2025-2028 Community Health Needs Assessment and Improvement Plan

Barnes-Jewish West County 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 Angelleen Peters-Lewis, President, Barnes-Jewish West County 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 West County 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.

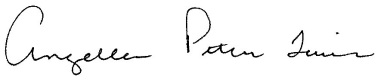
For Barnes-Jewish West County Hospital, we are committing to focused efforts around obesity and maintaining healthy weight. This priority was carefully determined through conversations with community members and leaders across the region, as well as a community health needs survey, public health data, 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



Angelleen Peters-Lewis, PhD, RN, FAAN
President, Barnes-Jewish West County Hospital

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About BJC HealthCare

BJC Health System is the largest nonprofit health care organizations in Missouri. It is also one of the largest in the United States. 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.

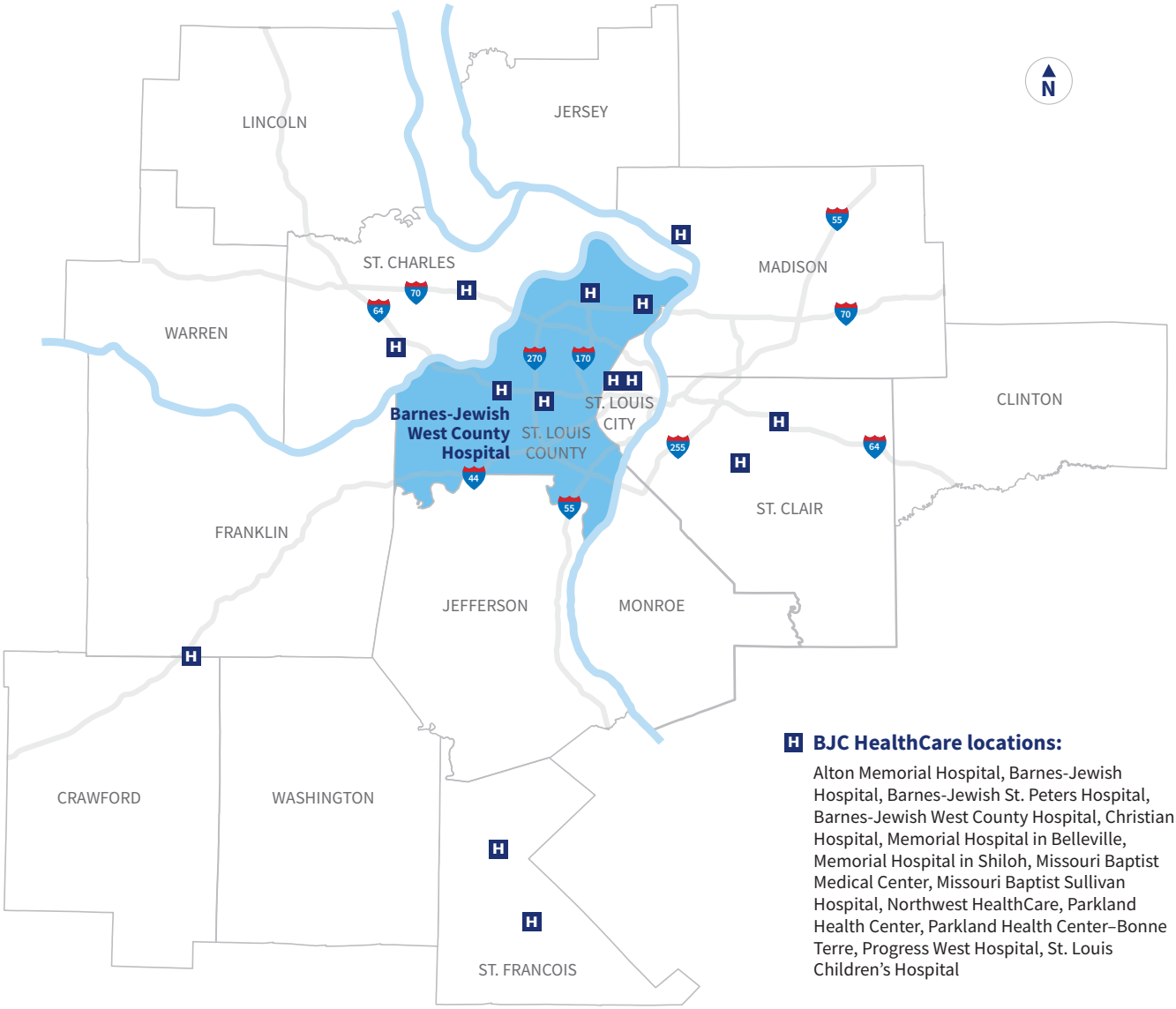
When their CHNAs are complete, hospitals create Community Health Improvement Plans (CHIPs). These plans set specific goals and actions to improve health needs in the community. In this report, we will share how we learned about health needs in the Barnes-Jewish West County Hospital community and chose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

Barnes-Jewish West County Hospital and the Community We Serve

The Barnes-Jewish West County Hospital Community Health Needs Assessment is focused on **St. Louis County, Missouri**. West County offers specialized medical and surgical services. Patients have access to physicians from WashU Medicine, BJC Medical Group, and private practice.

We designed the hospital to have a comforting environment. It has 96 private patient rooms, 14 operating rooms, and four intensive care unit rooms. We wanted the hospital to focus on patient experiences while being innovative and efficient.

Barnes-Jewish West County 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 hospital offers care in areas like pain management, advanced radiology, sleep medicine, therapy and rehabilitation, inpatient and outpatient surgeries, bariatrics, digestive diseases, oncology, ophthalmology, orthopedics, otolaryngology, plastics, spine, and urology. The hospital also has a Siteman Cancer Center satellite location and a bariatric Center of Excellence.

Barnes-Jewish West County has been **nationally recognized for excellence in total hip, knee, and shoulder replacement**. *U.S. News & World Report* consistently ranks the hospital as high performing in knee replacement, kidney failure, hip fracture, hip replacement, pneumonia, and prostate cancer surgery.

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

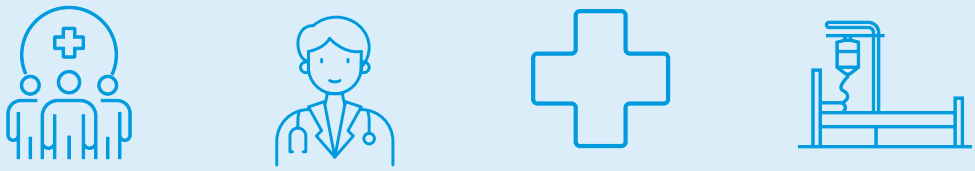
Over the years, West County has given back to the community in many ways. In 2023, the hospital provided **$32.4 million** in community benefit. This total includes:

- $17.6 million in **education and professional support** for current and future health professionals
- $6 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- $5.4 million in **unreimbursed care** for people with Medicaid and Medicare
- $3.4 million in **services that fill gaps** in health care access for the community
- $0.1 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**.

West County has dedicated staff who provide care for many community members. The team includes 1,015 employees and 1,123 physicians who practice at our hospital. In 2024, we cared for 3,734 inpatient admissions, 12,796 outpatient surgeries, and 17,831 Emergency Department visits. See more details in the graphic below.

Barnes-Jewish West County Hospital by the Numbers



1,015 Total Employees

1,123 Physicians

$286.4 Million Net Revenue (2023)

100 Staffed Beds

3,734 Inpatient Admissions

12,796 Outpatient Surgeries

17,831 Emergency Department Visits

About **one million people** call St. Louis County home.[1] Much of St. Louis County is the suburbs of the St. Louis metro area.[1] More than half of the people who live in St. Louis County are white, and about one in five residents are older than 65 years.[1] The life expectancy for St. Louis County residents is about 76 years, which is about a year more 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 County 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.

In St. Louis County, **nearly all residents have 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 County is about $81,000 per year.[1] This is higher than the median state household income.[1]

About one in eight children in St. Louis County live in poverty.[1] This is lower than the children across the state of Missouri, where one in six live in poverty.[1]

Community Feature: Millennium Park

Millennium Park is a 25-acre park near Barnes-Jewish West County Hospital.[3] Millennium Park includes places for community members to walk, gather, and play sports, like soccer and baseball.[3] Each summer, Millennium Park hosts a concert series. The historic Tappmeyer Homestead is also at Millennium Park. The house was built in 1884 and was home to four generations of the Tappmeyer family.[4] In 2003, the house was moved to Millennium Park.[4]

Millennium Park, Creve Coeur, Missouri

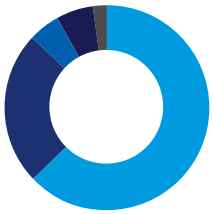
Barnes-Jewish West County Community Characteristics

St. Louis County

Population
996,618

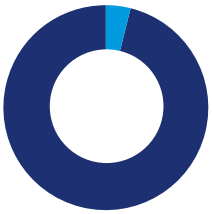
Land Area
508 sq. mi.

Race



63% White
24% Black
5% Asian
6% 2 or more races
2% Other*

Ethnicity



4% Hispanic/ Latino
96% Not Hispanic/ Latino

Most people have at least a high school education

St. Louis Co.	Missouri
94%	92%

Life Expectancy

St. Louis Co.	Missouri
76	75

The median household income in St. Louis County is higher than for the state of Missouri

St. Louis Co.	Missouri
$81,340	$68,920

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

St. Louis Co.	Missouri
45%	42%

Poverty rates among children in St. Louis County are lower than in the state of Missouri

St. Louis Co.	Missouri
13%	16%

People over 65

St. Louis Co.	Missouri
19%	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). Every 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.

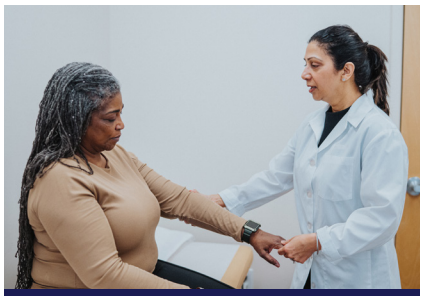
We made important progress across the region. These improvements came from the dedication of hospital teams and our collaborating organizations. Some successes include:

- **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 West County Hospital Community Health Needs and Goals from 2022–2025

In our last Barnes-Jewish West County Hospital Community Health Needs Assessment, we learned that obesity was the top health concern in St. Louis County. For this health need, we set two goals and made a plan to reach the goals.



Obesity

Goal: Reduce the amount of overweight and obese individuals in St. Louis County.

Obesity

Goal: Improve management of obesity-related diseases in individuals.

Obesity

Our Strategy ▸

We wanted to reduce how many people have overweight or obesity in St. Louis County. Obesity can cause health conditions and diseases if left unmanaged. We wanted to improve management of obesity-related diseases in our community members.

We planned to host a 12-week **healthy behavior education program**. The program talked about the behavioral causes of obesity and disease management. All community members with overweight or obesity were welcome to attend. We wanted 75% of participants to complete the session with 80% of attendance at the end of 12 weeks. We also wanted at least 75% of participants to increase their knowledge of the effect of healthy behavior on their weight by 10% at the end of 12 weeks.

We structured the program to set up our participants for success. During the first week, we planned to summarize the purpose of the program. We would give participants a test to see how much they knew about healthy behaviors. We also recorded participants' body mass index **(BMI)** and weight. We offered a free two-hour or four-hour consultation with a dietitian and a brochure about healthy meal choices to make at home.

BMI, or body mass index, is based on a person's weight and height.[5] BMI is measured by dividing a person's weight by their height.[5] Some BMIs can put people at higher risk of health problems, like high blood pressure and high cholesterol.[5]

The program also focused on physical activity. Once per week, we planned to meet to exercise together and discuss healthy nutrition choices. We considered public areas for this exercise with lots of greenery. Some of these spaces were already used by external walking groups, exercise classes, and organized sports. We wanted to encourage participants to use these spaces for walking groups, with a goal of exercising at least three times per week. We recorded participants' weights each week.

When the program ended, we had planned to give participants the same test as before. We wanted to see how their knowledge about healthy behaviors had changed after the program. We wanted participants to continue with their walking group, and we planned to follow up with participants every six months to keep track of their progress.

We tracked a lot of participant information during the program. We kept track of how many classes each participant attended. We recorded their weights. We planned to compare their test scores before and after the program to see how their knowledge of healthy behaviors changed.

We planned to tell community members about the program in many ways. We planned to use banners, flyers, promotional campaigns, and event days to spread the word about the program.

Our Progress ▸

The COVID-19 pandemic and staff changes impacted our plans to start the program. We did not start classes until November 2023. We also changed the class length from 12 sessions to three sessions because of limited resources.

The classes are still happening now. We offer all three sessions every other month. Class members learn about healthy eating, managing and monitoring diabetes, and continuing the journey over the long term. Each participant can choose a schedule that works for them. Some complete all three sessions in one month. Some take several months to complete all three sessions. Participants were between 52 and 80 years old.

So far, 84% of participants completed all three sessions. Another 13% canceled or did not attend their session, and 3% rescheduled for a future session.

Measuring learning can be difficult. Instead of tracking our progress by measuring changes in knowledge as we originally planned, we decided to track changes in participants' weight. So far, 74% of participants had a lower weight after the class than before the class. On average, participants lost eight pounds, or 4% of their weight. Participants lost up to 45 pounds. The 26% of participants who did not lose weight maintained their original weight.

Where We Are Today…

2025 Community Health Needs Assessment (CHNA)

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

Community Survey

Community Information

Community Conversations

Hospital Service Information

Hospital Team Survey

This information helped us understand the strengths and challenges in our community. We used this information to find where to build more support and learn 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 County** to fill out our survey and share their thoughts. They could take the survey in English or Spanish. This was the first time we have offered the survey in Spanish. BJC HealthCare employees who live in the county could take the survey, too. We asked about:

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

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

We shared the survey online and in print. We used a QR code to share the survey more easily. Community members and leaders 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 County. 1,701 community members completed the survey. See Appendix B and Appendix C for more details.

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

We learned that costs, scheduling problems, and transportation were serious challenges to getting care. The community needs more affordable housing, public transportation, and mental health and substance use services. See more details in the list on the right.

COMMUNITY SURVEY

Top 5 Health Problems

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

Top 5 Mental Health Concerns

1. Depression
2. Anxiety
3. Alcohol use
4. Drug use
5. Loneliness

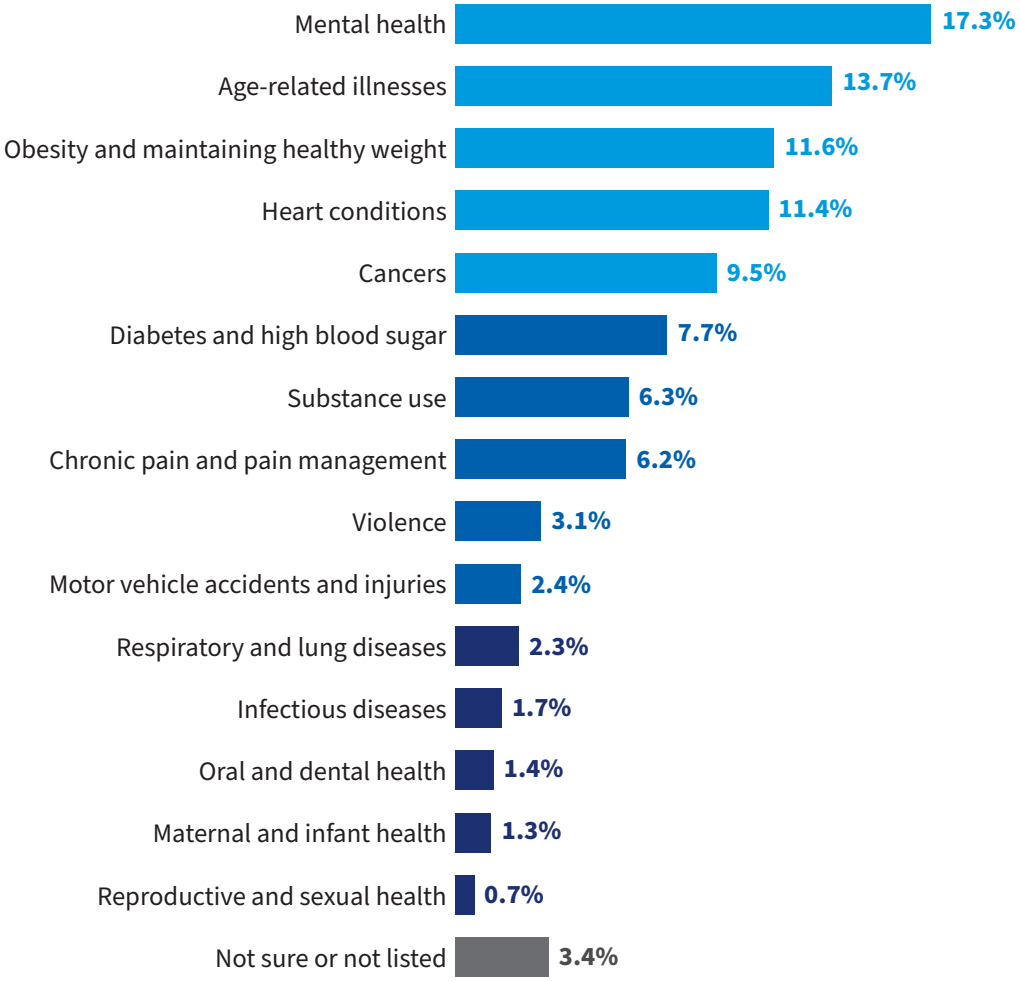
Top 5 Barriers to Care

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

Top 5 Community Resource Needs

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

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 County from 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 County with other communities, national goals from Healthy People 2030, and past community health information.

The top health needs from HCI were prevention of and safety from violence and injury; cancer; and maternal, fetal, and infant health. The top social determinants of health needs were community (like the use of public transportation and access to the internet), health care access and quality, and environmental health. See more details in the list on the right.

COMMUNITY INFORMATION

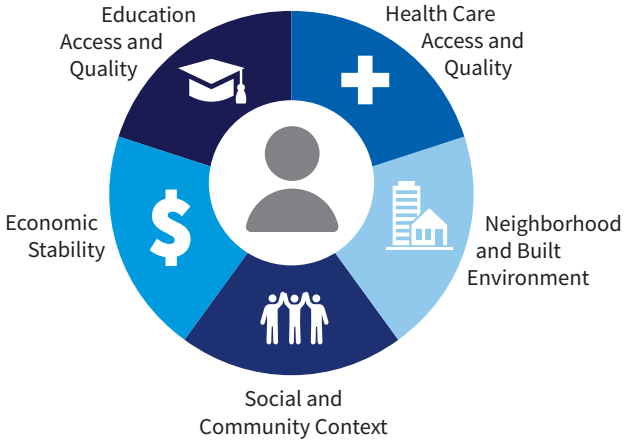
Top 5 Health Problems

1. Prevention and safety
2. Cancer
3. Maternal, fetal, and infant health
4. Alcohol and drug use
5. Older adults

Top 4 Most Needed Social Determinants of Health

1. Community
2. Health care access and quality
3. Environmental health
4. Economy

Social Determinants of Health



Community Conversations

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

Community Leaders

We invited many community leaders to meetings at St. Luke's Hospital. 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 many health needs, including mental health, obesity and maintaining healthy weight, and heart conditions.

Community leaders discussed needed resources, like affordable housing, public transportation, mental health and substance use services, and others. See more details in the list on the right.

Ann Abad, president of Missouri Baptist Medical Center, speaking at Community Leader Conversation*

COMMUNITY LEADER CONVERSATIONS

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

Discussed Community Health Needs

- Mental health
- Obesity and maintaining healthy weight
- Heart conditions
- Diabetes and high blood sugar
- Substance use
- Maternal and infant health

Discussed Community Health Resources

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

**Note: Barnes-Jewish West County Hospital and Missouri Baptist Medical Center Community Leader Conversations were hosted jointly.*

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 St. Louis Oasis. We asked community members which health needs were the most important to them. Community members discussed mental health, age-related illnesses, and cancers.

We then asked community members which community resources were most needed. They discussed resources including public transportation, health care services, and aging services. See more details in the list on the right.

St. Louis Oasis in Clayton, Missouri, where conversations with community members took place

COMMUNITY MEMBER CONVERSATIONS

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

Discussed Community Health Needs

- Mental health
- Age-related illnesses
- Cancers

Discussed Community Health Resources

- Public transportation
- Health care services
- Aging services
- Safe community
- Places to be physically active

Hospital Service Information

When patients receive care at a hospital, their care is billed to their insurance. This is known as a claim. We looked at the hospital claims data for Barnes-Jewish West County 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 West County Hospital, the most common reasons patients visit the hospital are for cancer; fibromyalgia, chronic pain, and fatigue; and hypertension. See more details in the list below.

HOSPITAL SERVICE INFORMATION

Top 5 Health Conditions

1. Cancer
2. Fibromyalgia, chronic pain, and fatigue
3. Hypertension
4. Diabetes
5. Obesity

Hospital Team Survey

Barnes-Jewish West County 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 West County Hospital CHNA team took a survey about local health needs. Team members were most concerned about cancers, chronic pain and pain management, and diabetes and high blood sugar. See more details in the list below.

HOSPITAL TEAM SURVEY

Top 5 Community Health Needs

1. Cancers
2. Chronic pain and pain management
3. Diabetes and high blood sugar
4. Mental health (tie)
4. Heart conditions (tie)

Top 5 Most Needed Community Health Resources

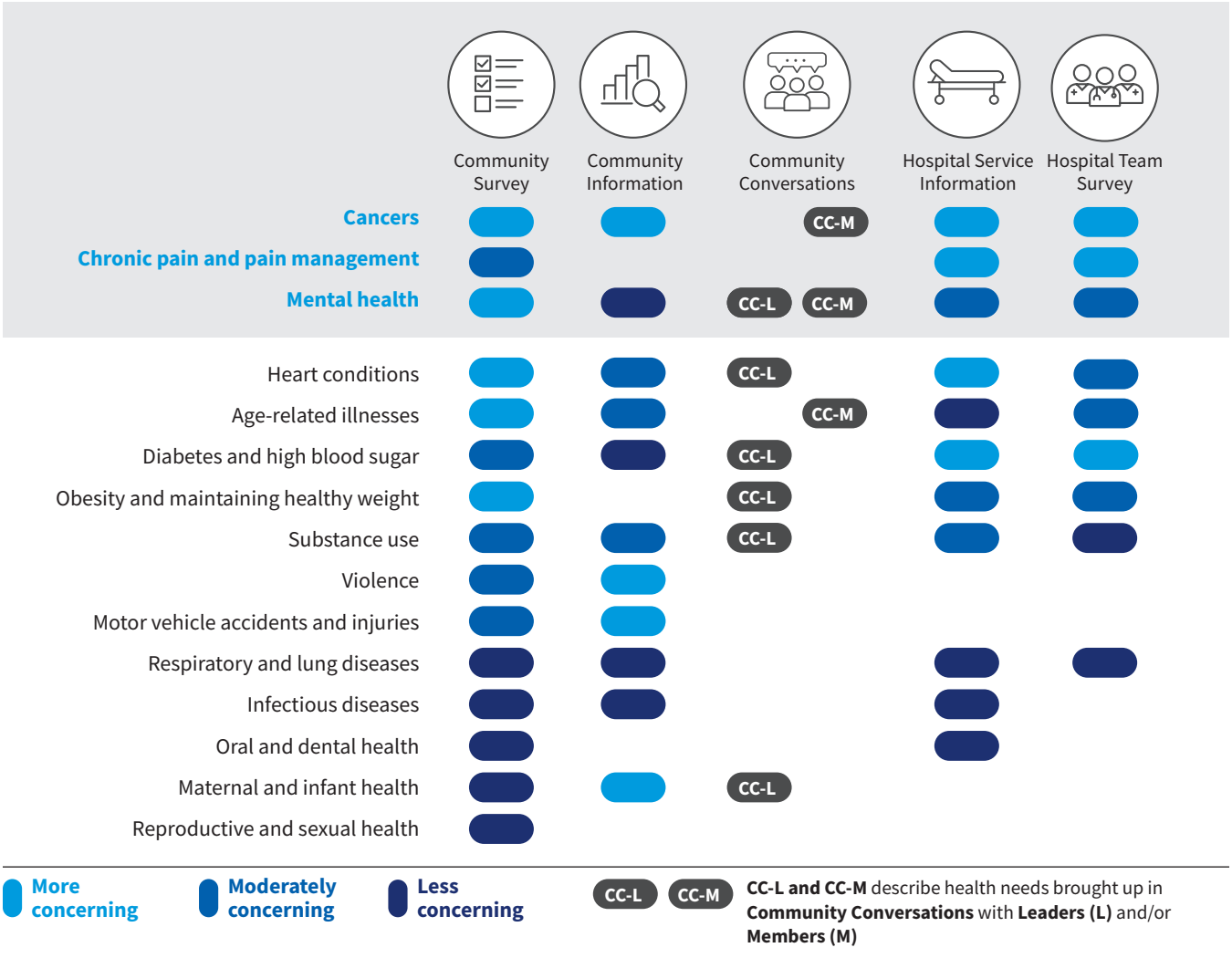
1. Affordable housing
2. Public transportation (tie)
2. Mental health and substance use services (tie)
3. Affordable, healthy food
4. Aging services

What We Learned: Our Selected Health Needs

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

We considered how important the health needs are to the audiences we spoke to. These include community members, community leaders, and BJC employees. We wanted to elevate the community's voice, so we made their answers count more than other information sources. We ranked four health needs as most important for Barnes-Jewish West County Hospital. These needs are **cancers**, **chronic pain and pain management**, and **mental health**. 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 West County 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.

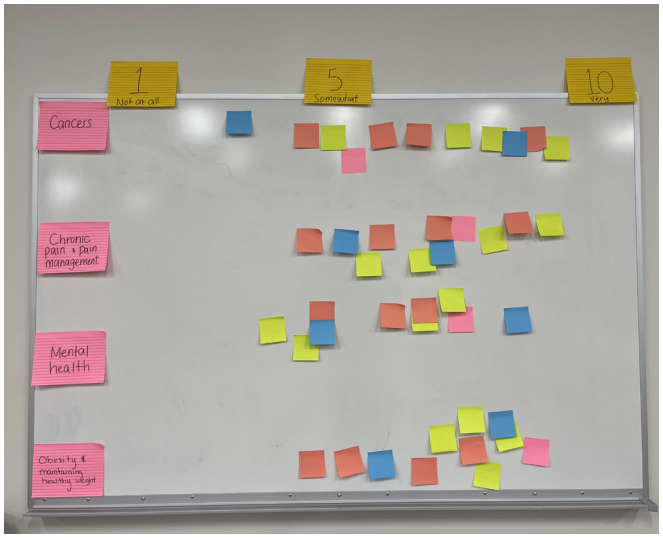
How the Needs Were Selected

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 cancers, chronic pain and pain management, and mental health.

Health Needs We Will Not Prioritize in This CHIP

While there were many community health needs that came up in our data sources, we cannot address everything at the same time. We only moved forward the elevated health needs identified through the health need ranking and hospital team discussion. The elevated needs then were discussed by the BJC team to assess resources available to improve them and what kind of difference they could make in the next few years.

Hospital Team Conversation



Results from our team's discussion of which health needs we have the resources and connections to improve (see list of team members in Appendix J)

Although mental health is a critical community need, we did not prioritize it at this time due to significant resource and infrastructure limitations. Our campus does not currently have the staff capacity or clinical expertise to lead new mental health initiatives. Developing a comprehensive program would require additional providers, space, and specialized services, which we do not have the ability to implement at this time. Inpatient and emergency department mental health needs continue to be supported through telemedicine partnerships, and we plan to strengthen these collaborations as we work toward long-term solutions. We also work with BJC Behavioral Health to help meet these needs of our community.

Cancer care remains an essential focus of our health system, but it was not selected as a CHIP priority because significant improvement efforts are already underway within our existing operations. We are investing heavily in cancer services, expanding access to treatments, and strengthening care coordination. Since these initiatives are already being addressed through dedicated resources and infrastructure, we chose to focus CHIP priorities on other areas where broader community-level impact can be made.

While chronic pain is an issue for many in our community, we did not prioritize it for the CHIP because we already provide a robust network of services to address this need. Our hospital offers a pain management clinic, physiatry services, extensive rehabilitation programs (including medical massage and dry needling), and orthopedic and spine care. Because these services are well-established and accessible, we believe our CHIP priorities should focus on other areas where unmet needs are greater and community-wide impact can be more significant.

Health Need We Will Prioritize in This CHIP

We decided to prioritize **obesity and maintaining healthy weight**. We made this decision for a few reasons. First, we know this is an important health need for our community because of our Community Health Needs Assessment. Second, we know we have the resources to improve this health need for our community. In our last Community Health Improvement Plan, we prioritized obesity and maintaining health weight. We have spent the last few years working to improve obesity and maintaining healthy weight for our community members. We would like to continue building on our momentum and prioritizing this health need. Finally, by working to improve obesity and maintaining a healthy weight, we may improve other health needs, too.

A Closer Look at Our Prioritized Health Need

We decided to focus on obesity and maintaining healthy weight. This is how we define this concern.

Obesity and Maintaining Healthy Weight

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

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

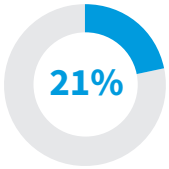
Many of these factors are **affected by social determinants of health** that make it easier or harder to be healthy. These determinants can include walkable neighborhoods and education.[6]

Obesity is linked to long-term health conditions like heart conditions, diabetes, and cancers.[7] About one in five people in St. Louis County get little to no physical activity.[8] This means that many adults in the county are more likely to develop long-term health conditions.

In St. Louis County, about

1 in 5 adults

get little or no exercise



SOURCE: Conduent Healthy Communities Institute

BMI, or body mass index, is based on a person's weight and height.[5] BMI is measured by dividing a person's weight by their height.[5] Some BMIs can put people at higher risk of health problems, like high blood pressure and high cholesterol.[5]

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:
Obesity and Maintaining Healthy Weight

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

Category: *Screening*

INITIATIVE: In partnership with campus physicians and clinics, create and launch the Lifestyle Medicine Screening event.

MEASURES:
- # of screening events
- # of community participants attending screening events
- % of screening event attendees who report benefiting from the information received
- % of screening event attendees who report an intention to take at least one action in the next week to improve their health

Category: *Connection to resources*

INITIATIVE: Establish a new initiative to increase access to healthy foods among Lifestyle Medicine Screening event attendees and Barnes-Jewish West County employees who screen positive as food insecure.

MEASURES:
- Development of initiative
- # of collaborations established

Category: *Health education*

INITIATIVE: Partner with Washington University Orthopedics' Living Well Center to offer movement classes to the community.

MEASURES:
- #/type of marketing materials developed to promote movement classes
- # of movement classes offered
- # of attendees per class

What Comes Next

Looking Forward

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

Acknowledgments

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

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

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

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

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

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

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Appendix A: Community Demographics

Demographics of St. Louis County and Missouri		
	St. Louis County	Missouri
POPULATION		
Population 2020	996,179	6,124,160
Population 2023 (estimate)	987,059	6,196,156
Population 2024 (estimate)	992,929	6,245,466
Population, Percent change - 2023 (estimate) to 2024 (estimate)	0.6	0.8
AGE		
Persons Under 5 Years, Percent, 2024	5.3	5.5
Persons Under 18 Years, Percent, 2024	21.6	21.9
Persons 65 Years and over, Percent, 2024	20.1	18.7
GENDER		
Female Persons, Percent, 2024	52.2	50.7
Male Persons, Percent, 2024	47.8	49.3
RACE/ETHNICITY		
White alone, Percent, 2024	62.9	77.6
White alone, not Hispanic or Latino, Percent, 2024	62.1	76.2
African American alone, Percent, 2024	23.3	10.5
Hispanic or Latino, Percent, 2024	4.1	5.6
Two or More Races, Percent, 2024	6.1	7.3
American Indian and Alaska Native alone, Percent, 2024	0.1	0.3
Asian alone, Percent, 2024	5.4	2.3
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.2	0.1
LANGUAGE		
Foreign Born Persons, Percent, 2024	8.5	4.9
HOUSING		
Housing Units, 2024	447,542	2,858,527
Homeownership Rate, Percent, 2024	69.9	68.6
Median House Value, Dollars, 2024	300,800	254,400
FAMILIES & LIVING ARRANGEMENTS		
Households, 2024	412,517	2,563,244
Persons per Household, 2024	2.4	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	11.0	7.4
EDUCATION		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	94.6	92.0
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	48.4	33.5
INCOME		
Median Household Income, Dollars, 2024	83,669	71,589
Per Capita Income in past 12 months (in dollars), 2024	52,297	40,284
People Living Below Poverty Level, Percent, 2024	9.7	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 Never	2 Rarely	3 Sometimes	4 Often	5 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 South-Mid-West St. Louis County, Missouri 1,701 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 6 to 144. On average, about 25% of participants chose not to answer the optional demographic. Among those who did respond, most were between 55 and 64 years old (16%), women (59%), White (64%), non-Hispanic (60%), and primarily English-speaking at home (73%). Many held advanced degrees such as a Master's, Professional, or Doctorate degree (32%), were employed full time (46%), and reported a household income between $100,000 and $149,999 (13%).

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

Mid/West St. Louis County

Key Survey Findings

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

2024 Community Health Needs Assessment Survey

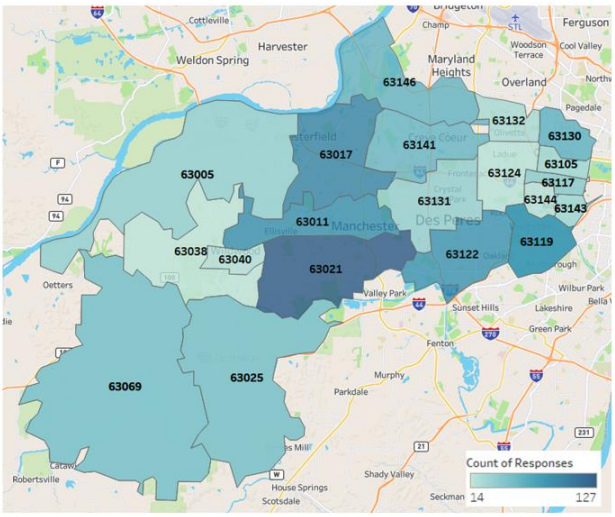
Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

941
Total Respondents in MidWest County

In Mid/West County, 941 community members responded to the community health needs survey.
The number of survey respondents in Mid/West St. Louis City ZIP codes ranged between 14 and 127.

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?

941 Total Respondents in Mid/West County

Over 21% of respondents in Mid/West County did not complete the optional demographic survey questions (non-respondents range from n=203 to 314, depending on the question).

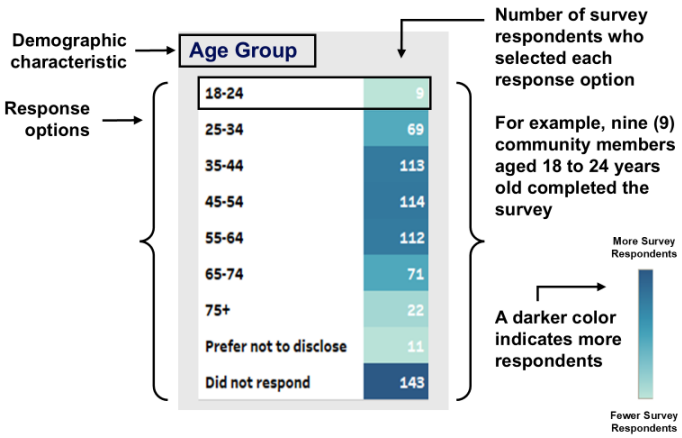
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=941).

Most respondents:

- Are between the age of 55 and 64 years old (16%)
- Are women (61%)
- Are White (65%)
- Are non-Hispanic (62%)
- Speak English at home (76%)
- Have a master's, professional, or doctorate degree (38%)
- Are employed full time (46%)
- Have a household income of $200,000 or more (16%)

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

Example: Survey Respondents by Age Group



Notes

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

941 Total Respondents in Mid/West County

Age Group

Under 18	2
18-24	7
25-34	65
35-44	137
45-54	133
55-64	153
65-74	144
75+	82
Prefer not to disclose	12
Did not respond	206

Educational Attainment

Less than high school	2
High school diploma/GED	29
Some college credit, no degree	48
2-year college/Vocational training	52
4-year college/Bachelor's degree	231
Master's, Professional, or Doctorate degree	356
Other or prefer to self-describe	6
Prefer not to disclose	14
Did not respond	203

Employment

Full-time	429
Part-time	57
Disabled	14
Retired	172
Self Employed	12
Student Full-time	2
Student Part-time	3
Not Employed	11
Other or prefer to self-describe	14
Prefer not to disclose	14
Did not respond	213

Income

Less than $10,000	8
$10,000 to $24,999	20
$25,000 to $49,999	47
$50,000 to $74,999	61
$75,000 to $99,999	58
$100,000 to $149,999	130
$150,000 to $199,999	112
$200,000 or more	154
Prefer not to disclose	142
Did not respond	209

More Survey Respondents

Fewer Survey Respondents

Gender

Woman	578
Man	139
Non-binary	4
Other or prefer to self-d..	1
Prefer not to disclose	12
Did not respond	207

Race

White	610
Black or African American	42
Asian	29
Other or prefer to self-describe	11
American Indian or Alaska Native	6
Prefer not to disclose	31
Did not respond	211
Native Hawaiian or Other Pacific I..	1

Ethnicity

Hispanic	10
Non-Hispanic	588
Prefer not to disclose	29
Did not respond	314

Language at Home

English	715
Hindi	3
Mandarin	1
Spanish	1
Other or prefer to self-d..	4
Prefer not to disclose	13
Did not respond	204

2024 Community Health Needs Assessment Survey

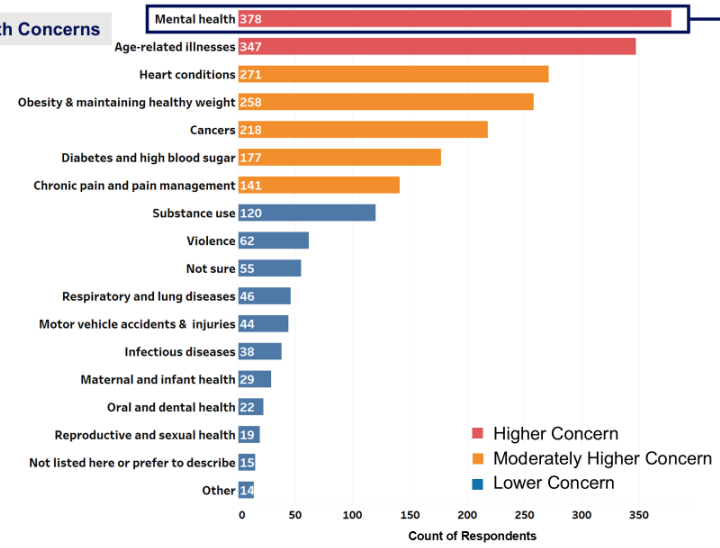
Preliminary survey data through June 2024 presented to community leaders

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.)

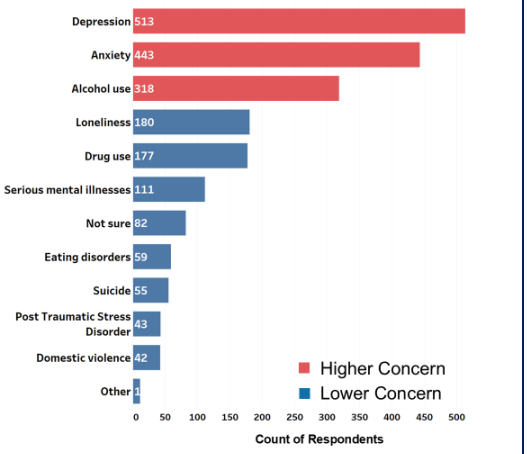
941 Total Respondents in Mid/West County

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

Health Concerns



Mental Health & Substance Use Concerns



Notes

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.)

941 Total Respondents in Mid/West County

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, infectious diseases were identified as a top concern among respondents of another race.

Higher Concern
Moderately Higher Concern
Lower Concern

Health Concerns by Race

Top Concerns	All Respondents n=941	White n=610	Black or African American n=42	Another Race* n=47	Did not respond or prefer not to disclose n=242
1	Mental health	Mental health	Diabetes	Diabetes	Mental health
2	Age-related illnesses	Age-related illnesses	Age-related illnesses	Mental health	Age-related illnesses
3	Heart conditions	Heart conditions	Obesity	Obesity	Obesity
4	Obesity	Obesity	Heart conditions	Heart conditions	Heart conditions
5	Cancers	Cancers	Mental health	Age-related illnesses	Cancers
6	Diabetes	Diabetes	Chronic pain and pain management	Chronic pain and pain management	Diabetes
7	Chronic pain and pain management	Chronic pain and pain management	Cancers	Cancers	Chronic pain and pain management
8	Substance use	Substance use	Substance use	**Infectious diseases**	Substance use

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

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.)

941 Total Respondents in Mid/West County

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, suicide was identified as a top concern among White respondents, and domestic violence was identified as a top concern among Black or African American respondents.

Mental Health & Substance Use Concerns by Race

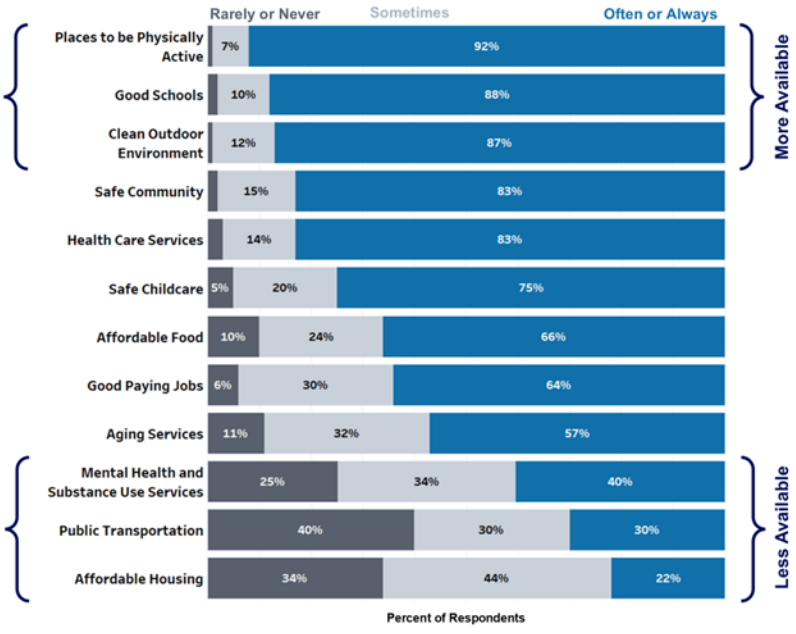
Higher Concern
Lower Concern

Top Concerns	All Respondents n=941	White n=610	Black or African American n=42	Another Race* n=47	Did not respond or prefer not to disclose n=242
1	Depression	Depression	Depression	Anxiety	Depression
2	Anxiety	Anxiety	Anxiety	Depression	Anxiety
3	Alcohol use	Alcohol use	Alcohol use	Alcohol use	Alcohol use
4	Loneliness	Loneliness	Drug use	Loneliness	Loneliness
5	Drug use	Drug use	Loneliness	Not sure	Drug use
6	Serious mental illnesses	Serious mental illnesses	Serious mental illnesses	Drug use	Serious mental illnesses
7	Not sure	Not sure	**Domestic violence**	Eating disorders	Not sure
8	Eating disorders	**Suicide**	Not sure	Serious mental illnesses	Domestic violence

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

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

941 Total Respondents in Mid/West County



Community members rated the availability of several resources in Mid/West County.

Places to Physically Active, Good Schools, and Clean Outdoor Environment were rated as being more available, with almost 90% of respondents indicating that the resources were often or always available in their community.

Mental Health and Substance Use Services, Public Transportation, and Affordable Housing were reported to be less available, with 40% or less of respondents indicating that the resources were often or always available in their community.

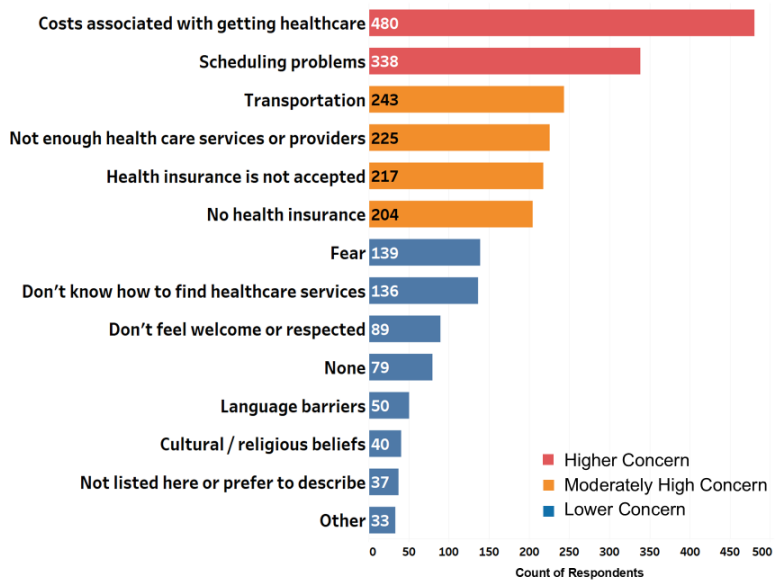
Notes

4

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

941
Total Respondents in Mid/West County

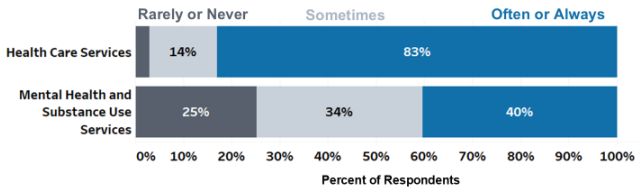
Barriers to Health Care Access



Eighty-three percent (83%) of community members who responded to the survey indicated that health care services were often or always available in Mid/West County. Only 40% indicated that mental health and substance use services had good availability.

Costs, scheduling problems, and transportation were most frequently identified as barriers to accessing health care.

Health Care Service Availability



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2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

South St. Louis County

Key Survey Findings

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

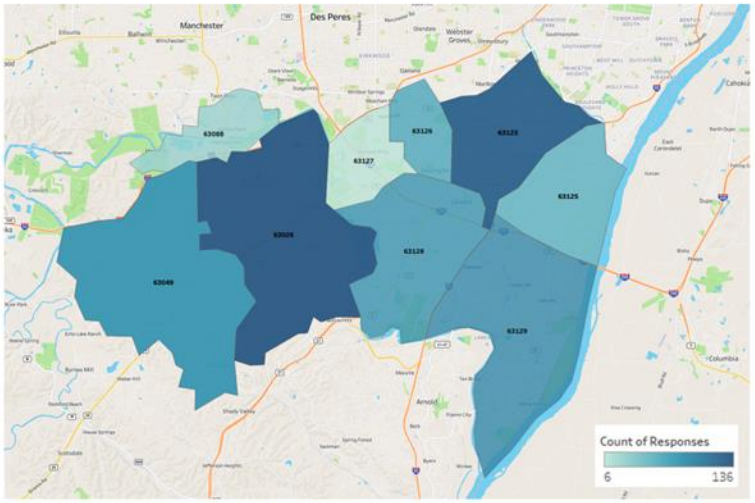
2024 Community Health Needs Assessment Survey

1 Who responded to the survey?

664
Total Respondents in South County

In South St. Louis County, 664 community members responded to the community health needs survey. The number of survey respondents in South County ZIP codes ranged between 6 and 136.

Survey Respondents by ZIP code



Notes

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

664
Total Respondents in South County

Over 20% of respondents in South St. Louis County did not complete the optional demographic survey questions (non-respondents range from n=142 to 210, depending on the question).

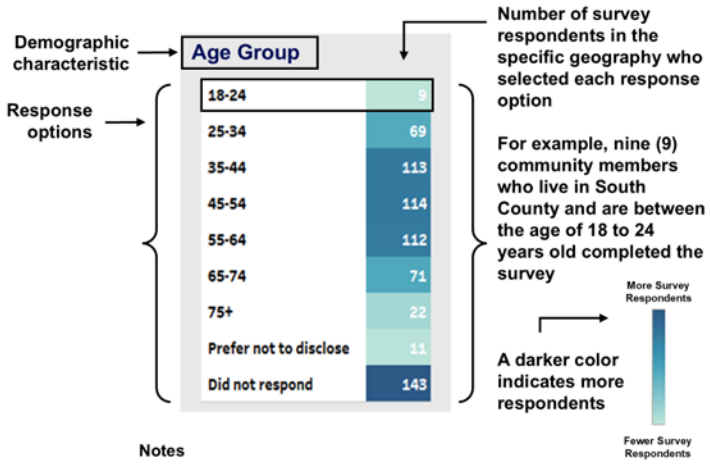
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=664).

Most respondents:

- **Are between the age of 35 and 64 years old (51%)**
- **Are women (61%)**
- **Are White (69%)**
- **Are non-Hispanic (63%)**
- **Speak English at home (76%)**
- **Have a master's, professional, or doctorate degree (27%)**
- **Are employed full time (51%)**
- **Have a household income between $100,000 and $149,999 (15%)**

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

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

664
Total Respondents in South County

Age Group

18-24	9
25-34	69
35-44	113
45-54	114
55-64	112
65-74	71
75+	22
Prefer not to disclose	11
Did not respond	143

Educational Attainment

Less than high school	4
High school diploma/GED	40
Some college credit, no degree	68
2-year college/Vocational training	62
4-year college/Bachelor's degree	145
Master's, Professional, or Doctorate degree	181
Other or prefer to self-describe	8
Prefer not to disclose	11
Did not respond	145

Employment

Full-time	340
Part-time	42
Disabled	24
Retired	76
Self Employed	7
Student Full-time	2
Student Part-time	1
Not Employed	7
Other or prefer to self-describe	6
Prefer not to disclose	11
Did not respond	148

Income

Less than $10,000	14
$10,000 to $24,999	32
$25,000 to $49,999	58
$50,000 to $74,999	70
$75,000 to $99,999	51
$100,000 to $149,999	97
$150,000 to $199,999	71
$200,000 or more	42
Prefer not to disclose	79
Did not respond	150

More Survey Respondents

Fewer Survey Respondents

Gender

Woman	407
Man	92
Genderqueer	3
Prefer not to disclose	20
Did not respond	142

Race

White	459
Black or African American	13
Asian	9
Other or prefer to self-describe	6
American Indian or Alaska Native	5
Prefer not to disclose	27
Did not respond	145

Ethnicity

Hispanic	11
Non-Hispanic	417
Prefer not to disclose	26
Did not respond	210

Language at Home

Bosnian	1
English	503
Spanish	1
Other or prefer to self-d..	3
Prefer not to disclose	10
Did not respond	146

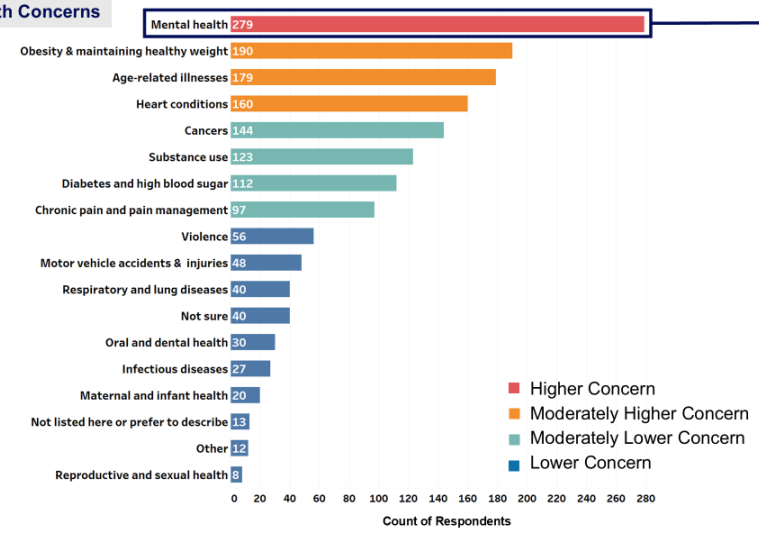
Preliminary survey data through June 2024 presented to community leaders

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.)

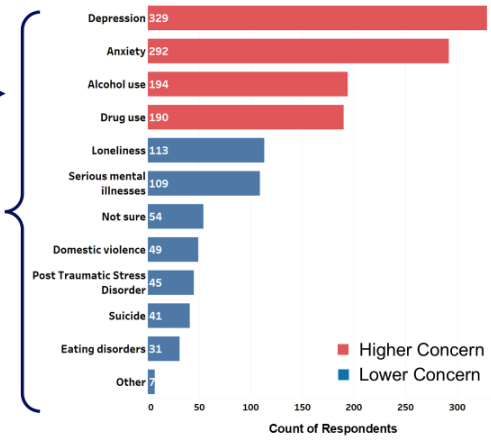
664
Total Respondents in South County

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

Health Concerns



Mental Health & Substance Use Concerns



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.)

664 Total Respondents in South County

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, respiratory and lung diseases, maternal and infant health, and violence were identified as top concerns by respondents who are Black or African American or another race.

- Higher Concern
- Moderately Higher Concern
- Moderately Lower Concern

Health Concerns by Race

Order of Top Concerns	All Respondents n=664	White n=459	Black or African American n=13	Another Race* n=20	Did not respond or prefer not to disclose n=172
1	Mental health	Mental health	Mental health	Obesity	Mental health
2	Obesity	Obesity	Age-related illnesses	Mental health	Obesity
3	Age-related illnesses	Age-related illnesses	Heart conditions	Diabetes	Cancers
4	Heart conditions	Heart conditions	Chronic pain	Heart conditions	Age-related illnesses
5	Cancers	Cancers	Obesity	Age-related illnesses	Substance use
6	Substance use	Substance use	Substance use	Substance use	Chronic pain
7	Diabetes	Diabetes	**Respiratory and lung diseases**	**Respiratory and lung diseases**	Heart conditions
8	Chronic pain	Chronic pain	**Maternal and infant health**	**Violence**	Diabetes

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

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.)

664 Total Respondents in South County

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, suicide, Post Traumatic Stress Disorder, and eating disorders were identified as top concerns by respondents who are Black or African American, another race, or among those who did not respond to the question about race.

- Higher Concern
- Lower Concern

Mental Health & Substance Use Concerns by Race

Order of Top Concerns	All Respondents n=664	White n=459	Black or African American n=13	Another Race* n=20	Did not respond or prefer not to disclose n=172
1	Depression	Depression	Depression	Alcohol use	Anxiety
2	Anxiety	Anxiety	Anxiety	Depression	Drug use
3	Alcohol use	Alcohol use	Serious mental illnesses	Drug use	Depression
4	Drug use	Drug use	Drug use	Anxiety	Serious mental illnesses
5	Loneliness	Loneliness	Alcohol use	Loneliness	Alcohol use
6	Serious mental illnesses	Serious mental illnesses	**Suicide**	Serious mental illnesses	Loneliness
7	Not sure	Not sure	Not sure	**Post Traumatic Stress Disorder**	Not sure
8	Domestic violence	Domestic violence	Loneliness	Not sure	**Eating disorders**

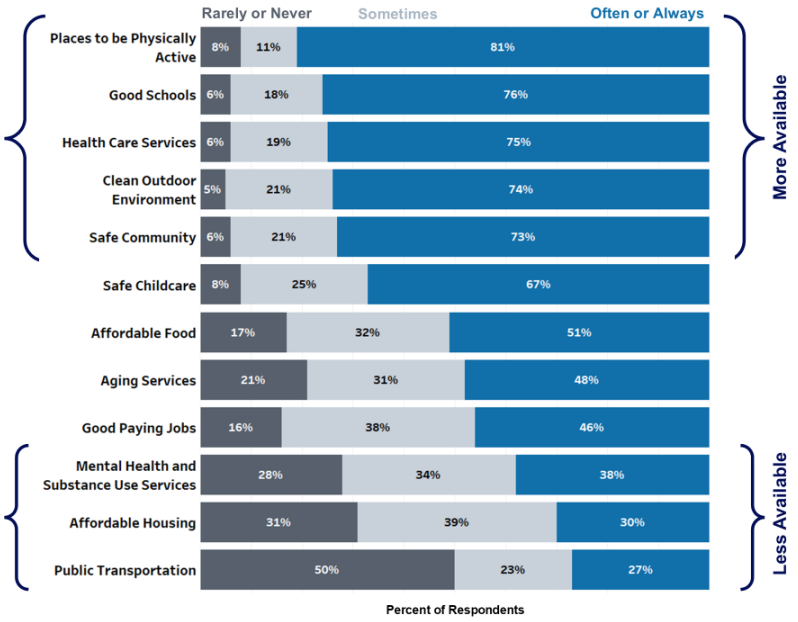
***Notes**: Bolded items are those that were not identified as a top concern among all respondents. Due to small sampling, several racial categories are combined in the *Another Race* category, including: American Indian or Alaska Native; Asian; Middle Eastern or North African; Native Hawaiian or Other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

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

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

664 Total Respondents in South County



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

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

Public transportation, affordable housing, and mental health and substance use services were reported to be less available, with more than 25% indicating that the resources were rarely or never available in their community.

Notes

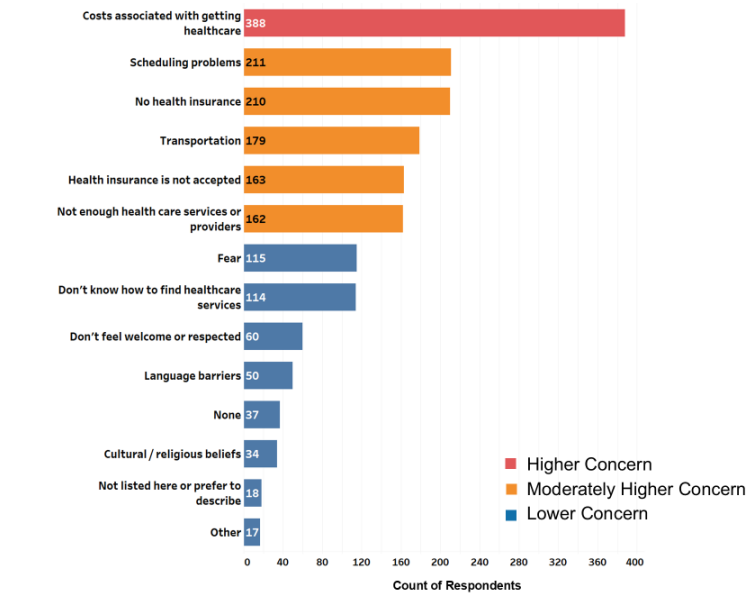
2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

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

664 Total Respondents in South County

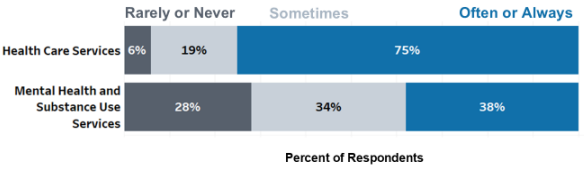
Barriers to Health Care Access



Seventy-five percent (75%) of community members who responded to the survey indicated that health care services were often or always available in South St. Louis County. Only 38% indicated that mental health and substance use services had good availability.

Costs, scheduling, and lack of insurance 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 West County Hospital: Community Leader Conversation Participants			
Organization	**First Name**	**Last Name**	**Title**
A Red Circle	Emma	Crocker	Program Manager for Food & Nutrition
Aging Ahead	Margi	Valleroy	Community Options and Services Manager
ALIVE – Alternatives to Living In Violent Environments	Melissa	Francisco	Volunteer/Outreach Coordinator
Circle of Concern	Cyndi	Miller	Executive Director
Compass Health Network	Patty	Vanek	
Deaconess Foundation	Amanda	Stoermer	Director, Grants & Partnerships
Eureka Fire Protection District	Greg	Brown	Chief
Feed My People	Carrie	LaChance	Director of Operations
Fenton Police Department	Aaron	Dilks	Police Officer
iFM Community Medicine	Carrie	Warren	Director of Mission Advancement
iFM Community Medicine	Lauren	Woll	Nurse Practitioner
Lutheran Senior Services	Melita	Hodzic	Director of Service Coordination
Lutheran Senior Services	Moniqui	Carter	Intern
Mehlville Fire Protection District	Jenny	Rieker	Battalion Chief, Mobile Integrated Health
Missouri SHIP	Yimar	Santos	Assistant Director
National Alliance on Mental Illness	Christine	Patterson	Executive Director
Operation Food Search Inc	Ashley	Snyder	Food Banking Relations Director
PreventEd	Amber	Campbell	Community Strategist
St. Louis County Health Department	Will	Bogan III	Business Manager
St. Louis County Police Department	Will	Munson	Police Officer
United Way of Greater St. Louis	Julia	Fuller	Portfolio Manager
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** | SSM St. Clare Hospital – July 9, 2024 – 16 participants
- **Community Leaders** | St. Luke's Institute for Health Education – July 23, 2024 – 8 participants
- **Community Members** | St. Louis Oasis – October 16, 2024 – 12 participants

Community Leader Conversation on Health Needs

Mental Health

- Mental health is the most pressing need in Mid-West and South St. Louis County areas
- The COVID-19 pandemic and economic instability have exacerbated mental health issues, including anxiety, depression, and substance use
- Access to mental health services is limited
- Education around mental health needs is needed and will help prevent the need for clinical interventions
- Stigma related mental health remains an issue and is a barrier to care
- Framing mental health as "wellness" may help reduce stigma around mental health care
- Culturally competent mental health care is lacking, especially for communities of color and immigrant populations

Obesity and Maintaining Healthy Weight

- Food and nutrition insecurity are significant issues and contribute to diet-related health conditions, including obesity
- Many community members lack the knowledge or resources to make healthy choices
- Health education programs that focus on healthy eating and culturally relevant nutrition are needed

Heart conditions

- Food and nutrition insecurity are significant issues and contribute to diet-related health conditions, including cardiovascular conditions
- Many community members lack the knowledge or resources to make healthy choices
- Health education programs that focus on healthy eating and culturally relevant nutrition are needed

Diabetes and High Blood Sugar

- Food and nutrition insecurity are significant issues and contribute to diet-related health conditions, including diabetes
- Many community members lack the knowledge or resources to make healthy choices
- Health education programs that focus on healthy eating and culturally relevant nutrition are needed

Substance Use

- Substance use disorders often co-occur with mental health issues, however there is a lack of integrated care models that address both needs holistically
- The COVID-19 pandemic and economic instability have exacerbated mental health issues, including anxiety, depression, and substance use
- In some communities, fentanyl abuse is perceived as an epidemic
- Comprehensive mental health services are needed to address the underlying, root causes of substance use

Maternal and Infant Health

- Access to maternal health care services is limited
- Long wait times, a shortage of healthcare providers accepting Medicaid, and logistical barriers such as transportation and scheduling all impact access
- Housing insecurity can lead to poor health outcomes for new mothers and their babies
- Families struggle to with access the resources they need during pregnancy and post-birth

Community Leader Conversation on Health Resources

Affordable Housing

- Affordable housing is a major social determinant of health that affects health outcomes in the Mid-West St. Louis County region
- Access to multifamily units and rental assistance programs are limited
- Housing insecurity is a particular issue for families
- The community health survey did not adequately address the realities/needs of unhoused populations or families living in precarious housing situations

Public Transportation

- Access to public transportation is a major social determinant of health that affects access to health care, employment, and other services
- Some public transportation options, such as Metro's $2 service, are available but underutilized
- Increased communication and awareness raising around transit options and resources are needed
- Public transportation options are also unreliable, costly, and not-user friendly, especially for older adults or those with mobility challenges

Mental Health and Substance Use Services

- Access to mental health care services is limited
- There is a growing need for mental health services, especially among low-income and uninsured individuals
- Long wait times, a shortage of healthcare providers accepting Medicaid, and logistical barriers such as transportation and scheduling all impact access
- Other gaps/barriers include a lack of access to trauma-informed and culturally competent mental health care
- More comprehensive support systems/integrated care models for individuals with addictions are needed
- Expanding access to mental health services, especially for substance use disorders, serious psychological illnesses, and mental health crises, were recommended

- Embedding mental health counselors in schools is needed to provide early intervention

Affordable, Healthy Food

- Food insecurity is a major social determinant of health that affects health outcomes
- Access to food, especially nutritious food, is an issue
- Food pantries provide essential services, but many offer primarily non-perishable, unhealthy items

Good Paying Jobs

- The COVID-19 pandemic and economic instability have exacerbated mental health issues, including anxiety, depression, and substance use

Health Care Services

- Access to health care services is limited
- Community members find it difficult to navigate the health care services that are available
- Long wait times, a shortage of healthcare providers accepting Medicaid, and logistical barriers such as transportation and scheduling all impact access
- Health care services are fragmented
- The lack of coordination between healthcare providers, community organizations, and social services is a barrier to accessing care
- Improved relationships and communication between hospitals and community organizations, especially community mental health organizations, are needed to ensure seamless referrals and support
- Mobile health clinics and telehealth should be prioritized to bring healthcare services to neighborhoods, schools, and community events
- Culturally competent health care is lacking, especially for communities of color and immigrant populations

Good Schools

- Description

Community Member Conversation on Health Needs

Mental Health

- A healthy community is one that encourages physical activity, social connection, and mental well-being
- Safe, well-maintained community areas, such as parks, walking trails, and accessible sidewalks, are essential for fostering physical and mental health
- Mental health is a critical priority for older adults
- Social isolation and loneliness are some of the most pressing mental health-related needs for older adults
- Group therapy and peer support options are needed
- Access to mental health care is limited by long wait times and a lack of accessible providers

Age-Related Illnesses

- Chronic disease management for older adults, including care for sleep apnea, is a high priority need

- The fragmented nature of healthcare services and information is frustrating and prevents older adults from accessing preventive services and understanding their health care status
- More integrated health care services are needed

Cancers

- Accessing preventive services, including cancer screenings, is a priority need in the region
- The fragmented nature of healthcare services and information is frustrating and prevents older adults from accessing preventive services and understanding their health care status
- More integrated health care services are needed

Community Member Conversation on Health Resources

Public Transportation

- Transportation is a significant barrier for older adults
- Some communities offer transportation services, but access is limited and inconsistent across the region
- Gaps in transportation can be a barrier to attending routine health appointments
- Investment in and expansion of transit solutions that address the specific needs of older adults are needed

Health Care Services

- Navigating Medicare and private insurance is a challenge for many
- Insurance policies and benefits are confusing
- Many older adults rely on family members, friends, and insurance agents to help them understand their health care options
- Clearer, more direct communication from insurers and healthcare providers is needed
- Convenient, localized access to health care services is needed
- Local healthcare providers should visit neighborhood centers

Aging Services

- Community resources, such as the Silver Sneakers fitness program, local gym memberships covered by Medicare Advantage, and Oasis' health education and wellness classes, encourage physical activity and provide a social outlet for older adults
- Community resources, such as the Silver Sneakers fitness program, local gym memberships covered by Medicare Advantage, and Oasis' health education and wellness classes, encourage physical activity and provide a social outlet for older adults

Safe Community

- A healthy community is one that offers accessible, safe spaces for physical activity, social connection, and mental well-being
- Some communities experience crime, which is a significant concern for some and can be a barrier for older adults to confidently engage in outdoor activities

Places to be Physically Active

- A healthy community is one that offers accessible, safe spaces for physical activity, social connection, and mental well-being
- Safe, well-maintained community areas, such as parks, walking trails, and accessible sidewalks, are essential for fostering physical and mental health
- Communities need more places to walk and meet with others
- Communities need to be inclusive, welcoming, and attuned to the unique challenges that older adults face in staying active and engaged
- Community resources, such as the Silver Sneakers fitness program, local gym memberships covered by Medicare Advantage, and Oasis' health education and wellness classes, encourage physical activity and provide a social outlet for older adults
- Some older adults are not aware of or lack access to these community resources
- Healthcare providers and insurance companies need to take a more active role in connecting older adults to community resources

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 West County Hospital 2025 Community Health Needs Selection Team Attendees 06/03/2025			
Last Name	**First Name**	**Title**	**Department**
Brenegan	Teryn	Manager, Case Coordination	Care Coordination
Butler	Sara	Director, Pharmacy Services	Pharmacy Administration
Chan	Phil	Asst Prof of Emergency Medicine	Emergency Department
Covington	Starrletta	Manager, Sterile Processing / Community Health Improvement Lead	Autoclaving
Cowart-Oberle	Andrew	Patient Experience Partner	Patient Experience
Ellena	John	Physician	Primary Care
Fishbein	Norma	Director, Surgical Services	Operation Room Administration
Gillihan	Jason	Chief Medical Officer	Executive Administration
Hodzic	Amina	Director, Clinical Services	General Administration
Maness	Michelle	Director, Strategic Planning	BJC Chief Strategy Officer
Mayer	Angela	Director, Clinical Services / Community Health Improvement Lead	General Administration
Mihm	Matt	Director, Finance/Decision Support	Fin Ops - BJH & BJWC
Peters-Lewis	Angelleen	President - BJCWC & COO - BJH	Executive Administration
Petrich	Derek	Strategic Planning Manager	Strategic Planning-Corporate
Sergent	Lisa	Manager, Human Resources - SR	Shared Services HR - BJWCH
Spence	Diane	Director, Patient Care Services	Nursing Administration
Sprecher	Kevin	Managerm Program - CSL	Performance Improvement Dept
Wolf	Maggie	VP, PCS/Chief Burse Officer	Executive Administration

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			