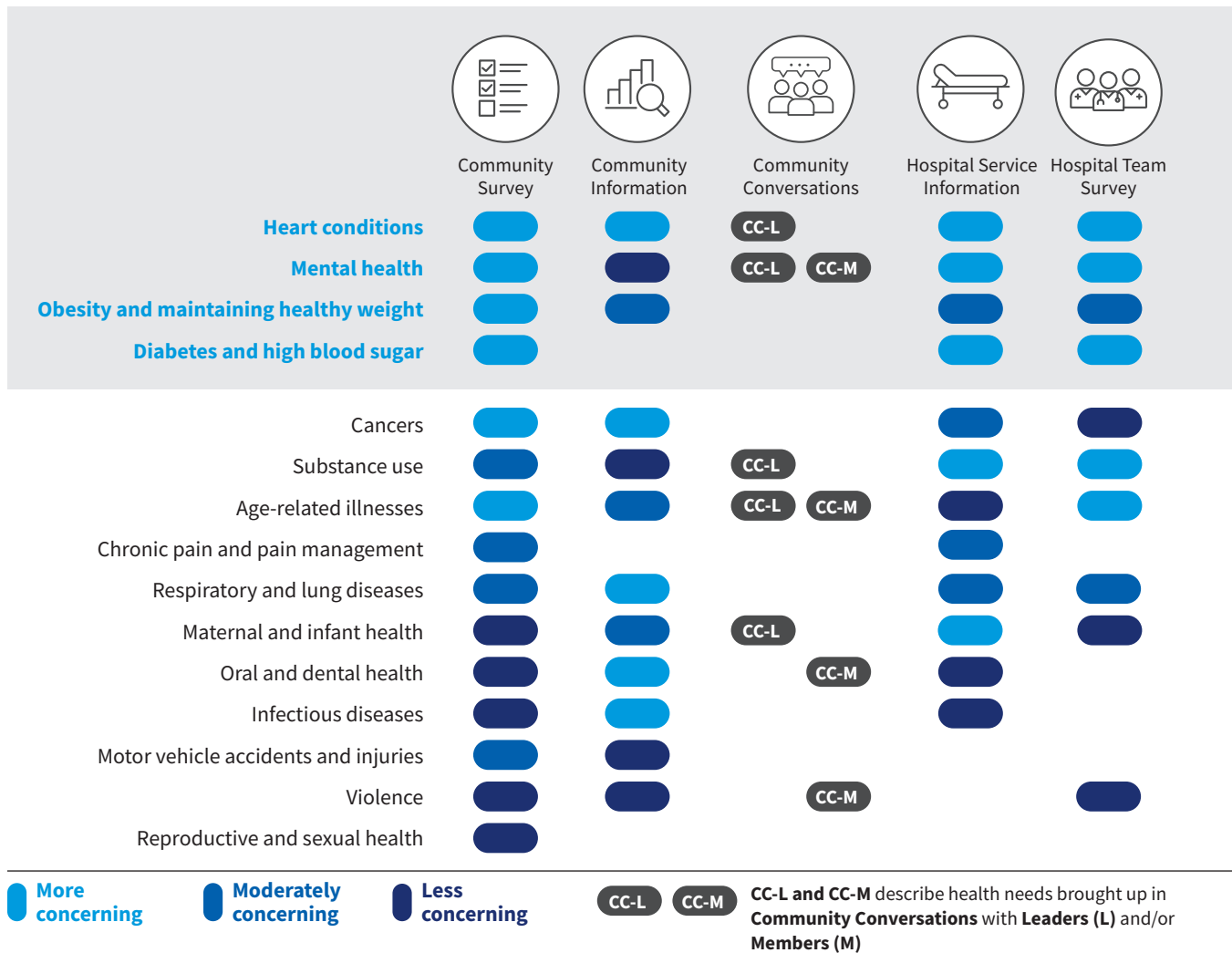
1. Mental health and substance use services (tie)
1. Good paying jobs (tie)
2. Affordable, healthy food
3. Safe childcare (tie)
3. Safe community (tie)

# What We Learned: Our Selected Health Needs

We learned about the community’s challenges and successes from our many data sources. We used these sources to help identify health needs that are important to the community. Then, we met to plan how to improve these health needs.

We considered how important the health needs are to the audiences we spoke to. These include community members, community leaders, and BJC employees. We wanted to elevate the community’s voice, so we made their answers count more than other information sources. We ranked four health needs as most important for Alton Memorial Hospital. These needs are **heart conditions, mental health, obesity and maintaining healthy weight, and diabetes and high blood sugar**. See more details about the full health rankings in the graphic below.

The 15 community health needs were ranked from highest to lowest, from **most concerning** to **moderately concerning** to **least concerning**, according to six different data sources. Looking across sources, the Community Health Improvement team **elevated four health needs to consider working on in the Alton Memorial Hospital community**.



When ranking the health needs, we wanted to pay extra attention to the needs community members shared. To do this, we used a math equation to give extra weight to the community survey results. You can read more about the ranking process in Appendix K.

## How the Needs Were Selected

After we ranked the health needs, we met as a team to discuss the rankings and decide what to include in our Community Health Improvement Plan (CHIP). We talked about which needs we had both the ability and the resources to improve. We also thought about how we could collaborate with others, like community organizations and hospital programs, to meet our goals. Based on this process, the greatest health needs determined were heart conditions, mental health, obesity and maintaining healthy weight, and diabetes and high blood sugar.

### Hospital Team Conversation



*Hospital team discussion (see list of team members in Appendix J)*



*Hospital team group activity*

### Health Needs We Will Not Prioritize in This CHIP

While there were many community health needs that came up in our data sources, we cannot address everything at the same time. We only moved forward the elevated health needs identified through the health need ranking and hospital team discussion. The elevated needs then were discussed by the BJC team to assess resources available to improve them and what kind of difference they could make in the next few years. While heart conditions are important to our community and our hospital, we did not prioritize them because heart health is connected to other health issues like obesity and maintaining healthy weight and diabetes. Working on these other issues can help us improve heart health as well.

### Health Needs We Will Prioritize in This CHIP

Mental health and substance use are closely connected to each other. We decided to focus on **mental health** while including substance use treatment and prevention as a strategy. We see patients with mental health conditions and substance use in the Emergency Department every day. We already have a goal to train all Alton Memorial staff in crisis prevention. This will help us provide better care for patients experiencing mental health and substance use emergencies while keeping patients and staff safe. We are also connected to regional mental health resources like BJC Behavioral Health. Improving mental health and substance use is one of our organizational goals. Focusing on this health need in our CHIP will help us continue to make progress. Diabetes and obesity are also closely related. We decided to combine them and focus on **obesity and maintaining healthy weight** while using diabetes education as one of our strategies. We already have resources to work on this, including a diabetes educator and dietitian. Through our CHIP, we plan to increase our staff and capacity for diabetes and obesity care and education. Obesity and diabetes are also part of our organizational goals. Focusing on these health needs in our CHIP will help us continue to make progress.

## A Closer Look at Our Prioritized Needs

We decided to prioritize mental health and obesity and maintaining a healthy weight. This is how we define these concerns.

### Mental Health

Mental health includes **emotional, psychological, and social well-being**. When we talk about mental health and substance use challenges, we are talking about a lot of conditions. Anxiety, depression, loneliness, and suicide all fall under the umbrella of mental health.

When we talk about substance use, we include **alcohol, drug, and tobacco use**. We also specifically focus on substance use disorder, where someone misuses substances and this use interferes with their daily life.

People with serious mental health conditions are **more likely to die from violence** like homicide, suicide, and accidents.<sup>8</sup> They are also more likely to die from **chronic conditions**, like cardiovascular disease and respiratory diseases.<sup>8</sup> By prioritizing mental health and substance use, we can impact other health conditions, too.

About one in five adults in Madison County have had depression.<sup>9</sup> This is about the same as in the United States.<sup>9</sup>

One part of mental health is suicide. About 2 in 10,000 people die from suicide in Madison County.<sup>9</sup> In Illinois, about 1 in 10,000 people die from suicide.<sup>9</sup> These numbers on deaths take into account the impact of age on illness.



In Madison County, about  
**1 in 5 adults**  
have been diagnosed  
with depression  
which is the same as  
in the nation



Madison Co.  
**21%**



U.S.  
**21%**

SOURCE: Conduent Healthy Communities Institute



Older people are more likely to die from suicide.<sup>10</sup> For this reason, when talking about death from suicide, we have to consider the impact of age on deaths. When data sources have been **adjusted for age**, this means they have used math to take into account deaths across other age groups. When we adjust for age, we can compare death rates across younger and older communities.

## Obesity and Maintaining Healthy Weight

Obesity is usually determined by a person's body mass index (BMI). Both obesity and maintaining a healthy weight are complicated. Many factors can affect a person's weight, like:

- Physical activity and safe places to do physical activity
- Access to healthy food
- Stress
- Genetics and family health history

Many of these factors are **affected by social determinants of health** that make it easier or harder to be healthy. These determinants can include walkable neighborhoods and education.<sup>11</sup>

Obesity is linked to long-term health conditions like heart conditions, diabetes, and cancers.<sup>12</sup> About one in four people in Madison County get little to no physical activity.<sup>9</sup> In Illinois, about one in seven people get little to no physical activity.<sup>9</sup> This means that many adults in Madison County are more likely to develop long-term health conditions.



In Madison County, about  
**1 in 4 adults**  
get little or no exercise  
which is the more than in the  
state of Illinois or the nation



Madison Co.  
**24%**



Illinois  
**14%**



U.S.  
**15%**

SOURCE: Conduent Healthy  
Communities Institute



**BMI**, or body mass index, is based on a person's weight and height.<sup>13</sup> BMI is measured by dividing a person's weight by their height.<sup>13</sup> Some BMIs can put people at higher risk of health problems, like high blood pressure and high cholesterol.<sup>13</sup>

# Where We're Going

## 2026–2028 Community Health Improvement Plan (CHIP)

Through our Community Health Needs Assessment (CHNA), we learned about our community's needs. We did this in collaboration with our community leaders, community members, hospital staff, and others interested in improving community health. After we completed the CHNA, it was time to create our Community Health Improvement Plan (CHIP). The purpose of our CHIP is to identify an approach to address the community health needs we selected through our CHNA.

Our CHIP includes a goal statement, initiatives, and measures. The **goal statement** provides a vision for our work. **Initiatives** identify the activities we are implementing to address the identified health needs. **Measures** will help us track our progress toward implementing our initiatives.

For this CHIP, we decided to share ideas and best practices about how to address the needs across all our BJC East Region hospitals. We decided to have region-wide workgroups focused on shared community health needs. For example, if a hospital chose obesity and maintaining a healthy weight as a need, the hospital community health improvement team members met with other BJC hospitals that chose that need to share ideas and best practices across the hospitals.

At the same time, each hospital brought together team members with different kinds of expertise about the selected health needs. These teams became hospital working groups, and they drafted plans to address each of our selected health needs. When developing our CHIPs, the workgroups thought about the resources available at each hospital, community programs and initiatives, and how to align our work with local public health initiatives.

Please see the next page for our 2026–2028 Community Health Improvement Plan.





## CHNA Health Need: Mental Health

**Goal:** Increase access to integrated, patient-centered mental and behavioral health care, prevention, and education, and advance community and system-level coordination to improve behavioral health and well-being

### **Category:** *Connection to care*

**INITIATIVE:** Through the Warm Handoff Program, screen patients identified with substance use disorders and provide up to 90 days of support, including seamless linkage to treatment and other identified community resources.

- MEASURES:**
- # of patients receiving services from Warm Hand Off
  - # of Warm Hand Off patients attending initial treatment appointment
  - % of Warm Hand Off patients attending initial treatment appointment

**INITIATIVE:** In partnership with the Women's Health and Childbirth Center, conduct assessments for substance use disorder and social determinants of health with perinatal and postpartum women, and link patients who screen positive with treatment and provide ongoing intervention support for up to a year post discharge.

- MEASURES:**
- # of perinatal or postnatal screenings completed
  - % of positive perinatal or postnatal screenings
  - # of patients screening positive that are linked to treatment or services

### **Category:** *Connection to resources*

**INITIATIVE:** Distribute naloxone kits through the Alton Memorial Drug Overdose Prevention Program (D.O.P.P.) to patients and/or families identified with substance use disorders or those prescribed narcotics for the management of pain.

- MEASURES:**
- # of naloxone kits distributed to patients and families with identified substance use disorders or prescribed narcotics for pain management.



## CHNA Health Need: Obesity and Maintaining Healthy Weight

**Goal:** Improve access to education, connections to resources, and supportive physical activity to reduce overweight and obesity

**Category:** *Health education*

**INITIATIVE:** Collaborate with local businesses and community institutions to deliver diabetes and weight management health education, resources, and support to community members at community-based events.

**MEASURES:**

- # of community-based events attended by an outpatient diabetes educator

**INITIATIVE:** Collaborate with providers to refer patients with diabetes to a three-part education series to support patients in managing diabetes.

**MEASURES:**

- # of individuals enrolled in education series
- # of individuals reporting knowledge and behavior change
- % of individuals reporting knowledge and behavior change

**Category:** *Group/peer support*

**INITIATIVE:** Facilitate a monthly diabetes support group featuring guest speakers presenting topics specific to obesity, weight management, and/or healthy eating.

**MEASURES:**

- # of diabetes support group meetings
- # of individuals reached

# What Comes Next

## Looking Forward

At Alton Memorial Hospital, we want to ensure everyone has access to the care they need to live their healthiest life. We do this by **centering our community's needs**. One way we center our community's needs is through needs assessments and health improvement plans. We looked at the current health needs of our community with the 2025 Community Health Needs Assessment (CHNA). Then, we thought about what we can do to improve those health needs. We made a plan to meet our prioritized health needs. This plan is our 2026–2028 Community Health Improvement Plan (CHIP). We have laid the groundwork to center our community's voice with our CHNA. Now, we will continue centering our community's voice and improving the health of our communities with the CHIP.

Health needs like mental health and obesity and maintaining healthy weight are complex. With our plan, we will continue to uphold our **long-term commitment** to our community. We will continue to provide timely and high-quality care for our community's needs. Over the next three years, we will build collaborations and create initiatives for our community's health needs. We will also gather important information about the health needs. These steps are crucial to ensure continued progress toward our community's health needs beyond the next three years. We also look forward to sharing our progress along the way. We will collaborate with community organizations and community members to improve the lives of people in Madison County for many years to come.



# Acknowledgments

At BJC HealthCare, we believe in the value of collaboration, and that value was important for our 2025 Community Health Needs Assessment (CHNA) and 2026–2028 Community Health Improvement Plan (CHIP). We want to acknowledge the many individuals and organizations that helped make this effort the best it could be. We want to thank everyone for the countless hours spent to ensure that we centered community voices as we determined our prioritized community health needs and strategies to address them.

First and foremost, BJC would like to thank the community members and community organizations that helped with this initiative across our East region, from Sullivan, Belleville, and Alton to Farmington, St. Charles, and St. Louis. Special thanks to members of BJC’s Community Health Data Council, who provided feedback and guidance to our team throughout the CHNA process. Community is at the center of all we do, and we thank everyone who provided their time and expertise to this effort.

We also want to thank the members of the St. Louis Regional Hospital CHNA Collaborative, as our hospitals came together across the region to collaborate on this effort and will continue to work together with the public health departments across the region to improve the health of our communities. We especially want to thank the community organizations who collaborated with us to host community leader and community member conversations: AltonWorks, Beyond Housing, Boys & Girls Clubs of St. Charles County, DOORWAYS, Downtown Belleville YMCA, Farmington Public Library, Grace United Methodist Church, Great Mines Health Center, International Institute of St. Louis, Paraquad, Senior Services Plus, Shiloh Church, St. Charles City-County Library, St. Patrick Center, St. Louis Oasis, Urban League of Metropolitan St. Louis, and Vision for Children at Risk.

We would like to also acknowledge the team at the Center for Public Health Systems Science at the WashU School of Public Health, for their dedicated help with the writing and design of this report. The team helped craft a product that we are most proud of. Additionally, we would like to thank the team at Key Strategic Group, which helped with our approach including partnering on community leader and member conversations across the region.

Lastly, we want to thank the many individuals across BJC’s East Region who worked tirelessly to make this a reality. Led by our Office of Community Health Improvement (CHI), our CHNA/CHIP efforts aim to create a system structure to improve the health of the communities that we serve. We are also most grateful to colleagues across many critical BJC departments including but not limited to Behavioral Health, Children’s Health Advocacy and Outreach, Executive Leadership, Marketing and Communications, Office of Belonging and Inclusion, and our Health Service Organization CHI leads and the individual hospital teams across the region.

Together, we can work to improve the health of the communities we serve.

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## Appendix A: Community Demographics

Demographics of Madison and Illinois		
	Madison	Illinois
<b>POPULATION</b>		
Population 2020	264,403	12,716,164
Population 2023 (estimate)	262,752	12,549,689
Population 2024 (estimate)	263,017	12,710,158
Population, Percent change - 2023 (estimate) to 2024 (estimate)	0.1	1.3
<b>AGE</b>		
Persons Under 5 Years, Percent, 2024	5.0	5.2
Persons Under 18 Years, Percent, 2024	20.8	21.2
Persons 65 Years and over, Percent, 2024	19.6	17.9
<b>GENDER</b>		
Female Persons, Percent, 2024	51.1	50.6
Male Persons, Percent, 2024	48.9	49.4
<b>RACE/ETHNICITY</b>		
White alone, Percent, 2024	82.4	60.2
White alone, not Hispanic or Latino, Percent, 2024	81.3	57.1
African American alone, Percent, 2024	8.1	13.2
Hispanic or Latino, Percent, 2024	4.6	19.4
Two or More Races, Percent, 2024	6.6	10.7
American Indian and Alaska Native alone, Percent, 2024	0.2	0.8
Asian alone, Percent, 2024	0.9	6.4
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.0	0.0
<b>LANGUAGE</b>		
Foreign Born Persons, Percent, 2024	2.4	15.4
<b>HOUSING</b>		
Housing Units, 2024	119,589	5,482,133
Homeownership Rate, Percent, 2024	74.4	67.6
Median House Value, Dollars, 2024	195,500	280,700
<b>FAMILIES &amp; LIVING ARRANGEMENTS</b>		
Households, 2024	111,452	5,105,448
Persons per Household, 2024	2.3	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	3.2	24.5
<b>EDUCATION</b>		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	93.7	90.7
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	32.0	39.2
<b>INCOME</b>		
Median Household Income, Dollars, 2024	78,751	83,211
Per Capita Income in past 12 months (in dollars), 2024	42,403	46,937
People Living Below Poverty Level, Percent, 2024	9.2	11.6

# Appendix B: Community Survey Tool

## St. Louis Community Health Needs Assessment

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

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

### Tell Us About Your Community

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Select all that apply.

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

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

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

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

- Alcohol use
- Anxiety
- Depression
- Domestic violence
- Drug use
- Eating disorders
- Loneliness
- Post Traumatic Stress Disorder (PTSD)
- Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder)
- Suicide
- Not listed here or prefer to describe: \_\_\_\_\_
- Not sure

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

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

- Alcohol use
- Anxiety
- Bullying
- Depression
- Drug use

- Eating disorders
- Loneliness
- Post Traumatic Stress Disorder (PTSD)
- Serious mental illnesses (schizophrenia, major depressive disorders, bipolar disorder)
- Suicide
- Not listed here or prefer to describe: \_\_\_\_\_
- Not sure

## Tell Us About You

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

### 8. What is your age group?

Choose one answer.

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

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

Choose all that apply.

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

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

Listed in alphabetical order. Choose all that apply.

- American Indian or Alaska Native
- Asian
- Black or African American
- Middle Eastern or North African

- Native Hawaiian or Other Pacific Islander
- White
- Other or prefer to self-describe: \_\_\_\_\_
- Prefer not to disclose

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

Choose one answer.

- Hispanic
- Non-Hispanic
- Prefer not to disclose

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

Choose one answer.

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

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

Choose all that apply.

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

**14. What best describes your employment status?**

Choose one answer.

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

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

Choose one answer.

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

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

**Thank you for your time and input!**

## Appendix C: Community Survey Respondents Demographics

In Madison County, Illinois, 241 people took part in the Community Health Needs Survey. The number of participants from each Madison County ZIP code ranged from 1 to 33. On average, about 25% of respondents chose not to answer the optional demographic questions. Among those who did respond, most were between 55 and 64 years old (21%), women (62%), White (65%), non-Hispanic (61%), and primarily English-speaking at home (75%). Additionally, many held advanced degrees such as a Master's, Professional, or Doctorate degree (28%), were employed full time (56%), and reported a household income between \$100,000 and \$149,999 (16%).

# Appendix D: Community Leader Conversation Guide

## Facilitation Guide: Stakeholder Conversations for the Community Health Needs Assessment

### 1. Welcome and Introductions

- a. Welcoming remarks
- b. Hospital leadership remarks (if applicable)
- c. Brief introduction to the session's objectives and structure.
- d. Explain current efforts (St. Louis Regional Collaborative – if applicable)
- e. Reference pre-event info that was shared via email-make mention of the CHNA handout/one-page
- f. Introductions of CHI members, their roles, and future/continued engagement

### 2. Presentation of Survey Process

- a. Share:
  - i. How the questions were developed, limitations
  - ii. Dissemination process/communication strategy
  - iii. Survey timeline
  - iv. High level, key themes and findings from the community survey.
- b. Provide high level overview of survey development and dissemination process. Speak briefly to the gaps/limitations/areas of opportunity, such as bolstering efforts to gain a stronger representative sample size.

### 3. Gallery Walk of Survey Data and Facilitated Discussion: Reaction to Survey Data

- a. If applicable - Introduce the gallery walk exercise and placement of foam boards. Ask individuals to mindfully walk through the survey visuals to reflect on the data presented, starting at any board they choose. Participants are free to use a sticky note to jot down reflections as they move around the room. \*If table groups get through this before time is called, they can move to the next section to prioritize needs.
- b. Discussion prompt questions:
  - i. *Does anything about the data surprise you?*
  - ii. *Based on the community you serve, is the survey data aligned with the identified needs of the community?*
  - iii. *Does it resonate with their experiences and awareness?*
  - iv. *What best practices/tactics have been implemented to capture underrepresented survey respondents?*
  - v. *What's missing?*

### 4. Prioritizing Community Health Needs

- a. Based on their understanding of survey data and their experiences serving & supporting community members, ask each participant to respond to the prompts:
  - i. *What do you feel are the most critical health needs?*
  - ii. *Considering Health-Related Social Needs (HRSN) and Social Determinants of Health (SDOH), how should hospitals prioritize these needs from a community health level?*

*iii. In what ways should community be embedded in this process?*

## **5. Capturing Ideas for Community Conversations**

- a. Purpose: Identify key topics and questions for community conversations.
- b. Discussion prompt questions:
  - i. What specific information should we seek from community members?*
  - ii. How can we ensure diverse and inclusive participation from all community segments?*
  - iii. Where would you like to see the HSO active in your community?*
  - iv. In what ways should community be embedded in this process?*

## **6. Brief recap and Next Steps**

- a. Recap from each table to entire group
- b. Final thoughts, reflections
  - i. What are you taking from this conversation?*
- c. Summary of key points from the discussion.
- d. Discuss next steps in the CHNA/CHIP process.
- e. Urge participants to take the Post-event survey before leaving the meeting. Share that we are in the process of planning community conversation invites with their communities. Invite them to share.

## **7. Closing Remarks and Adjournment**

- a. Express gratitude for stakeholder participation and valuable input.

# Appendix E: Community Member Conversation Guide

## Facilitation Guide: Community Conversations for the Community Health Needs Assessment

### 1. Welcome, Introduction, and Overview of Health Needs Assessment Process

- a. Explain the purpose of the conversation and how the input will be used.
- b. Be transparent and honest about where the Collaborative is in the CHNA process and the longer-term goals
- c. Note that there are opportunities to engage the community on the front end and ongoing basis moving forward.
- d. Introduce facilitators and any supporting staff. - Discuss CHNA data processes, including survey process, data highlights, gaps in data/responses, and secondary sources.
- e. Note that Community Conversations represent one way to gather more information that supports the CHNA.
- f. Review the expectations/outcomes from this meeting/process

### 2. Segment 1: Identifying Community Health Needs

- a. Opening Reflection:
  - i. *"To start, can you share what a healthy community looks like to you?"*
- b. Personal and Community Health Concerns:
  - i. *"What are the health issues or challenges you personally face, or that you see most often in your community?"*
- c. Impact of These Health Concerns:
  - i. *"How do these health issues affect your daily life or the well-being of your family and neighbors?"*
- d. Solutions Already in the Community:
  - i. *"What are some ways that people in your community are already trying to address these health concerns?"*

### 3. Segment 2: Barriers to Health

- a. Challenges to Accessing Care:
  - i. *"What gets in the way of you or others in your community getting the health care or services you need?"*
- b. Systems and Structures:
  - i. *"Are there particular systems or processes (like transportation, finances, or navigating healthcare) that make it harder to get care?"*
- c. Addressing Barriers:
  - i. *"What would make it easier for you or others to access the care you need? What changes would be most helpful?"*
- d. Building on Strengths:
  - i. *"What is working well right now? How can the healthcare system support and build on what's already helping in the community?"*

#### **4. Segment 3: Prioritizing Health Issues**

- a. Community Priorities:
  - i. *"Out of everything we've discussed, what health issues feel most urgent to you right now?"*
- b. Addressing the Most Critical Issues:
  - i. *"If we could work on just one issue today, what would it be, and what's one solution you think could make a real difference?"*
- c. Collaborative Solutions:
  - i. *"How can the healthcare system and the community work together to solve these issues? What role would you like to see the healthcare system play?"*
- d. Closing Reflection:
  - i. *"Before we finish, is there anything else you'd like to share—any other ideas or concerns we should consider as we move forward?"*

#### **5. Co-Creating Action Plans and Next Steps**

- a. Collective Action Discussion:
  - i. *"What actions can we take together to start addressing the top priority issue?"*
  - ii. *"Who needs to be involved in these efforts?"*
  - iii. *"What resources or support would be needed from the healthcare system?"*
- b. Closing Reflection and Commitments:
  - i. *"What is one commitment or idea you will take forward based on the discussion?"*

#### **6. Thank You and Closing Remarks**

- a. Thank participants for their time, input, and contributions to the discussion.
- b. Acknowledge the importance of their feedback in shaping the CHNA process.
- c. Reiterate the expectations/outcomes from this meeting/this process.
- d. Provide information on the next steps, how their input will be incorporated, and any opportunities for future involvement.
- e. Encourage participants to stay engaged and invite them to share any additional thoughts after the meeting if they wish.

# Appendix F: Community Leader Data Handout

## Madison County, IL

### Key Survey Findings



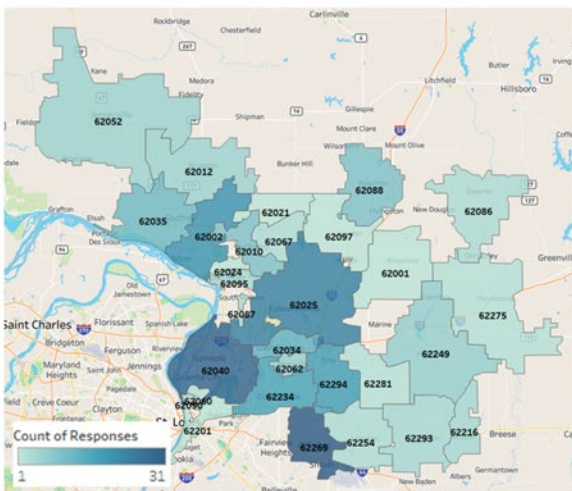
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### Who responded to the survey?

235  
Total Respondents in  
Madison County

In Madison County, 235 community members responded to the community health needs survey. The number of survey respondents in Madison County ZIP codes ranged between 1 and 31.

#### Survey Respondents by ZIP code



Notes

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# Who responded to the survey?

Over 20% of respondents in Madison County did not complete the optional demographic survey questions (non-respondents range from n=51 to 73, depending on the question).

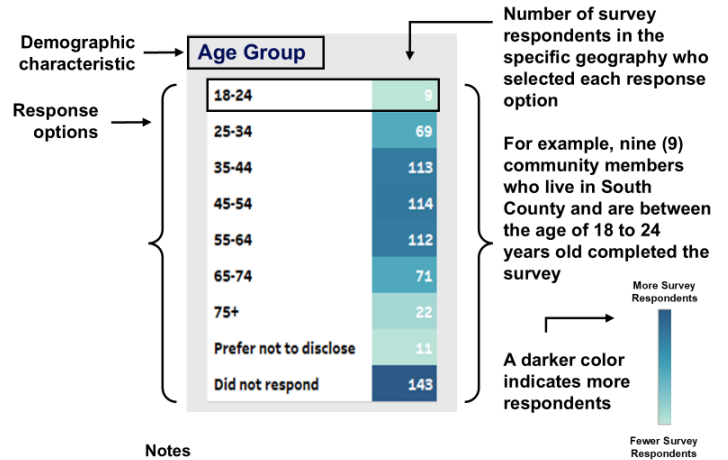
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=235).

**Most respondents:**

- Are between the age of 35 and 64 years old (53%)
- Are women (63%)
- Are White (66%)
- Are non-Hispanic (63%)
- Speak English at home (76%)
- Have a master's, professional, or doctorate degree (28%)
- Are employed full time (57%)
- Have a household income between \$100,000 and \$149,999 (17%)

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

Example: Survey Respondents by Age Group



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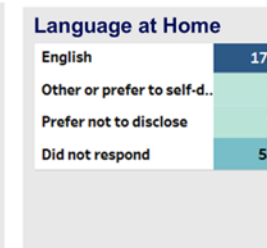
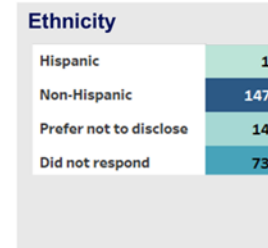
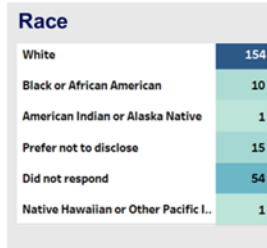
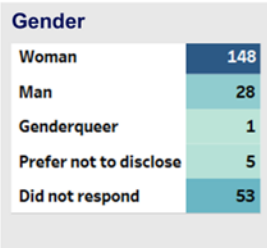
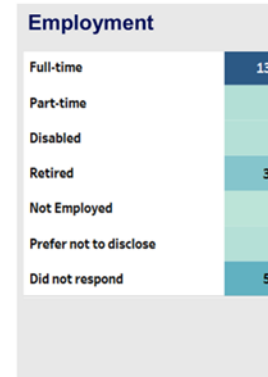
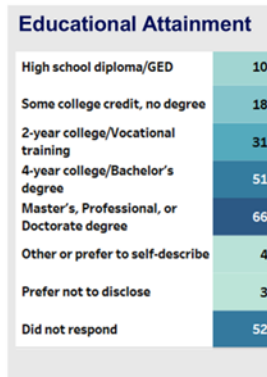
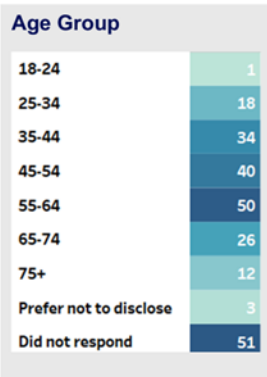


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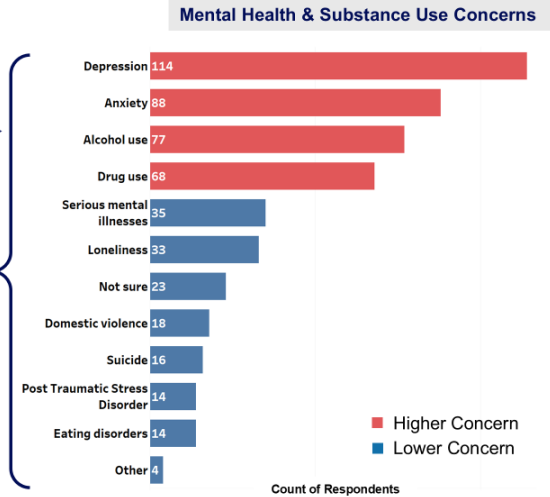
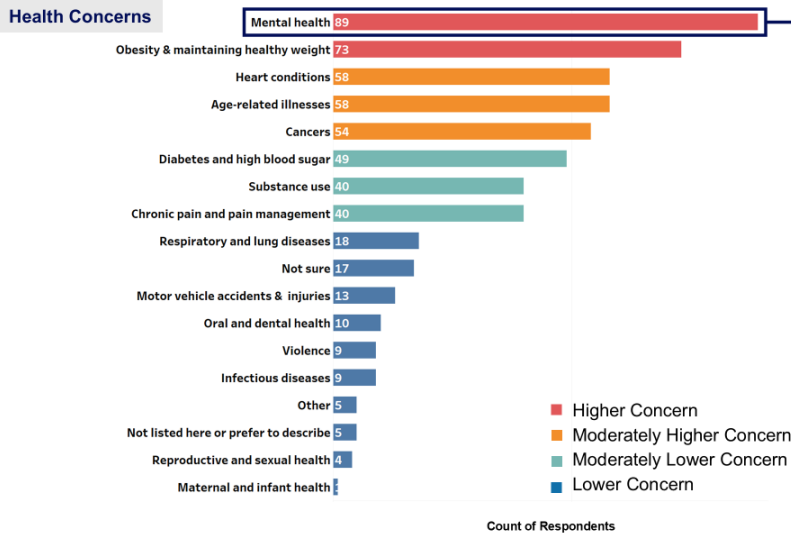
# Who responded to the survey?



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

235  
Total Respondents in  
Madison County

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



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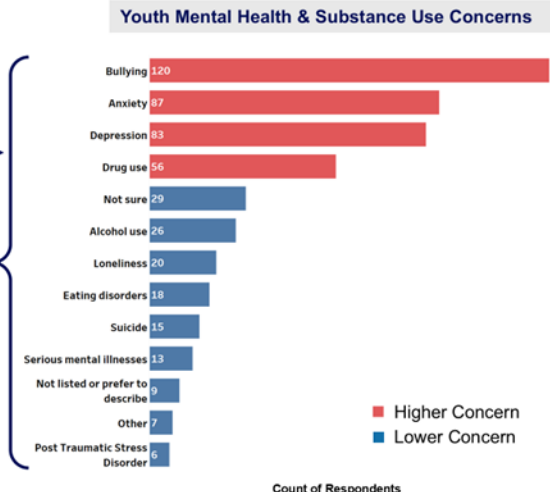
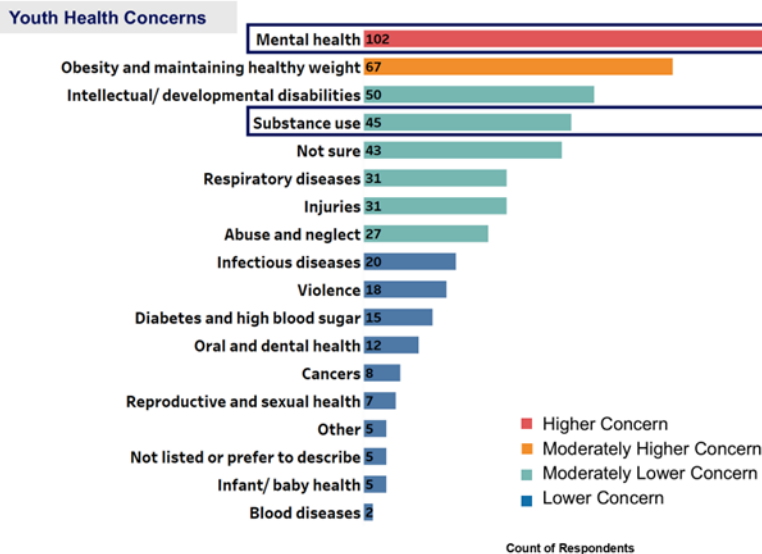


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## Thinking about your or other children in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

235  
Total Respondents in  
Madison County

Community members identified **mental health, obesity, intellectual/developmental disabilities, and substance use** as the top health concerns for children and youth in Madison County. Among mental health and substance use-related needs, **bullying, anxiety, depression, and drug use** are top of mind.



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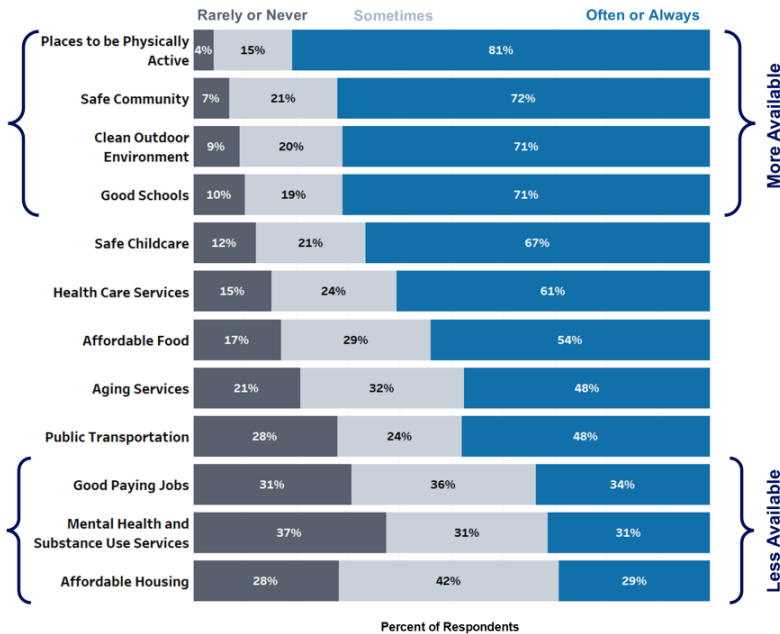


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## Thinking about the community where you live, how available are the following resources?



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

Places to be physically active, safe community, clean outdoor environment, and good schools were rated as being more available, with over 70% of respondents indicating that the resources were often or always available in their community.

Affordable housing, mental health and substance use services, and good paying jobs were reported to be less available, with less than 35% indicating that the resources were often or always available in their community.

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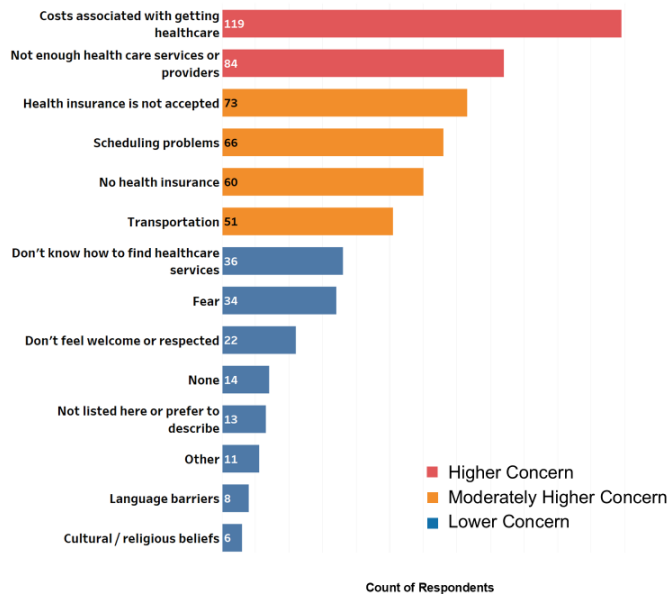
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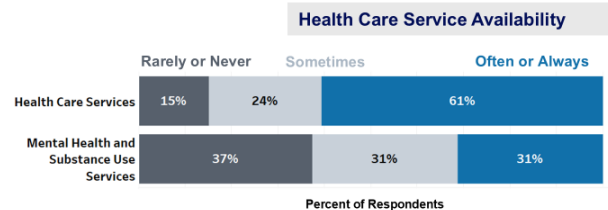
## Thinking about the community where you live, which barriers prevent access to health care?

### Barriers to Health Care Access



Sixty-one percent (61%) of community members who responded to the survey indicated that health care services were often or always available in Madison County. Only 31% indicated that mental health and substance use services had good availability.

Costs, lack of providers or services, and insurance not being accepted were most frequently identified as barriers to accessing health care.



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## Appendix G: Community Leader Conversation Participants

Alton Memorial Hospital: Community Leader Conversation Participants			
Organization	First Name	Last Name	Title
Alton School District	Elaine	Kane	Superintendent
IMPACT Center for Independent Living (CIL)	Wendy	Settles	Independent Living Specialist
Madison County Health Department	Emily	Won	Community Health Director
NAMI Southwestern Illinois	Kelly	Jefferson	Executive Director
Overnight Warming Locations	Bill	Valyo	Leadership Team
Riverbend Family Ministries, NFP	Tammy	Iskarous	Executive Director
Riverbend Head Start and Family Services, Inc.	Gene	Howell	President / CEO
Senior Services Plus	Emily	Jackson	Development Director

## Appendix H: Community Conversations Summary

BJC held community conversations with community leaders and members to gather insights on each local community. Community leaders and members shared their perspective on the most pressing health needs, and the strengths, challenges, and resources available in their community. The following pages provide an overview of key topics and insights that were shared related to health needs and health resources.

The following community conversations are summarized below:

- **Community Leaders** | Alton Works – October 30, 2024 – 8 participants
- **Community Members** | Senior Services Plus – December 9, 2024 – 9 participants

### Community Leader Conversation on Health Needs

#### Mental Health

- COVID worsened existing mental health challenges
- Social media is affecting mental health
- Anxiety and depression among young people
- Cyberbullying is an issue for youth
- Mental health is an issue among older adults
- The county has high suicide rates
- Anxiety, depression, loneliness

#### Heart Conditions

- Heart conditions are the number one cause of death and likely tied with healthy living

#### Age-Related Illnesses

- Older adults are unlikely to report loneliness, but it is observed by organization staff
- Mental health as an issue among older adults

#### Substance Use

- Mental health is tied to substance use disorder

#### Maternal and Infant Health

- Infant child mortality

### Community Leader Conversation on Health Resources

#### Mental Health and Substance Use Services

- Need access to more clinicians/mental health providers for all ages
- Need more education and awareness of mental health issues
- Gaps exist in addiction recovery resources for high school students
- Social workers need to have greater availability in the evening and at night

- There is a high need for mental health and substance use services in the community
- Residential psychiatry services are needed
- Mental health resources are needed for people in crisis
- Children need access to resources to cope with feelings and emotions
- School districts have created programs to help with cyberbullying

### **Affordable Housing**

- Affordable housing is an issue across the board but especially with older adults

### **Public Transportation**

- Limited availability during certain times of day and routes (ex. Second/third shift, Across the river)

### **Affordable, Healthy Food**

- Food insecurity is an issue among older adults both in terms of access and ability to afford healthy foods

### **Health Care Services**

- Need access to affordable healthcare
- Often individuals state they cannot afford to go to the hospital
- Need a focus on education and health literacy

### **Safe Childcare**

- Childcare is a need in the community

### **Places to be Physically Active**

- The community is lacking places to be physical active

## **Community Member Conversation on Health Needs**

### **Mental Health**

- Mental health is becoming more serious for both adults and children

### **Age-Related Illnesses**

- Elderly are often dismissed because they are “old”

### **Oral and Dental Health**

- Lack of dentist

### **Violence**

- Fighting in schools is bad – both Middle and High School

# Community Member Conversation on Health Resources

## Mental Health and Substance Use Services

- A lack of mental health services makes it hard to find a service and keeping the service is also difficult
- Small community hospitals need access to mental health resources
- Crisis Line is an existing service that is working well
- Center Stone in Bethalto has a crisis team that could be used in schools

## Affordable Housing

- Need access to affordable housing

## Aging Services

- Need quality senior services/homes. Staff turnover is high.
- Minimal advertising/awareness of existing senior services
- Senior Services Plus is an existing resource

## Public Transportation

- Doesn't work well for children as no car seats are available
- Challenges with navigating the bus system
- Not having a car is a barrier

## Affordable, Healthy Food

- Need to enhance access to healthier foods and create more opportunities
- Need to involve parents
- Cost of food is a barrier to getting healthy meals and snacks

## Health Care Services

- Children are aging out of health insurance
- Cost is a barrier
- Virtual technology can be a challenge to try and use for accessing services
- Finding a dentist is hard
- Not enough providers
- Long wait times for an appointment
- HSOs in the region overall provide good care

## Safe Childcare

- Need to have intergenerational daycares where children come with their grandparents
- Teachers receive threats from parents for disciplining children

## Good Schools

- Schools are not always seen as welcoming environments

- Fighting in schools is bad

### **Clean Outdoor Environment**

- Unsure if public spaces, parks, roads, sidewalks are safe

### **Safe Community**

- Alton is not safe for children to go out alone

### **Places to be Physically Active**

- There is access to places to be healthy and active – river walks, parks, trails, arboretum

# Appendix I: Hospital Team Survey

Thank you for participating in your Hospital's Community Health Needs Assessment (CHNA) Team. Your time and expertise are appreciated! The purpose of this survey is to gather your feedback about the top health concerns of the patients and community members that your hospital serves. **Your input is important to us and will be used to help identify priorities and develop solutions.**

The survey will take about 5 minutes. **All responses are confidential and anonymous.** You will not be asked for your name, and we will only share combined results. Thank you for sharing your time and thoughts.

## Tell Us About Your Community

### 1. Which hospital do you represent?

Enter the name of the hospital where you primarily work: \_\_\_\_\_

### The next question asks about the resources that help your patients be healthy.

### 2. Thinking about the community that your hospital serves, how available are the following resources?

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

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

**The next few questions ask about the health needs of your patients.**

**3. [For hospital team members who work at adult-serving hospitals] Thinking about your patients or other adults in the community that your hospital serves, what are the top three health problems ?**

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

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

**4. [For hospital team members who work at SLCH] Thinking about your patients or other children in the community that your hospital serves, what are the top three health problems?**

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

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

**5. Is there anything else you want to share ahead of your hospital's CHNA Team meeting?**

Please share any questions or thoughts.

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

**Thank you for your time and input!**

## Appendix J: Hospital Community Health Needs Selection Team

Alton Memorial Hospital 2025 Community Health Needs Selection Team Attendees 05/16/2025			
Last Name	First Name	Title	Department
Brown	Jeremy	Manager, Patient Care - IV	Emergency Room
Cloninger	Kristen	Educator, Diabetes	Diabetes Care Center
DeRienzo	Ken	Director, Food & Nutrition	Dietary
Easton	Alex	Supervisor, Operations - Patient Care	Hospital Screen & Warm Handoff
Fraley	Shannon	Manager, Foundation & Development	General Admin-Fund Raising
Henson	Sherri	Director, Clinical Services / Community Health Improvement Lead	Executive Administration
Ingram	Rusty	Director, Operations & Support Services	Physician Practice Development
Parker	Meredith	Manager, Case Coordination/Clinical Services	Medical Stabilization
Tillman	Robert	SPEC, SC Strategic Change Management	SC PMO (Amici)
Turpin	Debra	VP, Chief Nurse Officer	Executive Administration
Yates	Jeremy	Manager, Professional Practice Development / Community Health Improvement Lead	Education Department

# Appendix K: Elevated Health Needs Ranking Process

## Our Goal

We wanted a simple and fair way to understand which health needs matter most to our community. To do this, we looked at four types of information and gave each one a score. The score was used to identify several elevated health needs for each hospital’s needs selection team to consider and discuss.

## Data Sources Used

We used four different sources to learn about health needs in the community and prioritized each by giving it a weight from most valued (weight =3) to least (weight=1).

- **Community Survey Data (Weight=3)** tell us what people that live in the community feel and experience. We gave this the most weight because of the importance and relevance of the community’s input.
- **Hospital Claims Data (Weight=2)** show which health issues bring people to the hospital. We gave this a medium-strong weight because it reflects real medical use.
- **Hospital Team Survey Data (Weight=2)** reflect the community needs that our hospital team sees every day as they care for and live in the community they serve. We used a medium-strong weight because their insights are based on direct patient care.
- **Community Health Information Data (Weight=1)** include information from public health sources. We gave this a lower weight because it adds helpful background but is often limited and several years old.

## How we Sorted Each Need

To get to a final score, we looked at where each health need ranked for each data source, compared to all the other needs that were represented in that data source. Needs at the top of the list received a higher score. That score was then multiplied by the weight given for that data source. After completing this for each data source, the four weighted scores were averaged. The top health needs were highlighted for the hospital’s needs selection team to discuss.

The math formula that we used to determine **weighted scores** for each health need was:

$$((\text{Number of health needs for data source} + 1) - \text{Rank of health need in data source}) \times \text{Weight of data source}$$

The math formula that we used to determine the **final score** for each health need was:

$$\frac{\text{Community Survey Score} + \text{Hospital Claims Score} + \text{Hospital Team Survey Score} + \text{Community Health Data Score}}{4}$$

Below is a made-up example for one health need.

Data sources:	Community Survey	Hospital Claims	Hospital Team Survey	Community Health Information
Rank:	4	2	4	7
Number of Needs:	16	12	7	12
Weight:	3	2	2	1
Weighted score:	39	22	8	6
Final score:	18.75			

