2025-2028 Community Health Needs Assessment and Improvement Plan

Barnes-Jewish Hospital

BJC HealthCare

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

A Message from Bob Cannon, President, BJC HealthCare, and John P. Lynch, President, Barnes-Jewish 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 Barnes-Jewish 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 Barnes-Jewish Hospital, we are committing to focused efforts around age-related illness, violence, and mental health. 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

John Lynch, MD
Group President, BJC HealthCare
President, Barnes-Jewish Hospital

Table of Contents

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.

BJC HealthCare

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)

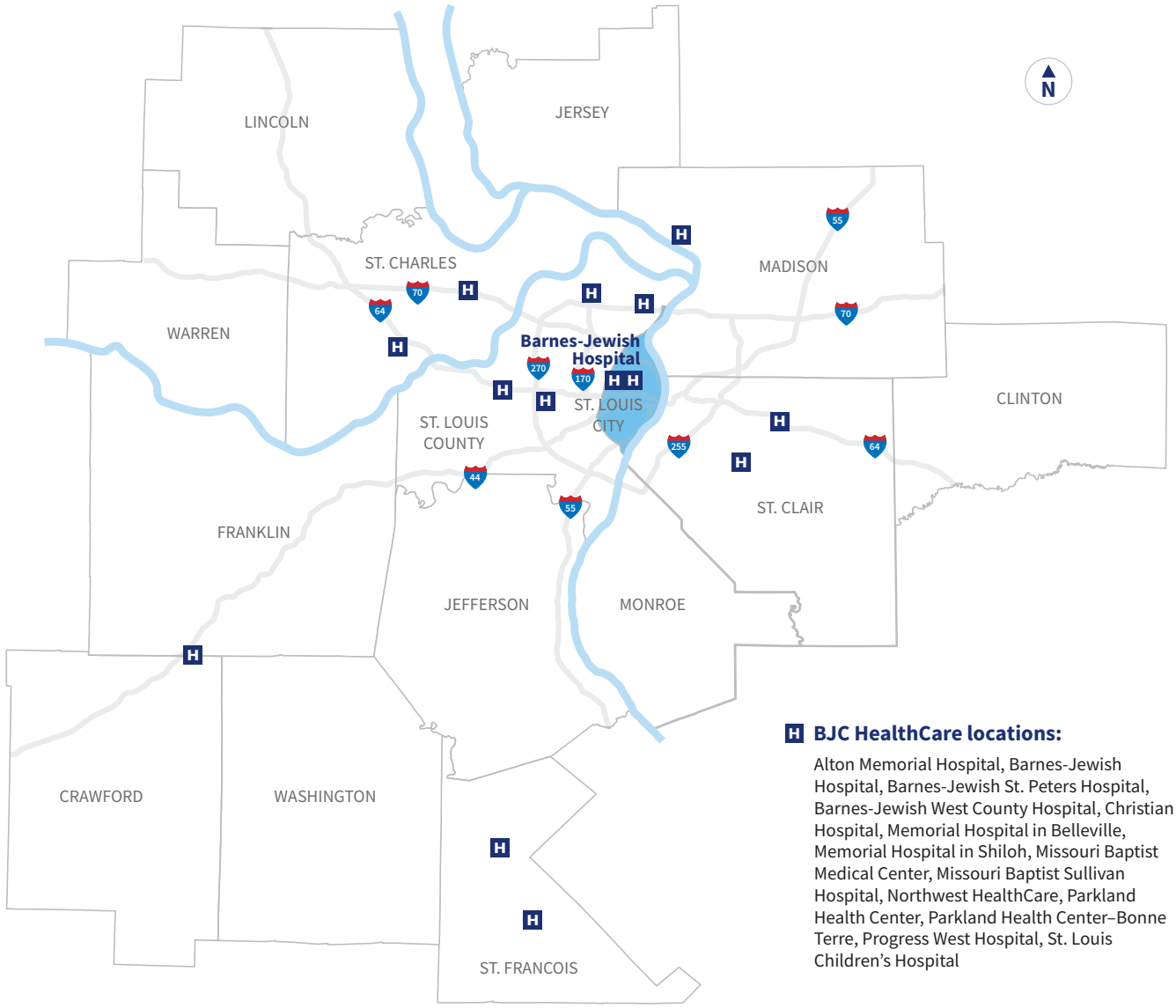
All nonprofit hospitals, including all BJC HealthCare hospitals, are required to complete a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community 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 Barnes-Jewish Hospital community and chose which health needs to work on. Then, we will talk about our goals and plans for building a healthier community.

Barnes-Jewish Hospital and the Community We Serve

The Barnes-Jewish Hospital Community Health Needs Assessment is focused on **St. Louis City, Missouri**. The hospital educates future physicians and medical professionals. Barnes-Jewish partners with WashU Medicine to provide new treatments and care for the community we serve and has WashU doctors practicing in the hospital. This academic partnership has led to new treatments and procedures that are practiced globally.

Barnes-Jewish Hospital is part of the larger BJC service area, which includes health care locations across the St. Louis region.



BJC HealthCare locations:

Alton Memorial Hospital, Barnes-Jewish Hospital, Barnes-Jewish St. Peters Hospital, Barnes-Jewish West County Hospital, Christian Hospital, Memorial Hospital in Belleville, Memorial Hospital in Shiloh, Missouri Baptist Medical Center, Missouri Baptist Sullivan Hospital, Northwest HealthCare, Parkland Health Center, Parkland Health Center–Bonne Terre, Progress West Hospital, St. Louis Children's Hospital

The Siteman Cancer Center at Barnes-Jewish and WashU Medicine is a designated Comprehensive Cancer Center by the National Cancer Institute. This designation is used for cancer centers that demonstrate leadership and conduct research that is broad, detailed, and solves real-world problems. The Siteman Cancer Center is the only Comprehensive Cancer Center in Missouri.

The hospital is recognized as one of the best in the nation and the best in Missouri. *U.S. News & World Report* has ranked Barnes-Jewish **on the Best Hospitals Honor Roll for over three decades**. The hospital is recognized nationally for its excellence in 11 specialties. Barnes-Jewish was the first hospital in Missouri to be a Magnet®-recognized hospital, the highest achievement for excellent nursing.

Barnes-Jewish Hospital Community Health Needs Assessment service area close-up

Over the years, Barnes-Jewish has given back to the community in many ways. In 2023, Barnes-Jewish provided **$463.2 million** in community benefit. This total includes:

- $205.7 million in **unreimbursed care** for people with Medicaid and Medicare
- $120.3 million in **education and professional support** for current and future health professionals
- $101.8 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- $31 million in **services that fill gaps** in health care access for the community
- $4.4 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**.

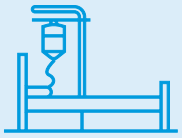
Barnes-Jewish has dedicated staff who provide care for many community members. The team includes 12,337 employees and 2,120 physicians who practice at our hospital. In 2024, we cared for 52,280 inpatient admissions, 26,730 outpatient surgeries, and 80,087 Emergency Department visits. More details are in the graphic below.

Barnes-Jewish Hospital by the Numbers

12,337
Total Employees

2,120
Physicians

$3.5
Billion Net Revenue (2023)



1,278
Staffed Beds

52,280
Inpatient Admissions

26,730
Outpatient Surgeries

80,087
Emergency Department Visits

3,620
Deliveries

About **300,000 people** call St. Louis City home.[1] St. Louis City is an urban area.[1] About half of the people who live in St. Louis City are white, and about one in seven residents are older than 65 years.[1] The life expectancy for St. Louis City residents is about 72 years.[2] This is about three years less than the life expectancy for Missouri residents.[2]

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

Almost half of all St. Louis City households spend more than 30% of their income on housing costs like rent or mortgages.[1] When housing is expensive, it can be hard to meet other needs, like food or transportation. The median home value in St. Louis City is about $185,000.[1] In neighboring St. Louis County, the median home value is about $260,000.[1] When homes are worth less in your neighborhood, you have less to gain from selling your house. Houses that are worth less are taxed less, so less money goes to fund local schools, roads, and other infrastructure.

In St. Louis City, **nearly all residents have at least a high school degree**.[1] High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in St. Louis City is about $55,000 per year.[1] The median state household income is about $69,000 per year.[1]

About one in four children in St. Louis City live in poverty.[1] This is higher than the children across the state of Missouri, where one in six live in poverty.[1]

Community Feature: Forest Park

The City of Saint Louis is home to Forest Park, one of the country's largest urban parks.[3] Forest Park hosts over 15 million visitors a year, who enjoy picnic spaces, bike trails, and recreation facilities.[4] The park's Nature Reserve houses over 600 plant species, over 200 bird species, and over 200 known insect species.[5] Within the park, there are five cultural institutions: the Saint Louis Art Museum, the Saint Louis Science Center, the Missouri History Museum, The Muny and the Saint Louis Zoo.[4] Forest Park hosted the 1904 World's Fair, which was the largest of all world fairs.[6] More than 20 million people went to the fair, with an average of more than 100,000 visitors each day.[6]

Forest Park, St. Louis, Missouri

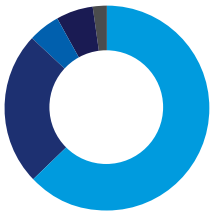
Barnes-Jewish Hospital Community Characteristics

St. Louis City

Population
293,109

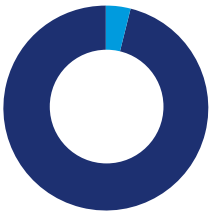
Land Area
62 sq. mi.

Race



- **46%** White
- **43%** Black
- **3%** Asian
- **6%** 2 or more races
- **2%** Other*

Ethnicity



- **5%** Hispanic/ Latino
- **95%** Not Hispanic/ Latino

Most people have at least a high school education

St. Louis City	Missouri
91%	**92%**

Life Expectancy

St. Louis City	Missouri
72	**75**

The median household income in St. Louis City is lower than for the state of Missouri

St. Louis City	Missouri
$55,279	**$68,920**

The median home value in St. Louis City is much lower than in St. Louis County

St. Louis City	St. Louis County
$185,100	**$260,700**

Poverty rates among children in St. Louis City are much higher than in the state of Missouri

St. Louis City	Missouri
27%	**16%**

People over 65

St. Louis City	Missouri
15%	**18%**

SOURCE: County Health Rankings,[2] U.S. Census Bureau[1]

**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.

Barnes-Jewish Hospital Community Health Needs and Goals from 2022–2025

In our last Community Health Needs Assessment at Barnes-Jewish Hospital, we learned that mental health was the top health concern in St. Louis City. For this health need, we set three goals and made a plan to reach these goals.

Mental Health

Goal: Improve the overall health of patients who frequently go to the Emergency Department by connecting patients to resources.

Mental Health

Goal: Improve access to recovery coaches and outpatient addiction-related health care for those who present to the Barnes-Jewish Emergency Department or hospital with or after recently experiencing an opioid-related overdose or medical complication related to opioid use disorder.

Mental Health

Goal: Improve health of St. Louis City residents through housing and case management; provide at least 20 Complex Care Emergency Department patients housing annually.

Mental Health

Our First Strategy ▸

Some patients with mental health needs visit the Emergency Department often. This can happen when they do not have the resources or care they need to manage mental health conditions outside the hospital.

We want patients to come to the Emergency Department when they are having a mental health crisis. We also **want patients to have access to care in the community**, like a primary care doctor or therapist. This can help patients get the care they need and may reduce visits to the Emergency Department.

When people visit the Emergency Department often for nonurgent care, the Emergency Department can become crowded. Crowds can cause delays and decrease quality of care for everyone. Other types of care, like primary care, are much more affordable. We want patients with mental health needs that are not emergencies to be able to use these other types of care.

We wanted to work with patients with mental health needs that visit the Emergency Department often. We wanted to improve their overall health and connect them to community resources.

First, we looked at hospital visit information. We wanted to see which of our patients visited the Emergency Department the most. Then, the next time these patients came to the Emergency Department, we asked them if they wanted to join our Complex Care program. If they agreed, the **Complex Care program connected patients with a social worker**.

The social worker worked with patients to identify their mental health and social needs. Next, the social worker connected patients to outpatient community resources. That way, if patients needed nonurgent care, they were already connected to community resources. They would not need to visit the Emergency Department.

Emergency Department staff also worked with these patients in many ways. First, they referred patients to another program we have, called the Emergency Room Enhancement program. In this program, patients could quickly get in touch with behavioral health community support workers. They would not need to visit the Emergency Department.

Second, they connected patients to community resources that could help meet their social and physical needs. That way, patients could meet their social and physical needs, like shelter, outside of the Emergency Department. Staff also worked directly with physicians to coordinate patient care.

Finally, Emergency Department staff, physicians, and key community stakeholders met each month to talk about the program. They looked at patient progress and made changes to their care plans as needed.

We wanted patients in the Complex Care program to use outpatient resources to meet their needs. We wanted them to reduce their visits to the Emergency Department by 5% after six months of completing the program.

Our Progress on Our First Strategy ▸

Patients in the Complex Care program decreased their Emergency Department visits by 92%. We recorded this progress between January 2022 and December 2024.

Our Second Strategy ▸

We wanted to **improve access to care for our patients with opioid use disorder**. Patients with opioid use disorder come to us because of overdoses or because of medical complications related to the disorder. We have many patients that come to our Emergency Department and hospital because of opioid use disorder.

We wanted to ensure our patients in recovery have access to care after they leave the hospital. Specifically, we wanted to ensure access to recovery coaches and addiction-related health care. We planned multiple ways to meet our patients' needs.

First, we focused on **medication assisted treatment**, or MAT. MAT is a treatment for opioid use disorder.[7] We wanted to make sure our patients that need MAT can receive it. We planned to increase MAT use by 10% each year for our patients. We wanted patients to leave the hospital with enough medication for three days.

Medication assisted treatment (MAT) combines prescription medication, counseling, and social support to treat substance use disorder.[7]

We planned to lead medication assisted treatment (MAT) trainings for physicians at any BJC facility. We wanted to support our physicians to care for our patients with opioid use disorder.

In addition to offering training, we planned to offer **Continuing Medical Education courses** to physicians so they could learn the most recent information on treating opioid use disorder. We also planned to train all Emergency Medicine residents on MAT and treating opioid use disorder.

Emergency Medicine, Medical Toxicology, and Psychiatry planned to work together to care for hospital patients. We also planned to enhance our addiction medicine clinic run by Medical Toxicology.

Next, we wanted to **connect patients to community resources**. We thought our patients would manage their conditions best with additional outpatient support. We wanted to improve this coordination of care by 10% each year.

Finally, we focused on **harm reduction** for our patients. Engaging in harm reduction means reducing the negative effects of behaviors, like misusing opioids. This means that even though some people will continue to use opioids, we will provide them with resources to reverse overdoses if they happen. We planned to increase distribution of naloxone, a medicine that reverses opioid overdoses and is also called Narcan, by 10% each year.

We collaborated with the Behavioral Health Network to plan a new program around harm reduction. This program was called Engaging Patients in Care Coordination (EPICC). Through EPICC, we led regional efforts to help opioid overdoses. We emphasized the importance of harm reduction for our patients. Many types of organizations joined EPICC at the local, regional, and statewide levels.

The EPICC program included:

- Testing and treating patients for HIV and Hepatitis C
- Providing MAT
- Helping patients get care through community substance use disorder clinics and outreach coordinators

We are committed to providing the best care possible for our patients with opioid use disorder. We planned to apply for multiple grants to ensure our programs are funded. We also wanted to increase the number of facilities available to care for patients. Finally, we planned to use more telehealth appointments for treating addiction.

Our Progress on Our Second Strategy ▸

From October 2024 to July 2025, we referred 643 patients to community substance use disorder clinics.

Our Third Strategy ▸

We wanted to improve the health of St. Louis City residents. We planned to do so by **connecting community members without homes to housing resources**. We called this the Hospital to Housing program.

We worked specifically with patients in the Complex Care, EPICC, and Emergency Room Enhancement program. These are programs dedicated to meeting health and social needs for people who use substances and often visit the Emergency Department. We wanted to provide housing to at least 20 of these patients each year.

We looked at which of the patients were homeless, had mental illness, misused substances, and often visited the Emergency Department. We also looked at the patients referred to the Hospital to Housing program by Emergency Department physicians.

We helped program participants move into individual housing units. We wanted to help 80% of participants leave the program with stable housing. We also helped participants meet their personal, education, employment, and health goals.

We hoped this program would reduce health care costs. We planned to report the difference in health care costs for patients who joined the program.

Our Progress on Our Third Strategy ▸

From 2022 to 2024, we enrolled 42 patients in the EPICC program. We have information from 2022 because the program had already begun when we created our 2023–2025 Community Health Improvement Plan.

Over the same time period, 53% of those enrolled patients moved into stable housing. We did not meet our goal because we wanted to meet each participant's unique needs. We gave extra attention to the social, emotional, and mental health needs of each person. This was the right thing to do, even if it meant we did not reach as many people as planned. The lack of affordable housing in St. Louis also made it difficult for us to find stable housing for everyone.

When we were able to help patients find stable housing, they used the Emergency Department 58% less than before they had stable housing. This means about $226,000 was saved in Emergency Department costs.

Where We Are Today…

2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of the St. Louis City 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 St. Louis City's current needs, we used many **sources of information**. These included:

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 St. Louis City** 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 city 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 this 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 St. Louis City. 1,158 community members completed the survey. See Appendix B and Appendix C for more details.

The top concerns among community members were mental health, violence, and obesity and maintaining healthy weight. Specifically, mental health challenges like depression, anxiety, and drug use were concerns for the community.

We learned that costs, no health insurance, and transportation were serious challenges to getting care. The community needs more affordable housing, mental health and substance use services, and aging services. See the list on the right for more details.

COMMUNITY SURVEY

Top 5 Health Problems

1. Mental health
2. Violence
3. Obesity and maintaining healthy weight
4. Substance use
5. Heart conditions

Top 5 Mental Health Concerns

1. Depression
2. Anxiety
3. Drug use
4. Alcohol use
5. Serious mental illnesses

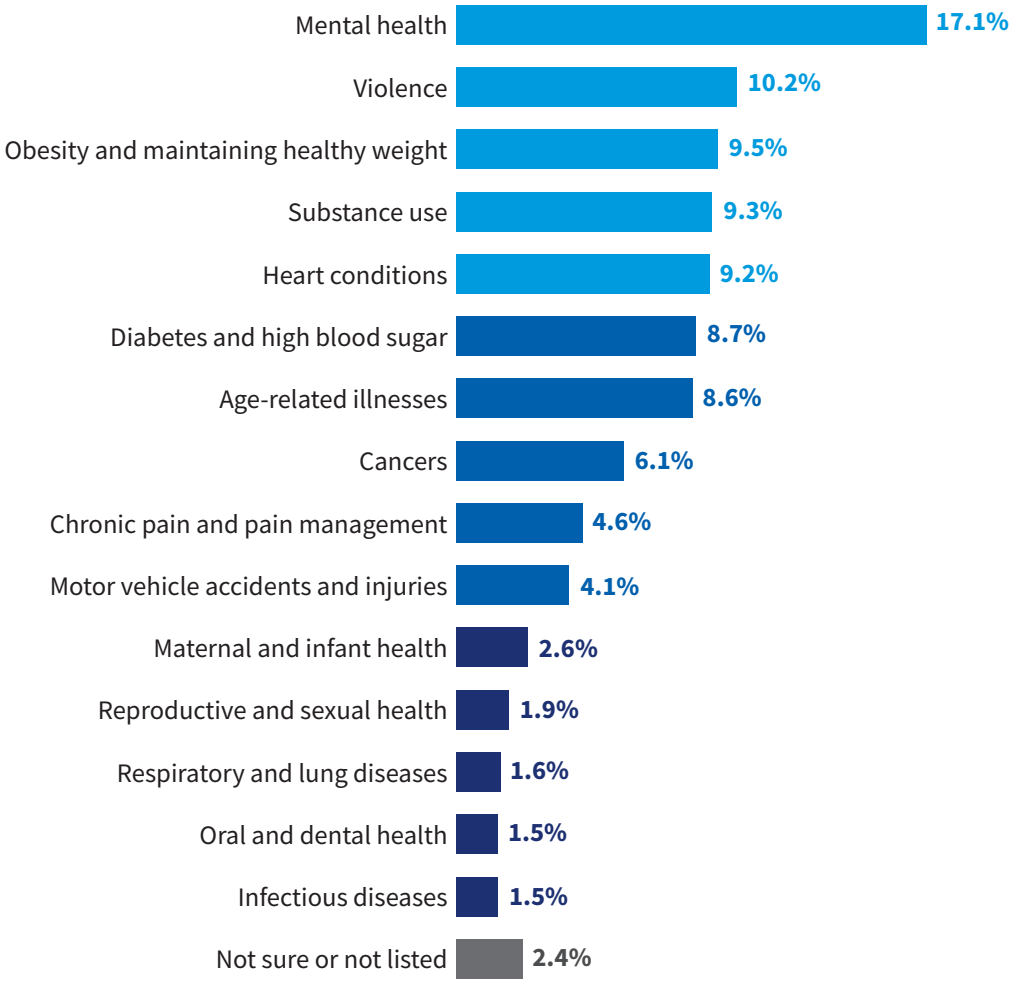
Top 5 Barriers to Care

1. Costs
2. No health insurance
3. Transportation
4. Scheduling problems
5. Not enough services or providers

Top 5 Community Resource Needs

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

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 St. Louis City 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, the United States Census Bureau, and Missouri Department of Health and Human Services. 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 St. Louis City with other communities, national goals from Healthy People 2030, and past community health information.

The top health needs from HCI were immunizations and infectious diseases; older adults; and maternal, fetal, and infant health. The top social determinants of health needs were economy (like poverty and employment rates), community (like the use of public transportation and access to the internet), and environmental health. See the list on the right for more details.

COMMUNITY INFORMATION

Top 5 Health Problems

1. Immunizations and infectious diseases
2. Older adults
3. Maternal, fetal, and infant health
4. Prevention and safety
5. Heart disease and stroke

Top 3 Most Needed Social Determinants of Health

1. Economy
2. Community
3. Environmental 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 the Urban League of Metropolitan St. Louis. 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. They thought mental health was the most important need to focus on.

They also talked about needed community resources. The community leaders discussed affordable housing, mental health and substance use services, and good schools. See the list on the right for more details.

Katie Henderson, CMO of Barnes-Jewish Hospital, speaking at Community Leader Conversation at the Urban League of Metropolitan St. Louis, St. Louis, Missouri

COMMUNITY LEADER CONVERSATIONS

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

Discussed Community Health Need

- Mental health

Discussed Community Health Resources

- Affordable housing
- Mental health and substance use services
- Good schools
- Affordable, healthy food
- Public transportation
- Health care services

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 met with community members at DOORWAYS, International Institute of St. Louis, and St. Patrick Center. We asked community members which health needs were the most important to them. Community members discussed mental health, violence, substance use, and oral and dental health.

We then asked community members which community resources were most needed. They discussed affordable housing, mental health and substance use services, good paying jobs, and safe community. See the list on the right for more details.

DOORWAYS, St. Louis, Missouri

International Institute, St. Louis, Missouri

St. Patrick Center, St. Louis, Missouri

COMMUNITY MEMBER CONVERSATIONS

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

Discussed Community Health Needs

- Mental health
- Violence
- Substance use
- Oral and dental health

Discussed Community Health Resources

- Affordable housing
- Mental health and substance use services
- Good paying jobs
- Safe community
- Affordable, healthy food
- Public transportation
- Health care services
- 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 Barnes-Jewish Hospital. 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 Barnes-Jewish Hospital, the most common reasons patients visit the hospital are for hypertension, substance use disorder, and cancer. See the list below for more details.

HOSPITAL SERVICE INFORMATION

Top 5 Health Conditions

1. Hypertension
2. Substance use disorder
3. Cancer
4. Diabetes
5. Behavioral health disorder

Hospital Team Survey

Barnes-Jewish Hospital 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 Barnes-Jewish Hospital CHNA team took a survey about local health needs. Team members were most concerned about mental health, heart conditions, and substance use. See the list below for more details.

HOSPITAL TEAM SURVEY

Top 5 Community Health Needs

1. Mental health
2. Heart conditions
3. Substance use
4. Violence
5. Diabetes and high blood sugar

Top 5 Most Needed Community Health Resources

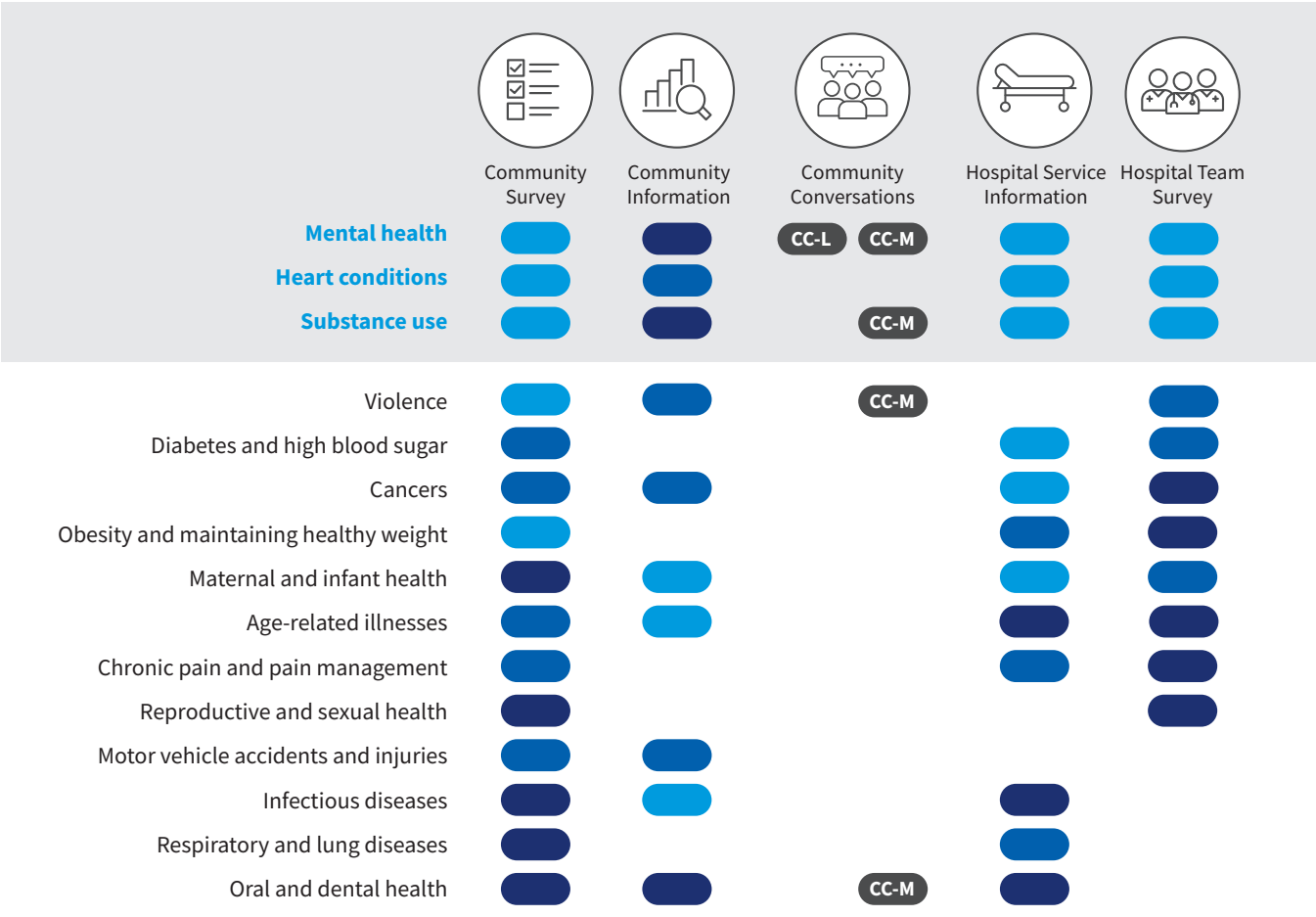
1. Affordable healthy food (tie)
1. Good schools (tie)
1. Safe community (tie)
2. Mental health and substance use services (tie)
2. Safe childcare (tie)

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 three health needs as most important for Barnes-Jewish Hospital. These needs are **mental health**, **heart conditions**, and **substance use**. 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 three health needs to consider working on in the Barnes-Jewish 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 mental health, heart conditions, and substance use.

Hospital Team Conversation

Hospital team group activity (see list of team members in Appendix J)

Hospital team group activity

Health Need 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.

We decided not to prioritize heart conditions. We know this is an important health need for our community because of our Community Health Needs Assessment (CHNA). We do not currently have the resources to prioritize this health need.

Health Needs We Will Prioritize in This CHIP

We decided to prioritize **age-related illness**. We think our community members are greatly affected by age-related illnesses. We believe we have the resources we need to improve health outcomes in this area. We also decided to prioritize **violence**. We made this decision for two reasons. First, we know this is an important health need for our community because of our CHNA. Second, many of our community members' health needs are impacted by violence. By working to impact violence, we may improve other health needs, too. Finally, we prioritized **mental health and substance use**. We know both of these needs are important to our community members because of our CHNA. We are connected to regional mental health resources like BJC Behavioral Health. We also worked on these needs in our last CHIP. We would like to continue building on our success. We think working on mental health and substance use together will be a good use of resources.

A Closer Look at Our Prioritized Needs

We decided to prioritize age-related illness, violence, and mental health and substance use. This is how we define these concerns.

Age-Related Illness

Age-related illnesses affect people with advanced age. Some of these illnesses are related to **memory problems, movement issues, falls, and strokes**.

Americans can enroll in Medicare once they turn 65 or have other qualifying conditions.[8] These qualifying conditions include disability, end-stage renal disease, and ALS.[8] By looking at the health of people with Medicare, we can get a good idea of how healthy older people are.

In St. Louis City, about 8% of adults with Medicare have Alzheimer's disease or dementia.[9] In Missouri, about 7% of adults with Medicare have Alzheimer's disease or dementia.[9]

Many factors can cause strokes, like **smoking, a sedentary lifestyle, advanced age, and unmanaged heart disease**. In both St. Louis City and across the nation, about one in three adults have high blood pressure.[9] This means that these adults have an increased risk for stroke.

In St. Louis City, about 5% of adults with Medicare have had a stroke.[9] In Missouri, about 5% of adults with Medicare have had a stroke.[9] In St. Louis City, about 5 in 10,000 people die from strokes.[9] In Missouri, about 4 in 10,000 people die from strokes.[9] These numbers on deaths take into account the impact of age on illness. See more detail on **adjusting for age** below.

In St. Louis City,

5% of people with Medicare have had a stroke

which is the same as in the state of Missouri and lower than in the nation

St. Louis City	Missouri	U.S.
5%	5%	6%

SOURCE: Conduent Healthy Communities Institute

Older people are more likely to die from heart conditions, diabetes, and cancers.[14-16] For this reason, when talking about deaths from diseases, 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.

Violence

Violence includes **assaults, domestic violence, and gun violence**. Many of our health needs are impacted by violence.

Aggravated assault is one type of violence. In Missouri, people who attempt to kill or seriously harm another person can be charged with aggravated assault.[10]

In St. Louis City, there are about 3,500 aggravated assaults per year.[11] In neighboring St. Louis County, there are about 1,500 aggravated assaults per year.[12] There are more than twice as many aggravated assaults in St. Louis City than in St. Louis County.[12]

Another type of violence is gun violence. Gun violence can be accidental or intentional. In St. Louis City, about 5 in 10,000 people die from gun violence.[9] This is more than twice as many as in Missouri or the U.S.[9]

In St. Louis City,

more than twice the number of people die because of guns

than in the state of Missouri or the nation

St. Louis City	Missouri	U.S.
5 deaths per 10,000	**2** deaths per 10,000	**1** deaths per 10,000

SOURCE: Conduent Healthy Communities Institute

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. They are also more likely to die from **chronic conditions**, like cardiovascular disease and respiratory diseases. By prioritizing mental health and substance use, we can impact other health conditions, too.

About one in four adults in St. Louis City have had depression.[9] In the United States, about one in five adults have had depression.[9]

One part of mental health is suicide. About 1 in 10,000 people die from suicide in St. Louis City.[9] In Missouri, about 2 in 10,000 people die from suicide.[9] These numbers on deaths take into account the impact of age on illness.

In St. Louis City,

1 in 4 adults have been diagnosed with depression

which is more than in the nation

St. Louis City	U.S.
24%	**21%**

SOURCE: Conduent Healthy Communities Institute

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:
Age-Related Illness

Goal: Increase access to education and connections to resources to support healthy aging and enhance quality of life for older adults and caregivers

Category: *Health education*

INITIATIVE: In partnership with WashU Medicine and community organizations, implement and evaluate A Matter of Balance, an evidence-based fall prevention program.

MEASURES:
- Establishment of resources and collaborators
- # of programs delivered
- # of community venues where programs are delivered
- # of participants reached
- % of participants who report an improvement in program-related outcomes (e.g., falls management, falls efficacy, level of activity/exercise)

INITIATIVE: Offer comprehensive stroke education programs to the St. Louis community to increase awareness of stroke prevention, signs, and symptoms.

MEASURES:
- # of education events held
- # of participants reached
- % of participants who report an increase in understanding of stroke signs, symptoms, and what to do when someone is having a stroke

Category: *Connection to resources*

INITIATIVE: Collaborate with partners to offer stroke survivorship support programming for patients and caregivers to enhance recovery and integration in community after stroke.

MEASURES:
- Establishment of resources and collaborators
- #/type of survivorship events held
- # of participants who attend at least one event
- % of participants who report higher community resocialization 90 days after stroke

CHNA Health Need:
Violence

Goal: Increase access to hospital-based violence intervention training, programs, and connections to resources to reduce violence

Category: *Training and capacity building*

INITIATIVE: Collaborate with hospital- and community-based partners to establish a hospital-based multidisciplinary team to support violence intervention training for staff.

MEASURES:
- Establishment of resources, collaborations, and membership to Health Alliance for Violence Intervention
- #/% of staff who serve high-risk patients trained
- % of staff who report improvement in training-related outcomes (TBD)
- Expansion of training across hospital

Category: *Connection to care and resources*

INITIATIVE: Collaborate with hospital- and community-based partners to establish a hospital-based multidisciplinary team to support evidence-informed programs for patients at risk for violence.

MEASURES:
- Establishment of resources, collaborations, and membership to Health Alliance for Violence Intervention
- # of evidence-informed programs implemented
- #/% of high-risk patients served/enrolled
- % of patients who report improvement in program-related outcomes (TBD)
- Expansion of program(s) across hospital

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: Collaborate with community providers and hospital-based community resource coordinators to expand Barnes-Jewish Hospital's Bridge Program to ensure patients with mental health diagnoses are connected to outpatient mental health services and resources.

MEASURES:
- Establishment of resources, collaborations, and expanded workflows
- # of patients who are connected to outpatient services and resources
- % of eligible patients who are connected to outpatient services and resources
- % of connected patients who attend follow-up appointments
- % reduction in mental health readmissions

What Comes Next

Looking Forward

At Barnes-Jewish 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 age-related illness, violence, and mental health 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 St. Louis 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.

References

1. Social Explorer Tables: ACS 2023 (5-Year Estimates). Suitland, MD: U.S. Census Bureau; 2023. Accessed July 31, 2025. https://www.socialexplorer.com/tables/ACS2023_5yr/R13882959.
2. County Health Rankings & Roadmaps. Accessed July 29, 2025. www.countyhealthrankings.org.
3. Forest Park. City of St. Louis. Accessed November 5, 2025. https://www.stlouis-mo.gov/government/departments/parks/parks/browse-parks/view-park.cfm?parkID=1&parkName=Forest%20Park.
4. About Forest Park. Forest Park Forever. Accessed November 6, 2025. https://www.forestparkforever.org/about-forest-park.
5. Conservation. Forest Park Forever. Accessed November 5, 2025. https://www.forestparkforever.org/conservation.
6. 1904 World's Fair in Forest Park. City of St. Louis. Accessed November 6, 2025. https://www.stlouis-mo.gov/archive/history-forest-park/fair.html.
7. Medication assisted treatment. Missouri Department of Mental Health. Accessed August 5, 2025. https://dmh.mo.gov/behavioral-health/medication-assisted-treatment.
8. Who's eligible for Medicare? U.S. Department of Health and Human Services. December 8, 2022. Accessed September 30, 2025. https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index.html.
9. Conduent Healthy Communities Institute (2025). Data Scoring Tool. Barnes-Jewish Hospital. Published online March 10, 2025. https://admin-memhosp.thehcn.net/login.
10. RSMo § 565.050. Accessed September 30, 2025. https://revisor.mo.gov/main/OneSection.aspx?section=565.050&bid=29279.
11. St. Louis Metropolitan Police Department. NIBRS crime comparison by city, December monthly, 2022 vs 2021. Published 2023. Accessed October 1, 2025. https://slmpd.org/wp-content/uploads/2024/06/22-DECEMBER.pdf.
12. The Bureau of Research and Analysis, St. Louis County Police Department. St. Louis County Police Department annual report. Accessed October 1, 2025. https://www.stlouiscountypolice.com/who-we-are/annual-reports/2023-annual-report/.
13. Alcohol use and your health. Centers for Disease Control and Prevention. February 25, 2025. Accessed September 30, 2025. https://www.cdc.gov/alcohol/about-alcohol-use/index.html.
14. Yazdanyar A, Newman A. The burden of cardiovascular disease in the elderly: morbidity, mortality, and costs. *Clinics in Geriatric Medicine*. 2009;25(4):563-vii. doi: 10.1016/j.cger.2009.07.007.
15. Deaths from diabetes, by age. Our World in Data. 2024. Accessed August 18, 2025. https://ourworldindata.org/grapher/deaths-from-diabetes-by-age.
16. Siegel R, Kratzer T, Giaquinto A, Sung H, Jemal A. Cancer statistics, 2025. *CA: A Cancer Journal for Clinicians*. 2025;75(1):10-45. doi: 10.3322/caac.21871.

Photo Credits

A. The Jefferson Avenue Campus. DOORWAYS. Retrieved from https://doorwayshousing.org/about/jefferson-campus/.

B. International Institute of St. Louis. Retrieved from https://www.iistl.org/contact-us/.

C. St. Patrick Center (2023). Feast Magazine. Retrieved from https://www.feastmagazine.com/community/st-patrick-center-in-downtown-st-louis-takes-a-multilayered-approach-to-assisting-the-unhoused/article_78ab5a94-92a7-11ed-9ed8-a3dc01a1bccc.html.

Appendices

Appendix A: Community Demographics

Demographics of St. Louis City and Missouri		
	St. Louis City	Missouri
POPULATION		
Population 2020	304,709	6,124,160
Population 2023 (estimate)	281,754	6,196,156
Population 2024 (estimate)	279,695	6,245,466
Population, Percent change - 2023 (estimate) to 2024 (estimate)	-0.7	0.8
AGE		
Persons Under 5 Years, Percent, 2024	5.3	5.5
Persons Under 18 Years, Percent, 2024	17.8	21.9
Persons 65 Years and over, Percent, 2024	16.6	18.7
GENDER		
Female Persons, Percent, 2024	51.8	50.7
Male Persons, Percent, 2024	48.2	49.3
RACE/ETHNICITY		
White alone, Percent, 2024	46.2	77.6
White alone, not Hispanic or Latino, Percent, 2024	44.9	76.2
African American alone, Percent, 2024	40.5	10.5
Hispanic or Latino, Percent, 2024	5.7	5.6
Two or More Races, Percent, 2024	7.1	7.3
American Indian and Alaska Native alone, Percent, 2024	0.3	0.3
Asian alone, Percent, 2024	3.9	2.3
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.0	0.1
LANGUAGE		
Foreign Born Persons, Percent, 2024	8.8	4.9
HOUSING		
Housing Units, 2024	174,694	2,858,527
Homeownership Rate, Percent, 2024	46.0	68.6
Median Housing Units, Dollars, 2024	214,500	254,400
FAMILIES & LIVING ARRANGEMENTS		
Households, 2024	148,637	2,563,244
Persons per Household, 2024	1.8	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	10.8	7.4
EDUCATION		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	90.8	92.0
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	45.0	33.5
INCOME		
Median Household Income, Dollars, 2024	53,374	71,589
Per Capita Income in past 12 months (in dollars), 2024	44,949	40,284
People Living Below Poverty Level, Percent, 2024	21.7	12.3

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	☐	☐	☐	☐	☐	☐
Affordable healthy foods	☐	☐	☐	☐	☐	☐
Affordable housing	☐	☐	☐	☐	☐	☐
Public transportation	☐	☐	☐	☐	☐	☐
Health care services	☐	☐	☐	☐	☐	☐
Mental health and substance use services	☐	☐	☐	☐	☐	☐
Places to be physically active, such as community parks	☐	☐	☐	☐	☐	☐
Services that support people as they age	☐	☐	☐	☐	☐	☐
Clean outdoor environment	☐	☐	☐	☐	☐	☐
Good paying jobs	☐	☐	☐	☐	☐	☐
Good schools	☐	☐	☐	☐	☐	☐
Safe community	☐	☐	☐	☐	☐	☐

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 heath 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 <u>yourself or other adults</u> in the community where you live, what are the <u>top three</u> mental health and substance use problems?**
   Choose **<u>three</u>** items from the list that are a concern for **<u>yourself or other adults</u>** 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 <u>your or other children</u> in the community where you live, what are the <u>top three</u> mental health and substance use problems?**
   Choose **<u>three</u>** items from the list that are a concern for **<u>your or other children</u>** 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 St. Louis City, Missouri, 1,158 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 1 to 134. On average, about 25% of participants chose not to answer the optional demographic. Among those who did respond, most were between 35 and 44 years old (17%), women (58%), White (49%), non-Hispanic (58%), and primarily English-speaking at home (72%). Many held advanced degrees such as a Master's, Professional, or Doctorate degree (31%), were employed full time (53%), and reported a household income between $100,000 and $149,999 (11%).

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

City of St. Louis

Key Survey Findings

BJC HealthCare Mercy Shriners Children's St. Louis SSMHealth St. Luke's

2024 Community Health Needs Assessment Survey

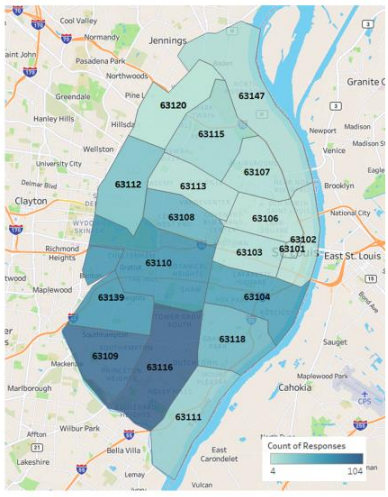
Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

612
Total Respondents in St. Louis City

In the City of St. Louis, 612 community members responded to the community health needs survey. The number of survey respondents in St. Louis City ZIP codes ranged between 4 and 104.

Survey Respondents by ZIP code



Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

612
Total Respondents in St. Louis City

Over 20% of respondents in the City of St. Louis did not complete the optional demographic survey questions (non-respondents range from n=129 to 195, depending on the question).

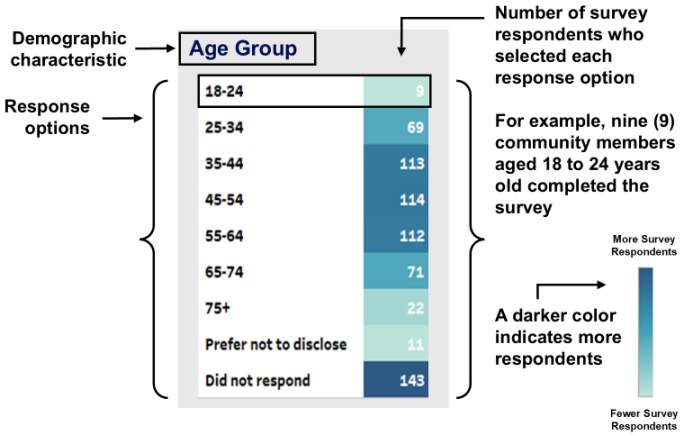
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=612).

Most respondents:

- Are between the age of 35 and 44 years old (19%)
- Are women (62%)
- Are White (52%)
- Are non-Hispanic (62%)
- Speak English at home (78%)
- Have a master's, professional, or doctorate degree (34%)
- Are employed full time (58%)
- Have a household income between $50,000 and $74,999 (14%)

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



Notes

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

612
Total Respondents in St. Louis City

Age Group

Under 18	1
18-24	17
25-34	88
35-44	117
45-54	88
55-64	79
65-74	75
75+	14
Prefer not to disclose	4
Did not respond	129

Educational Attainment

Less than high school	4
High school diploma/GED	23
Some college credit, no degree	53
2-year college/Vocational training	51
4-year college/Bachelor's degree	132
Master's, Professional, or Doctorate degree	208
Other or prefer to self-describe	4
Prefer not to disclose	8
Did not respond	129

Employment

Full-time	357
Part-time	25
Disabled	11
Retired	52
Self Employed	10
Student Full-time	5
Not Employed	7
Other or prefer to self-describe	7
Prefer not to disclose	5
Did not respond	133

Income

Less than $10,000	6
$10,000 to $24,999	27
$25,000 to $49,999	75
$50,000 to $74,999	87
$75,000 to $99,999	59
$100,000 to $149,999	74
$150,000 to $199,999	48
$200,000 or more	46
Prefer not to disclose	56
Did not respond	134

More Survey Respondents

Fewer Survey Respondents

Gender

Woman	380
Man	82
Genderqueer	6
Transgender/Trans man	1
Non-binary	5
Prefer not to disclose	9
Did not respond	129

Race

White	316
Black or African American	111
Asian	14
Other or prefer to self-describe	6
American Indian or Alaska Native	6
Middle Eastern or North African	2
Prefer not to disclose	22
Did not respond	135

Ethnicity

Hispanic	16
Non-Hispanic	380
Prefer not to disclose	21
Did not respond	195

Language at Home

English	478
Spanish	1
Prefer not to disclose	4
Did not respond	129

2024 Community Health Needs Assessment Survey

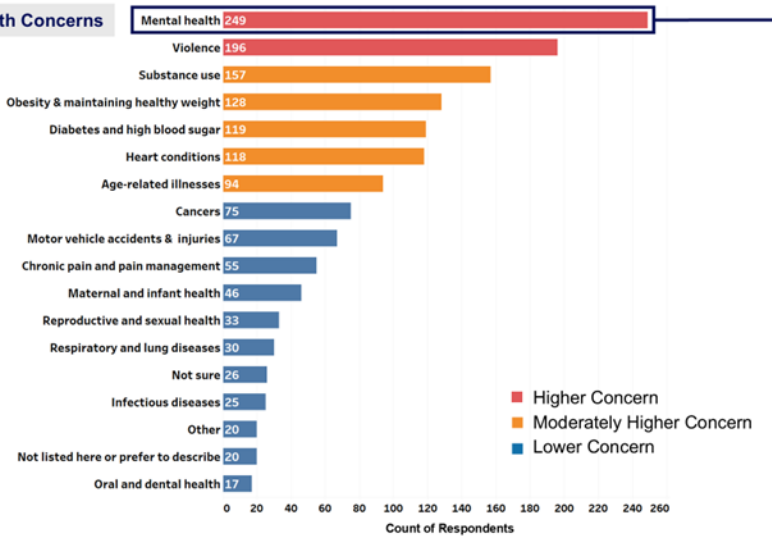
Preliminary survey data through June 2024 presented to community leaders

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

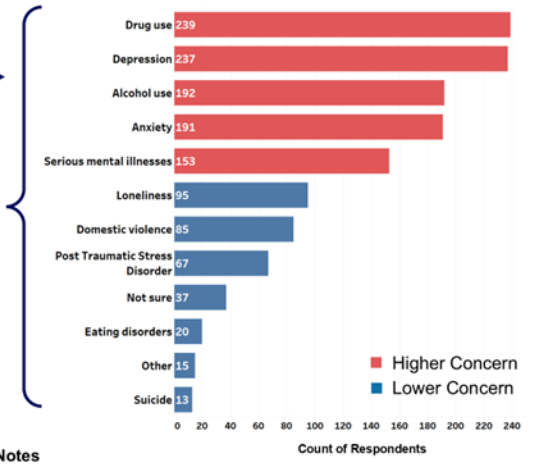
612 Total Respondents in St. Louis City

Community members identified mental health, violence, substance use, obesity, and diabetes as the top health concerns in the City of St. Louis. Among mental health and substance use-related needs, drug use, depression, alcohol use, anxiety, and serious mental illnesses are top of mind for community members.

Health Concerns



Mental Health & Substance Use Concerns



Notes

Preliminary survey data through June 2024 presented to community leaders

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

612 Total Respondents in St. Louis City

The table below details the top health concerns among respondents by race. Most of the top health concerns remained consistent across groups with some differences in the order of concerns. Notably, vehicle accidents and injuries and infectious diseases were identified as top concerns by respondents who are Black or African American or another race.

Higher Concern
Moderately Higher Concern
Lower Concern

Health Concerns by Race

Top Concerns	All Respondents n=612	White n=316	Black or African American n=111	Other n=28	Did not respond or prefer not to disclose n=157
1	Mental health	Mental health	Violence	Violence	Mental health
2	Violence	Violence	Mental health	Mental health	Violence
3	Substance use	Substance use	Diabetes	Diabetes	Diabetes
4	Obesity	Obesity	Substance use	Heart conditions	Heart conditions
5	Diabetes	Heart conditions	Obesity	Substance use	Substance use
6	Heart conditions	Age-related illnesses	Heart conditions	**Motor vehicle accidents and injuries**	Obesity
7	Age-related illnesses	Diabetes	Cancers	Obesity	Age-related illnesses
8	Cancers	Cancers	**Motor vehicle accidents and injuries**	**Infectious diseases**	Cancers

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

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

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

612 Total Respondents in St. Louis City

The table below details the top mental health and substance use concerns among respondents by race. Most of the top concerns remained consistent across groups with some differences in the order of concerns. Notably, serious mental illnesses were identified as the most concerning issue among those who did not respond to the question about race.

Mental Health & Substance Use Concerns by Race

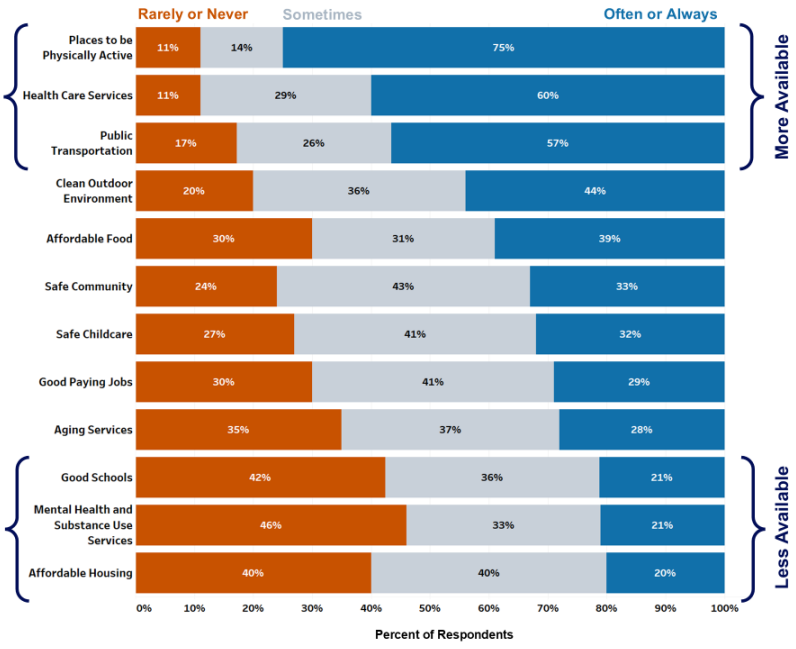
Higher Concern
Lower Concern

Top Concerns	All Respondents n=612	White n=316	Black or African American n=111	Other n=28	Did not respond or prefer not to disclose n=157
1	Drug use	Depression	Drug use	Depression	Serious mental illnesses
2	Depression	Drug use	Alcohol use	Drug use	Drug use
3	Alcohol use	Anxiety	Depression	Alcohol use	Depression
4	Anxiety	Alcohol use	Serious mental illnesses	Anxiety	Anxiety
5	Serious mental illnesses	Serious mental illnesses	Anxiety	Serious mental illnesses	Alcohol use
6	Loneliness	Loneliness	Post Traumatic Stress Disorder	Post Traumatic Stress Disorder	Post Traumatic Stress Disorder
7	Domestic violence	Domestic violence	Domestic violence	Domestic violence	Domestic violence
8	Post Traumatic Stress Disorder	Post Traumatic Stress Disorder	Loneliness	Loneliness	**Not sure**

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

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

612 Total Respondents in St. Louis City



Community members rated the availability of several resources in the City of St. Louis.

Places to be physically active, health care services, and public transportation were rated as being more available, with over 50% of respondents indicating that the resources were often or always available in their community.

Affordable housing, mental health and substance use services, and good schools were reported to be less availability, with more than 40% indicating that the resources were rarely or never available in their community.

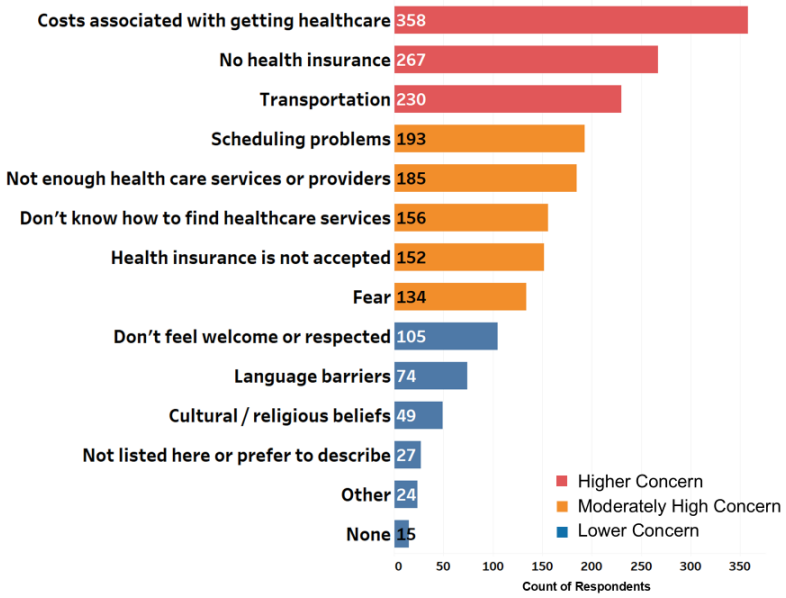
Notes

4

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

612
Total Respondents in St. Louis City

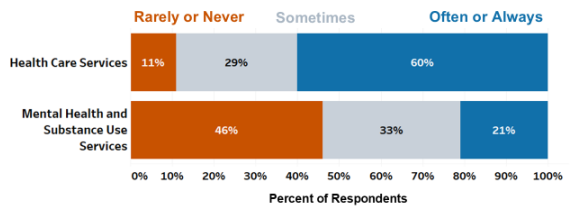
Barriers to Health Care Access



Sixty percent (60%) of community members who responded to the survey indicated that health care services were often or always available in the City of St. Louis. Only 21% indicated that mental health and substance use services had good availability.

Costs, lack of insurance, and transportation were most frequently identified as barriers to accessing health care.

Health Care Service Availability



Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders*

Appendix G: Community Leader Conversation Participants

Barnes-Jewish St. Peters Hospital and Progress West Hospital: Community Leader Conversation Participants			
Organization	**First Name**	**Last Name**	**Title**
Behavioral Health Network	Jennifer	Miller	Director of Community Programs
Boys & Girls Clubs of St. Charles County	Karen	Englert	Chief Executive Officer
Catholic Charities of St. Louis	James	Whitaker	Navigator
Community Council of St. Charles County	Todd	Barnes	Executive Director
Compass Health Network	Vicky	Walker	Provider
Crossroads Clinic	Susan	Baker	Office Coordinator
Gateway Region YMCA- O'Fallon Missouri	Matt	Jones	Executive Director
Gateway Region YMCA- St. Charles	Renee	Tillman	Executive Director
Missouri SHIP	Peg	Illert	
Operation Food Search Inc	Melanie	Aubrey	Agency Partnerships Manager
PreventED	Kristin	Bengtson	Director of Community Services
SSM Health	Mitch	Miller	Director - Strategy and Business Development
SSM Health	Lauren	Fagan	Administrative Director of Nursing Operations
St. Charles City-County Library	Jason	Kuhl	Chief Executive Officer
St. Charles County Ambulance District	Kelly	Cope	Chief Executive Officer
St. Charles County Ambulance District	Kyle	Gaines	Division Chief – Public Information Officer
St. Charles County Department of Health	Brennan	Burk	Epidemiologist
St. Charles County Department of Health	Samantha	VanNatta	Acting Assistant Department Director
St. Charles County Department of Health	Jessica	McHugh	Epidemiologist
St. Louis Oasis	Marissa	Sandbothe	Education Manager
Youth In Need	Carrie	Williams	Health and Nutrition Manager

United Way of Greater St. Louis	Julia	Fuller	Portfolio Manager
Urban League	Tiana	Kimbrow	Health Services Coordinator
Virtuously B'Earthed Doula Services	LaKisha	Redditt	Owner
Youth In Need	Carrie	Williams	Health and Nutrition Manager

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** | Urban League of Metropolitan St. Louis – July 11, 2024 – 32 participants
- **Community Members** | St. Patrick Center – September 24, 2024 – 9 participants
- **Community Members** | International Institute of St. Louis – October 23, 2024 – 10 participants
- **Community Members** | DOORWAYS – December 9, 2024 – 10 participants

Community Leader Conversation on Health Needs

Mental Health

- Mental health is the most significant health concern
- Trauma, anxiety, depression, and substance are the most pressing issues
- The COVID-19 pandemic intensified mental health issues, especially among youth, older adults, and socially isolated community members
- Mental health issues relate to social stressors such as poverty, housing instability, and food insecurity
- Mental health needs are often underreported
- Expanded access to culturally competent mental health services is needed, especially to serve low-income and uninsured community members

Community Leader Conversation on Health Resources

Affordable Housing

- Housing instability is an important social determinant of health that contributes to poor health and mental health outcomes
- Health care systems need to adopt a more holistic approach that integrates social determinants, like housing, of health into strategic planning and service delivery

Affordable, Healthy Food

- Food insecurity is an important social determinant of health that contributes to poor health and mental health outcomes
- Health care systems need to adopt a more holistic approach that integrates social determinants, like food security, of health into strategic planning and service delivery

Public Transportation

- Transportation is an important social determinant of health that contributes to poor health and mental health outcomes

- Health care systems need to adopt a more holistic approach that integrates social determinants, like transportation, of health into strategic planning and service delivery

Health Care Services

- Access to health care is a long-standing challenge for many community members in St. Louis City
- There are several barriers to accessing health care, including: Long wait times for specialists, inadequate transportation options, a lack of healthcare providers in certain geographic areas of the city, a lack of coordination between health care services, health literacy, and mistrust stemming from ineffective communication with healthcare providers (individual level) and health care system (community level)
- Some community members, including many young people, rely on emergency services for routine care
- Fragmentation of health care services is another barrier and exacerbates health disparities
- Health literacy is a barrier to knowing about and understanding how to navigate health care services
- There is a lack of trust between some communities and healthcare providers
- Mistrust is rooted in several concerns, including: Systemic neglect and underrepresentation of marginalized communities in data collection and health care services
- Community members identified the following ideas to overcome existing barriers to health care:
    - Equip healthcare providers to provide consistent, culturally competent care
    - Expand community health worker programs
    - Co-locate physical health, mental health services, and social services
    - Center health care services in community settings
    - Host regular community listening sessions

Community Member Conversation on Health Needs

Mental Health

- Mental health is closely connected with physical health
- Mental health issues can sometimes lead to violence
- People without homes need mental health support
- Providing mental health resources can help prevent other issues
- There is stigma around receiving mental health services, especially among immigrant populations
- Mental health is a top priority for people experiencing homelessness and immigrants, both of which face unique needs, stressors, and trauma

Violence

- A healthy community is one where there is not violence, which makes one feel stuck
- A healthy community is one where neighbors get along, take care of each other, and feel a sense of belonging
- Violence affects the St. Louis community, especially those who are unhoused or dealing with mental health issues
- Fear of experiencing violence often prevents community members from accessing community resources

Substance Use

- Substance use needs require increased attention

- Substance use needs intersect with mental health challenges
- Substance use in neighborhoods compromises community safety

Oral and Dental Health

- Dental health needs cause significant discomfort that affects daily life
- Access to dental health is limited by lengthy wait times and limited appointment availability
- Several appointments must be made for different dental services

Community Member Conversation on Health Resources

Affordable Housing

- Access to mental health services at shelters and safe spaces for people experiencing homelessness and trauma are needed
- Hospitals need to support patients when they are discharged, especially those who are unhoused or who have mental health needs
- Supportive, group living facilities are needed
- St. Patrick Center's Rosati housing program is a valuable resource
- The International Institute's housing assistance and support programs are a valuable resource

Mental Health and Substance Use Services

- Places for People is noted as a valuable resource
- Stigma is a barrier to seeking and accessing mental health services
- Hospitals need to support patients when they are discharged, especially those who are unhoused or who have mental health needs
- There is a need for more therapy groups, peer support, and other programs in shelters that allow individuals with similar experiences to come together, share experiences, and support one another

Good Paying Jobs

- Opportunities for meaningful work is needed, especially for those who are unhoused
- Jobs have both economic and psychological benefits

Safe Community

- A healthy community is one where people feel safe, supported, and empowered
- DOORWAYS was noted as having created a safe, positive community
- Fear of experiencing violence often prevents community members from accessing community resources

Affordable, Healthy Food

- A healthy community is one where everyone can eat healthy
- Food assistance from churches is a valuable resource

Public Transportation

- Many barriers to accessing and/or keeping health care services are related to transportation, including:

    - Long travel times
    - Unreliable public transportation
    - Long wait times for Medicaid-sponsored transportation
    - The location of health care facilities, especially if in an unfamiliar neighborhood
- Case managers can help set up transportation
- Medication delivery programs are important for those facing transportation barriers

Health Care Services

- A healthy community is one where everyone has access to adequate health care
- A healthy community is one where neighborhoods have health care clinics
- Community members face many barriers to accessing health care, including:
    - A fragmented and complicated system
    - Difficulty understanding and navigating the paperwork and forms required to receive insurance
    - A lack of health literacy and awareness about insurance benefits, coverage, and bills
    - Long wait times to see a provider (even with insurance, it can take 2-3 months)
    - Lack of insurance coverage by some facilities/services (e.g., urgent care may not accept Medicaid)
    - High cost of care and medications, even with the coverage provided by Emergency Medical Treatment and Labor Act (EMTALA)
    - Mistrust for the health care system
- Additionally, immigrant populations face additional barriers to accessing health care, including:
    - Limited, or delayed, access to Medicaid coverage (per Missouri's Medicaid expansion policies)
    - Limited awareness of healthcare providers who accept Medicaid
    - Unreliable hospital-based financial aid
    - Lack of knowledge of the U.S. health care system
    - Cultural differences in how health care services are delivered (e.g., appointments are scheduled ahead of time for individual services)
- It's frustrating that the responsibility is all on the consumer/patient (e.g., if a prescription isn't filled, the patient must call the pharmacy, then the provider, then the pharmacy, again)
- Long wait lists encourage people to use emergency rooms and urgent care facilities for routine care
- Community members identified the following ideas to overcome existing barriers to health care:
    - Provide an information center to answer questions
    - Have after-hour clinics to meet the needs of working people
    - Have a care team to support and coordinate care for patients
    - Have patient advocates or case managers to help them navigate the systems
    - Offer medication delivery programs
    - Offer community-based health care services and community events to improve awareness, access, and trust
    - Increase staff in emergency departments
    - Encourage healthcare providers to listen and engage patients with empathy
    - Provide training for health care providers and staff to understand the immigrant and refugee experience and how it impacts health
    - Support community volunteer efforts to build resilience and self-efficacy among community members
    - Advocate for the expansion of Medicaid to all immigrants

    - Increase transparency around health care costs
    - Expand language and disability services available at hospitals and other health care facilities
    - Partner with immigrant-serving organizations to increase education and awareness

Places to be Physically Active

- A healthy community is one where everyone can exercise

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

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.

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

Barnes-Jewish Hospital 2025 Community Health Needs Selection Team Attendees 05/19/2025			
Last Name	**First Name**	**Title**	**Department**
Arevalo	Jesse	Vice President, Facilities and Support Services	Executive Administration
Dow	Alen	Executive Director, Neuro/Spine/Brain	Neur/Spine Administration
Eikmann	Kaci	Executive Director, Siteman Cancer Center	Cancer Center Admin
Fan	Christopher	Director, Languages Services/Accessibility	Language Services Administration
Hackleman	Rob	Manager, Case Coordination	Stay Healthy OP Program
Haney	Latosha	Patient Experience Partner	Office of Patient Experience
Hanselman	Kelly	Director, Emergency Services	Emergency Room Administration
McEntee	Colene	Manager, Internal Communications - SR	MC-Internal Comm-HSOs
O'Connor	Madeline	Supervisor, House	Nursing Float
Poirier	Robert	Associate Professor of Emergency Medicine	Emergency Medicine
Randolph	Jacqueline	Executive Director, Ambulatory Services	Administration Ambulatory
Reeves	Janene	Associate Administrator - ACAD PRES	Directors Office
Smith	Nathanael	Asst Prof of Emergency Medicine	Emergency Medicine
Smith	Yvonne	Director, Women & Infants Services	Women & Infants Administration
Spencer	Mary	Vice President, Neurosciences & Spine Service Lines	Executive Administration
Stipsits	Martha	Director, Transplant Services Program	Administration Transplant Services
Wiley	Tigre	Director, Patient Care Services - Psych	Psych Admin

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 a 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:

$$((Number\ of\ health\ needs\ for\ data\ source\ +\ 1)\ -\ Rank\ of\ health\ need\ in\ data\ source)\ x\ Weight\ of\ data\ source$$

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

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

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			