

# 2025-2028 Community Health Needs Assessment and Improvement Plan





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

## A Message from Bob Cannon, President, BJC HealthCare, and Rick Stevens, President, Christian 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 Christian 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 Christian Hospital, we are committing to focused efforts around diabetes and high blood sugar, heart conditions, and respiratory and lung diseases. These priorities were carefully determined through conversations with community members and leaders across the region, as well as a community health needs survey, public health data, and hospital data. Taken together, they reflect our shared vision for meaningful, measurable improvements in community health.

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

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

Sincerely,



**Bob Cannon**  
President, BJC HealthCare



**Rick L. Stevens, FACHE**  
President, Christian Hospital

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# About BJC HealthCare

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

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



## Purpose

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

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

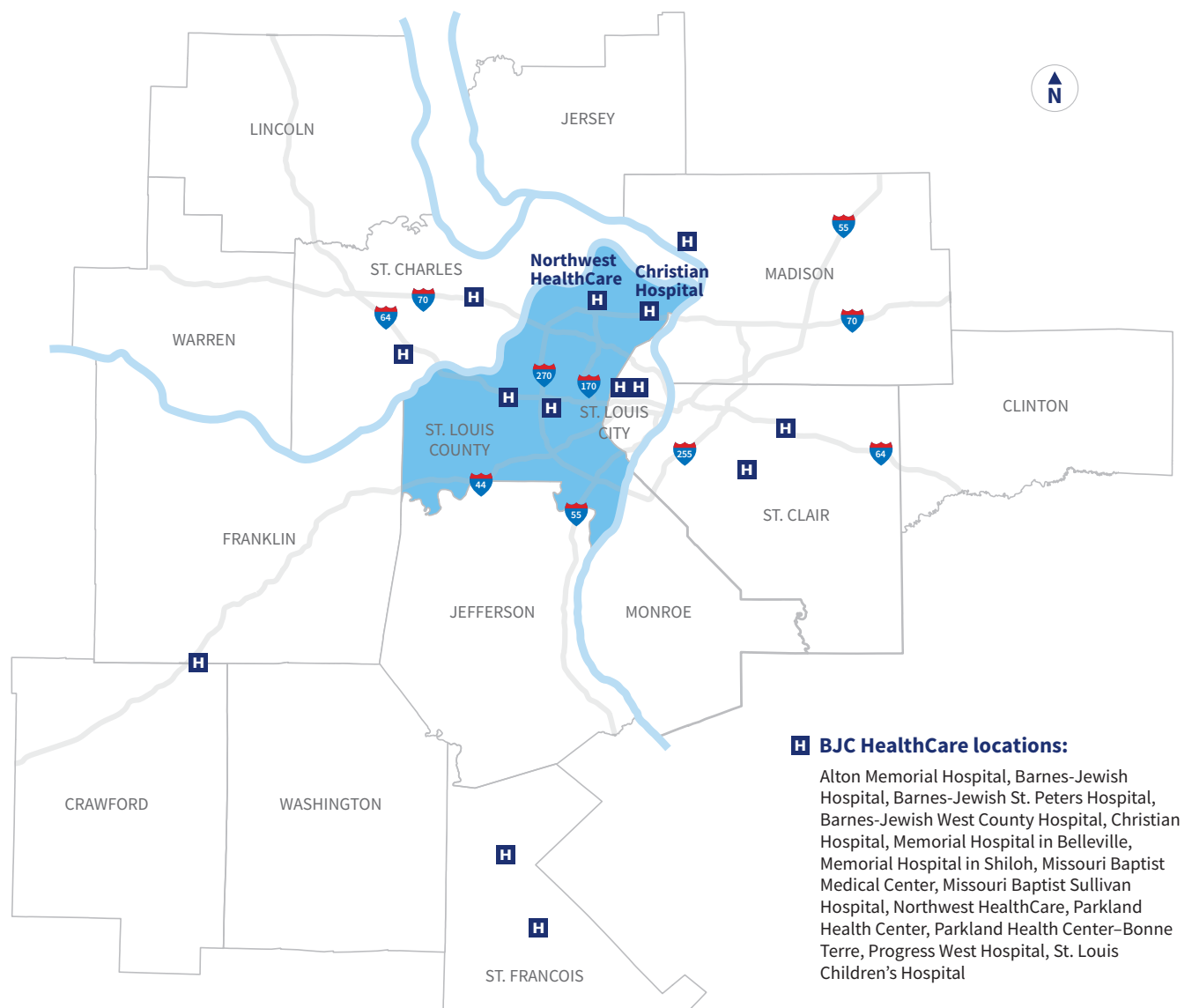
All nonprofit hospitals, including all BJC HealthCare hospitals, are required to do a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community of focus.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

# Christian Hospital and the Community We Serve

The Christian Hospital Community Health Needs Assessment is focused on **St. Louis County, Missouri**. The hospital partners with WashU Medicine. WashU physicians practice at Christian Hospital. Northwest HealthCare provides a 24-hour Emergency Department staffed with physicians from WashU Medicine and St. Louis Children’s Hospital.

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



Christian Hospital offers a full range of medical services. The hospital has been recognized for excellence in care for medical specialties like cardiology, cardiothoracic surgery, emergency medicine, neurosurgery, orthopedics, vascular surgery, endocrinology, nephrology, radiology, urology, and pulmonary care. The hospital has been recognized for excellence in care for health conditions and needs like infusion, breast health services, hyperbaric wound care, pain management, gastrointestinal care, stroke care, therapy, and sleep disorders.

Northwest HealthCare has **two specialty centers**, the Sleep Disorders Center and the Siteman Cancer Center. Northwest HealthCare offers outpatient diagnostic laboratory and imaging services. Siteman Cancer Center offers nationally recognized cancer care. This includes clinical trials and new cancer therapies.

### Christian Hospital Community Health Needs Assessment service area close-up



Over the years, Christian Hospital has given back to the community in many ways. In 2023, Christian Hospital provided **\$66 million** in community benefit. This total includes:

- \$25.1 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- \$21.9 million in **services that fill gaps** in health care access for the community
- \$17.9 million in **unreimbursed care** for people with Medicaid and Medicare
- \$0.6 million in **programs that bring health resources and education** to the community
- \$0.5 million in **education and professional support** for current and future health professionals



In the United States, health insurance pays for most of the cost of 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**.

Christian Hospital has a dedicated staff who provide care for many community members. The team includes 1,992 employees and 896 physicians who practice at our hospital. In 2024, we cared for 12,530 inpatient admissions, 2,767 outpatient surgeries, and 86,471 Emergency Department visits. See more details in the graphic below.

## Christian Hospital by the Numbers



**1,992**

Total  
Employees



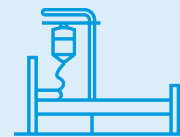
**896**

Physicians



**\$359**

Million  
Net Revenue  
(2023)



**240**

Staffed  
Beds



**12,530**

Inpatient  
Admissions



**2,767**

Outpatient  
Surgeries



**86,471**

Emergency  
Department  
Visits

About **one million people** call St. Louis County home.<sup>1</sup> Much of St. Louis County is the suburbs of the St. Louis metro area.<sup>1</sup> 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.<sup>1</sup> The life expectancy for St. Louis County residents is about 76 years.<sup>2</sup> This is about a year more than the life expectancy for Missouri residents.<sup>2</sup>

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

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

Almost half of all St. Louis County households spend more than 30% of their income on housing costs like rent or mortgages.<sup>1</sup> When housing is expensive, it can be hard to meet other needs, like food or transportation.

In St. Louis County, **nearly all residents have at least a high school degree**.<sup>1</sup> High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in St. Louis County is about \$80,000 per year.<sup>1</sup> This is higher than the median state household income.<sup>1</sup>

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

## Community Feature: Chain of Rocks Bridge


The Old Chain of Rocks Bridge links Illinois and Missouri.<sup>3</sup> The bridge opened in 1929 and became part of Route 66 in 1936.<sup>3</sup> Because of engineering challenges in this rough, rocky part of the Mississippi River, the bridge has a unique 30-degree bend halfway across.<sup>3</sup> The bridge fell out of use when the New Chain of Rocks Bridge opened in 1967.<sup>3</sup> After a local nonprofit organization, Trailnet, cleaned and restored the bridge, it reopened for walking and biking in 1999.<sup>4</sup> The Old Chain of Rocks Bridge is one of the world's longest pedestrian/bicycle-only bridges.<sup>4</sup>




*Chain of Rocks Bridge from Madison, Illinois, to St. Louis, Missouri*

# Christian Hospital Community Characteristics

## St. Louis County

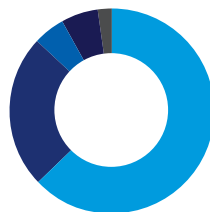


Population  
**996,618**



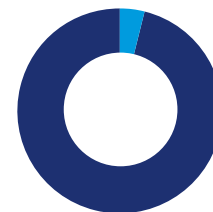
Land Area  
**508 sq. mi.**

## 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

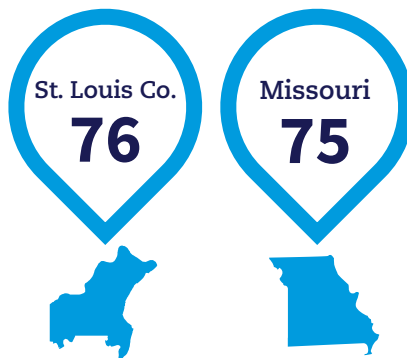



St. Louis Co.  
**94%**




Missouri  
**92%**


## Life Expectancy

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



St. Louis Co.  
**\$81,340**



Missouri  
**\$68,920**




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




St. Louis Co.  
**45%**




Missouri  
**42%**



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

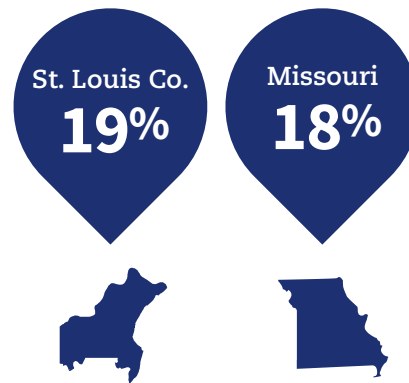


St. Louis Co.  
**13%**



Missouri  
**16%**

## People over 65



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

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

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



# Where We've Been...

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

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

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

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

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



# Christian Hospital Community Health Needs and Goals from 2022–2025

In our last Community Health Needs Assessment at Christian Hospital, we learned that heart health and diabetes were some of the top health concerns in St. Louis County. For each health need, we set a goal and made a plan to reach the goal.



## Heart Health

**Goal:** Reduce disease and economic impact of heart failure conditions. Improve the quality of life of people who are at risk of or have had heart failure.



## Diabetes

**Goal:** Reduce disease and economic impact of diabetes. Improve the quality of life for all persons who have or are at risk to have diabetes.

## Heart Health

### Our Heart Health Strategy ►

We wanted to **improve the health of people living with heart failure in north St. Louis County**. We planned to educate patients about nutrition and managing their condition. We wanted to increase the number of patients receiving education by 5% each year.

We planned to create a heart failure steering committee. We wanted to include all stakeholders on the committee.

We also planned to connect patients who are not staying in the hospital to dietitians. Dietitians are health care professionals who advise patients on nutrition. They can help patients plan meals to improve their health. Our dietitians planned to provide free support in multiple areas. These included:

- Individual heart health nutrition counseling
- Nutrition and chronic heart health conditions education
- Other educational resources

We planned to train physicians on how to make referrals for nutrition counseling and education by fax or electronic charting system.

We also wanted to **reduce heart failure in North County**. We planned to educate patients about the importance of preventive care, like medication. We wanted to increase the number of patients receiving formal education and preventive care by 5% each year. We planned to work closely with Family Care Pharmacy and the mobile pharmacy team to get medication to our patients before they left the hospital.

Finally, we planned to promote heart health resources on social media. We wanted to work with our marketing and communications team to talk about heart health on Christian Hospital's social media.

### **Our Progress on Our Heart Health Strategy ►**

We decided to change our strategy for addressing heart health. Our new strategy featured the Community Health Access Program (CHAP). CHAP helps patients learn about their disease and how to manage it.

A community health worker met with patients who have heart failure or are at risk of heart failure to enroll them in CHAP. The community health worker also found resources for any of their other health needs.

If patients agreed to be part of CHAP, a nurse practitioner called them weekly for a month after their hospital visit. During the month, the nurse practitioner shared health information and organized their medications. If the patient's symptoms got worse during the month, the nurse practitioner helped and assessed for health concerns.

Each year, we enrolled a larger percent of eligible patients into the program:

- In 2023, 3,114 patients were eligible for CHAP. 91% enrolled in the program.
- In 2024, 3,909 patients were eligible for CHAP. 94% enrolled in the program.
- In the first eight months of 2025, 2,944 patients were eligible for CHAP. 96% enrolled in the program.

Patients who are at risk of heart failure and live in certain ZIP codes can also join the Mobile Integrated Health (MIH) program. As part of the program, a paramedic visits patients at their home each week. The paramedic shares disease information, assesses health needs, and monitors symptoms. The paramedic visits weekly, at least, with each patient. Each patient has a care plan to meet their unique needs. The paramedic works with an Emergency Department physician to make these care plans.

We started the MIH program in 2024. In 2024, we enrolled 27 patients. In the first 8 months of 2025, we enrolled 25 patients.

We also started a heart failure steering committee. Our committee discussed our progress toward our goals for patients with heart failure. We wanted to decrease their hospital visits and the amount of time they stayed in the hospital. Committee members are experts in many topics, including nutrition, heart health, and medications. The committee meets monthly.

We worked with the American Heart Association to improve our care for heart health. Their program helped us make sure that our care matches the most recent guidelines.

We are still collecting data to understand these strategies' impact. So far, we see that the number of patients who have been readmitted to the hospital has declined.

## Diabetes

### Our First Diabetes Strategy ▶

We wanted to **offer more diabetes screenings** to help improve the lives of patients with diabetes in North County. Our patients with diabetes were able to enroll in a program called Community Health Access Program (CHAP). We planned to ask these patients about their access to healthy food and their financial resources. We wanted to increase the number of patients we asked by 5% every year.

### Our Progress on Our First Diabetes Strategy ▶

We asked patients with diabetes about their access to healthy food and financial resources. In 2022, before we started the Community Health Improvement Plan (CHIP), we spoke with 2,568 patients. Each year of the CHIP, we asked more patients than the previous year:

- In 2023, we spoke with 2,998 patients, an increase of 17% from the year before.
- In 2024, we spoke with 3,416 patients, an increase of 14% from the year before.

### Our Second Diabetes Strategy ▶

We wanted to improve the lives of patients with diabetes in North County by **educating those patients about nutrition**. Christian Hospital diabetes educators planned to schedule three education sessions with patients who were newly diagnosed with diabetes. Educators are medical professionals, like nurses and dietitians, who have additional training to help patients manage diabetes.

We focused on patients with an **A1C** greater than 8.0. We thought that education about nutrition could help reduce how many patients with diabetes are admitted to the hospital. We wanted to reduce hospital readmissions for patients with diabetes and an A1C greater than 8.0 by 2% each year.



An **A1C** test measures your average blood glucose, or blood sugar, over the past two to three months.<sup>5</sup> The results from the test can be used to screen for diabetes.<sup>5</sup>

Our educators planned to provide our patients with free supplies to manage their diabetes. These supplies included meters and continuous glucose monitor samples.

Our dietitians planned to talk to all patients in the hospital with an A1C greater than 8. They planned to add those patients to their daily visit list.

We planned to educate our physicians and nurses about the importance of diabetes educators for their patients.

## Our Progress on Our Second Diabetes Strategy ►

Our dietitians have continued caring for our patients with diabetes outside of the hospital. In 2022, before we started the Community Health Improvement Plan (CHIP), 1,053 patients were scheduled for appointments. Dietitians saw 720 patients, and 333 patients did not show up for their appointments. Each year of the CHIP, our dietitians saw more patients:

- In 2023, 1,128 patients were scheduled for appointments. Dietitians saw 735 patients and 393 patients did not show up for their appointments.
- In 2024, 1,152 patients were scheduled for appointments. Dietitians saw 806 patients and 346 patients did not show up for their appointments.

## Our Third Diabetes Strategy ►

We wanted to **educate our patients with diabetes about carbohydrates in food**. We planned to educate our patients in the hospital and the outpatient setting. We wanted to increase the overall knowledge of carbohydrates in food for our patients by 5% each year.

## Our Progress on Our Third Diabetes Strategy ►

Due to lack of staffing, our dietitians did not have time to test the knowledge level of patients. Their focus was on providing follow-up appointments so patients could continue with counseling.

# 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 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. Local community leaders and organizations helped us share the survey. This included people from:

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

We also shared it at BJC hospitals, clinics, and community sites in St. Louis County. 498 community members completed the survey. See more details in Appendix B and Appendix C.

The top concerns among community members were mental health, diabetes and high blood sugar, and heart conditions. Specifically, mental health challenges like depression, drug use, and alcohol use were concerns for the community.

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



### COMMUNITY SURVEY

#### Top 5 Health Problems

1. Mental health
2. Diabetes and high blood sugar
3. Heart conditions
4. Obesity and maintaining healthy weight
5. Violence

#### Top 5 Mental Health Concerns

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

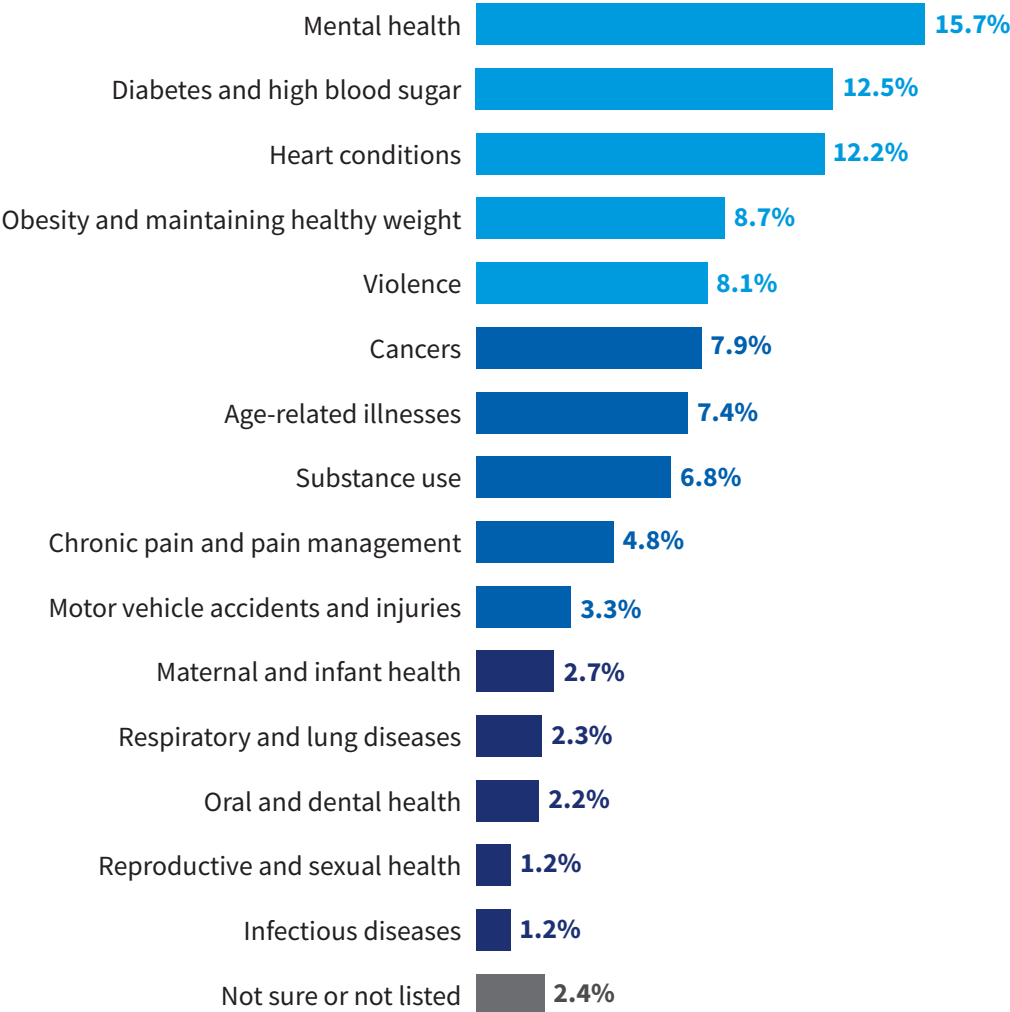
#### Top 5 Barriers to Care

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

#### Top 5 Community Resource Needs

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

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 Senior 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 the HCI were prevention of and safety from violence; 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

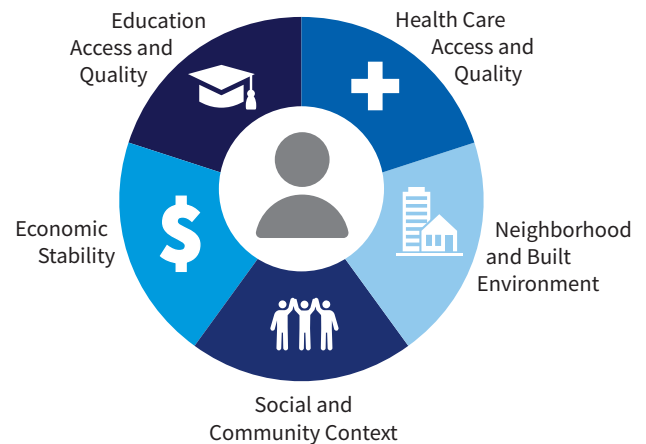
### Top 5 Health Problems

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 Beyond Housing. These leaders included:

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

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

Community leaders were concerned about mental health and substance use. They thought these health needs were the most important to focus on.

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



**Rick Stevens, president of Christian Hospital, speaking at Community Leader Conversation at Beyond Housing**



### COMMUNITY LEADER CONVERSATIONS

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

#### Discussed Community Health Needs

- Mental health
- Substance use

#### Discussed Community Health Resources

- Mental health and substance use services
- Affordable housing
- Affordable, healthy food
- Public transportation

## Community Members

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

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

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



**Beyond Housing (top) and St. Louis Oasis (bottom), St. Louis, 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
- Cancers
- Age-related illnesses

### Discussed Community Health Resources

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

## Hospital Service Information

When patients receive care at a hospital, their care is billed to their insurance. This is known as a claim. We looked at the hospital claims data for Christian 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 Christian Hospital, the most common reasons patients visit the hospital are for hypertension, diabetes, and substance use disorder. See more details in the list below.



### HOSPITAL SERVICE INFORMATION

#### Top 5 Health Conditions

1. Hypertension
2. Diabetes
3. Substance use disorder
4. Fibromyalgia, chronic pain, and fatigue
5. Chronic kidney disease

## Hospital Team Survey

Christian 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 Christian Hospital CHNA team took a survey about local health needs. Team members were most concerned about diabetes and high blood sugar, heart conditions, and mental health. See more details in the list below.



### HOSPITAL TEAM SURVEY

#### Top 6 Community Health Needs

1. Diabetes and high blood sugar
2. Heart conditions
3. Mental health
4. Respiratory and lung diseases
5. Obesity and maintaining healthy weight (tie)
5. Violence (tie)

#### Top 6 Most Needed Community Health Resources

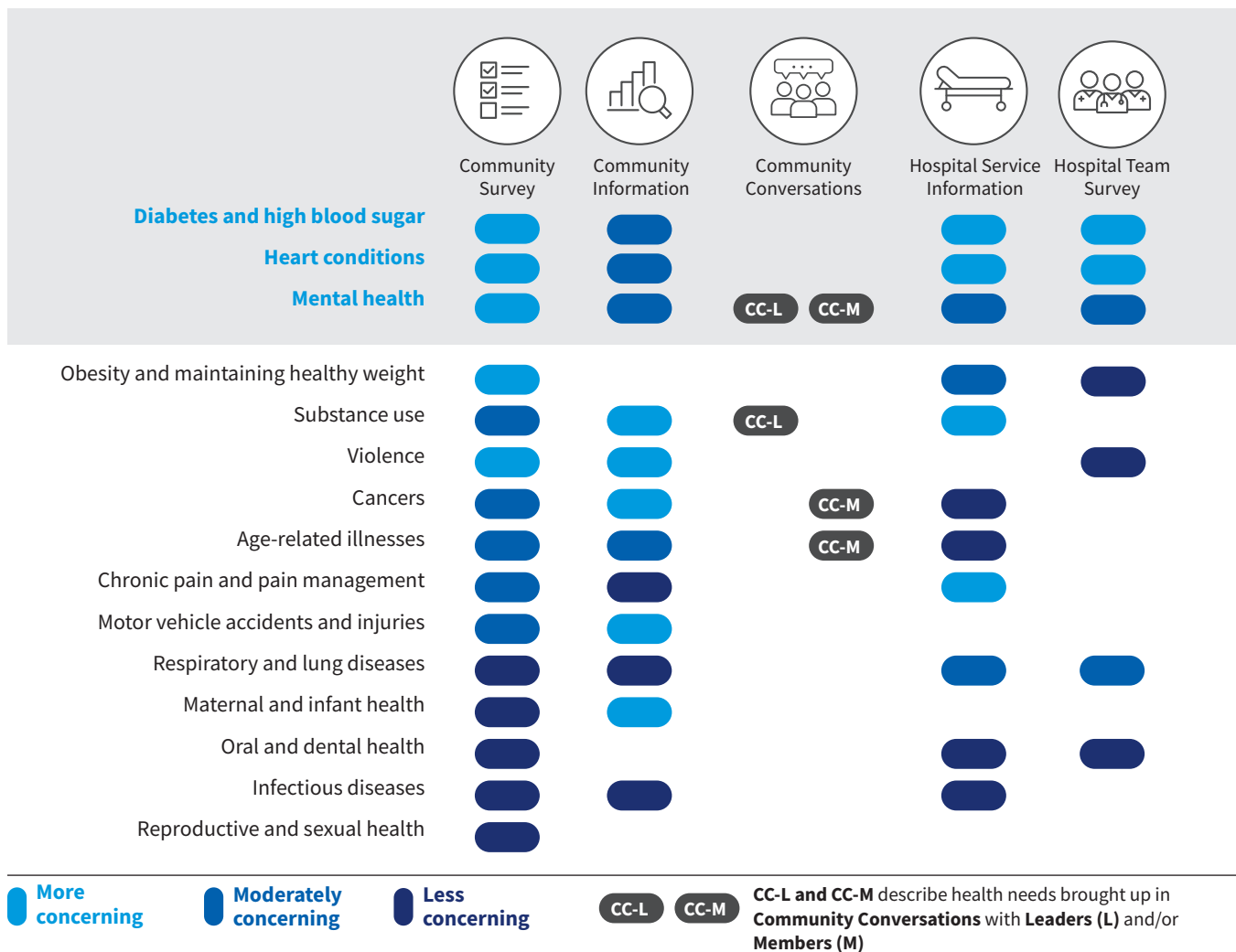
1. Good paying jobs (tie)
1. Good schools (tie)
1. Affordable healthy food (tie)
1. Safe community (tie)
1. Affordable housing (tie)
2. Mental health and substance use services (tie)

# What We Learned: Our Selected Health Needs

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

We considered how important the health needs are to the audiences we spoke to. These include community members, community leaders, and BJC employees. We wanted to elevate the community’s voice, so we made their answers count more than other information sources. We ranked three health needs as most important for Christian Hospital-Northwest HealthCare. These needs are **diabetes and high blood sugar, heart conditions, 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 Christian 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 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 diabetes and blood sugar, heart conditions, and mental health.

### Hospital Team Conversation



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



*Hospital team group activity*

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

We decided not to focus on mental health. We know mental health is an important need in our community because of our Community Health Needs Assessment (CHNA), but we do not have enough resources to prioritize mental health right now. We are connected to regional mental health resources like BJC Behavioral Health.

### Health Needs We Will Prioritize in this CHIP

We decided to prioritize **diabetes and high blood sugar**. We made this decision for a few reasons. First, we know this is an important health need for our community because of our CHNA. Second, we have worked to improve diabetes and high blood sugar in the past. Our last CHIP included diabetes and high blood sugar. As part of the CHIP, we offered a Food Pharmacy program to provide healthy meals, nutrition counseling, and social support for our patients with diabetes. We want to continue building on our hard work to support these patients. For these reasons, we decided to continue prioritizing diabetes and high blood sugar in our CHIP.

Next, we decided to focus on **heart conditions**. We made this decision for a few reasons. First, our CHNA found heart conditions to be an important health need for our community. Second, our community in North County is greatly affected by heart disease. Third, we already have resources that we can use to improve heart health in our community. For these reasons, we decided to prioritize heart conditions in our CHIP.

Finally, we prioritized **respiratory and lung diseases**. We made this decision after careful consideration. Respiratory and lung diseases were not ranked highly in our CHNA, but our patients with these illnesses require a lot of care. We also have the resources we need to help improve respiratory and lung diseases. For these reasons, we decided to prioritize respiratory and lung diseases in our CHIP.

## A Closer Look at Our Prioritized Needs

We decided to prioritize diabetes and high blood sugar, heart conditions, and respiratory and lung diseases. This is how we define these concerns.

### Diabetes and High Blood Sugar

Diabetes is a metabolic condition that affects how the body uses food for energy. There are three types of diabetes:

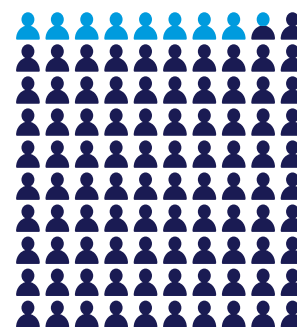
- **Type 1 diabetes** is an autoimmune disorder. An autoimmune disorder happens when the body's immune system attacks healthy cells. When people have Type 1 diabetes, their bodies attack the cells that make insulin. Insulin is a hormone that helps the body use or store energy from food. Without treatment, Type 1 diabetes can be life-threatening.
- **Type 2 diabetes** is a condition that is frequently connected to lifestyle. When people have Type 2 diabetes, their bodies are less reactive to insulin. When this happens, blood sugar stays at high levels, which can damage parts of the body.
- **Gestational diabetes** is a condition that affects pregnant people. When people have gestational diabetes, their bodies are less reactive to insulin. Like Type 2 diabetes, when this happens, blood sugar stays at high levels. High blood sugar levels can cause damage to parts of the body.

Without treatment for diabetes, all types of diabetes **can cause health problems**. These health problems include heart disease, kidney disease, and vision loss or blindness.<sup>6</sup> To manage all types of diabetes, patients can take medication for their blood sugar. Type 2 diabetes and gestational diabetes can be prevented with lifestyle changes.<sup>6</sup> These changes include exercising more and eating healthy foods.

In St. Louis County, 8.5% of people over 20 years old have diabetes.<sup>7</sup> About 2 in 10,000 people die from diabetes in both St. Louis County and across Missouri.<sup>7</sup> These numbers on deaths take into account the impact of age on illness. There is more information on **adjusting for age** below.



In St. Louis County, about  
**8.5% of adults  
over 20 have  
diabetes**



SOURCE: Centers for Disease Control and Prevention



Older people are more likely to die from heart conditions, diabetes, and cancers.<sup>8-10</sup> For this reason, when talking about deaths from diseases, we have to consider the impact of age on deaths. When data sources have **adjusted for age**, this means they have used math to take into account deaths across other age groups. When we adjust for age, we can compare death rates across younger and older communities.

## Heart Conditions

Heart conditions can be caused by lifestyle choices, genetics, age, or all three. Heart conditions can be caused by a variety of problems, including:

- Plaque buildup in the arteries, which can block blood flow and cause a heart attack or stroke
- High blood pressure
- A heartbeat that is too fast, too slow, or unsteady
- Problems with the heart's structure or muscle
- Heart failure

One heart condition is **heart disease**. If left untreated, heart disease can lead to disability, a lower quality of life, and even death.<sup>11</sup> Heart disease is the most common cause of death in the United States.<sup>12</sup> It can be treated by eating healthy food, being physically active, and quitting smoking.<sup>13</sup>

One aspect of heart disease is **high blood pressure**. High blood pressure puts stress on the heart and can contribute to heart failure. In St. Louis County, about four in five adults have taken medicine for high blood pressure.<sup>7</sup> This is about the same as the number of adults who have taken this medicine across the nation.<sup>7</sup>

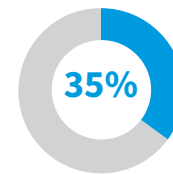
About 18 out of 10,000 people die because of heart disease in St. Louis County.<sup>7</sup> Across the nation, about 19 out of 10,000 people die because of heart disease.<sup>7</sup> These numbers take into account the impact of age on death.



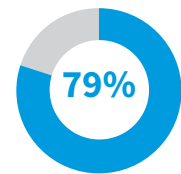
In St. Louis County, more than

**1 in 3 adults**  
have high blood pressure  
and

**4 out of 5 adults**  
have taken medicine for  
high blood pressure



have high  
blood pressure



have taken  
medicine for high  
blood pressure

SOURCE: CDC PLACES

## Respiratory and Lung Diseases

Respiratory and lung diseases affect the **parts of the body involved in breathing**. These diseases can be caused by the environment, genetics, smoking, and infections. Some diseases include:

- Allergic reactions to things like pollen and dust
- Chronic conditions, like asthma and chronic obstructive pulmonary disease (COPD)
- Infections, inflammation, or swelling from bacteria or viruses, like the flu, the common cold, pneumonia, and bronchitis

Patients with respiratory and lung diseases can take medication to manage their condition. Some diseases can be managed with physical activity, vaccines, and reducing exposure to air pollution.<sup>14</sup>

In St. Louis County, about 16% of adults smoke cigarettes.<sup>7</sup> Across the nation, about 13% of adults smoke cigarettes.<sup>7</sup> Smoking causes most lung cancers. In St. Louis County, about 3 in 10,000 adults die from lung cancer, which is about the same as in Missouri and the U.S.<sup>7</sup> These numbers take into account the impact of age on death.

Smoking can make COPD worse. About 8% of adults in St. Louis County have COPD, while about 7% of adults across the nation have COPD.<sup>7</sup>

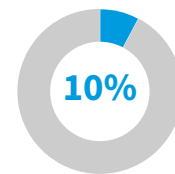
Air pollution also affects respiratory and lung health in other ways, like asthma and allergies. About 1 in 10 adults in St. Louis County and in the U.S. have asthma.<sup>7</sup>

Air pollution can make asthma and COPD symptoms worse.<sup>14</sup> Air pollution due to particles like dust, smoke, and chemical pollutants.<sup>14</sup> Air pollution in St. Louis County is similar to air pollution in Missouri.<sup>7</sup>

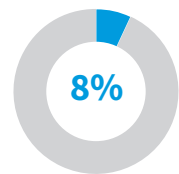


In St. Louis County

**1 in 10 adults  
have asthma and  
nearly 1 in 10  
have COPD**



have asthma



have COPD

SOURCE: CDC PLACES

# 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: Diabetes and High Blood Sugar

**Goal:** Improve blood sugar management to enhance quality of life for people who have, or are at risk for, diabetes

**Category:** *Connection to care*

**INITIATIVE:** Provide patients who are diagnosed with diabetes mellitus with outpatient dietitian services including initial assessment and follow-up visits.

- MEASURES:**
- # of patients diagnosed with diabetes mellitus seen for initial one-on-one assessments
  - % of patients diagnosed with diabetes mellitus seen for initial one-on-one assessments
  - # of total follow-up visits



## CHNA Health Need: Heart Conditions

**Goal:** Increase detection and access to treatment for risk factors to improve cardiovascular health outcomes

**Category:** *Connection to resources*

**INITIATIVE:** Identify patients who are food insecure and provide access to healthy foods and dietary education through “Food Pharmacy.”

- MEASURES:**
- # of families receiving support
  - % reduction in positive food insecurity screenings

**Category:** *Connection to care*

**INITIATIVE:** Increase follow-up appointments made within seven days after discharge for congestive heart failure patients.

- MEASURES:**
- % of follow-up appointments scheduled for seven days after discharge
  - % of appointments that are attended within seven days after discharge



## CHNA Health Need: Respiratory and Lung Diseases

**Goal:** Increase access to education and connection to resources to improve respiratory health

**Category:** *Health education*

**INITIATIVE:** Through the Respiratory Department (RT) patients admitted with primary acute respiratory illnesses will receive bedside education.

**MEASURES:**

- # of respiratory consults
- % of respiratory patients with respiratory disease that receive education and/or follow-up services

# What Comes Next

## Looking Forward

At Christian 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 diabetes and high blood sugar, heart conditions, and respiratory and lung diseases 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
<b>POPULATION</b>		
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
<b>AGE</b>		
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
<b>GENDER</b>		
Female Persons, Percent, 2024	52.2	50.7
Male Persons, Percent, 2024	47.8	49.3
<b>RACE/ETHNICITY</b>		
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
<b>LANGUAGE</b>		
Foreign Born Persons, Percent, 2024	8.5	4.9
<b>HOUSING</b>		
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
<b>FAMILIES &amp; LIVING ARRANGEMENTS</b>		
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
<b>EDUCATION</b>		
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
<b>INCOME</b>		
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	2	3	4	5	
	Never	Rarely	Sometimes	Often	Always	Not sure
Safe childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affordable healthy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health and substance use services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Places to be physically active, such as community parks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services that support people as they age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clean outdoor environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good paying jobs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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

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

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

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

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

Select all that apply.

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

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

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

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

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

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

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

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

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

## Tell Us About You

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

### 8. What is your age group?

Choose one answer.

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

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

Choose all that apply.

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

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

Listed in alphabetical order. Choose all that apply.

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

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

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

Choose one answer.

- Hispanic
- Non-Hispanic
- Prefer not to disclose

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

Choose one answer.

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

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

Choose all that apply.

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

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

Choose one answer.

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

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

Choose one answer.

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

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

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

## Appendix C: Community Survey Respondents Demographics

In North St. Louis County, Missouri 498 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 4 to 77. On average, just over 20% of participants did not answer the optional demographic. Among those who did respond, most were between 55 and 64 years old (18%), women (60%), White (33%), non-Hispanic (53%), and primarily English-speaking at home (74%). Many held a four-year college or bachelor's degree (22%), were employed full time (57%), and reported a household income between \$50,000 and \$74,999 (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

## North St. Louis County

### Key Survey Findings



2024 Community Health Needs Assessment Survey

*\*\*Preliminary survey data through June 2024 presented to community leaders\*\**

1

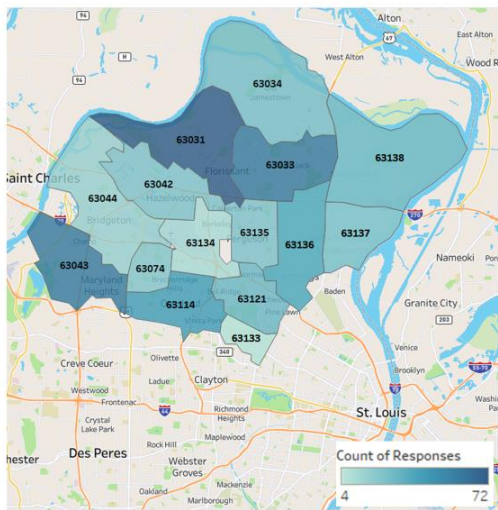
### Who responded to the survey?

449

Total Respondents in North County

In North County, 449 community members responded to the community health needs survey. The number of survey respondents in North County ZIP codes ranged between 4 and 72.

#### Survey Respondents by ZIP code



#### Notes

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2024 Community Health Needs Assessment Survey

*\*\*Preliminary survey data through June 2024 presented to community leaders\*\**

# Who responded to the survey?

Over 20% of respondents in North County did not complete the optional demographic survey questions (non-respondents range from n=91 to 171, depending on the question).

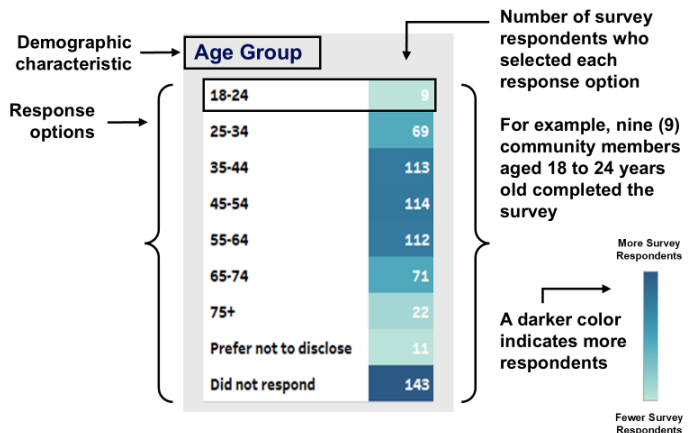
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=449).

**Most respondents:**

- Are between the age of 55 and 64 years old (19%)
- Are women (63%)
- Are White (35%)
- Are non-Hispanic (55%)
- Speak English at home (78%)
- Have a 4-year college or Bachelor's degree (24%)
- Are employed full time (60%)
- Have a household income between \$100,000 to \$149,999 (14%)

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

Example: Survey Respondents by Age Group



Notes

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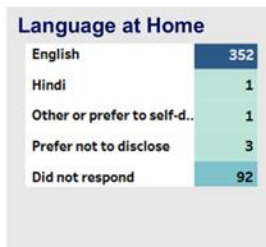
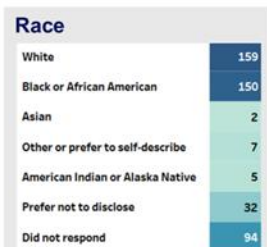
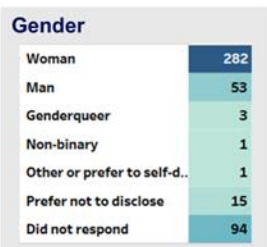
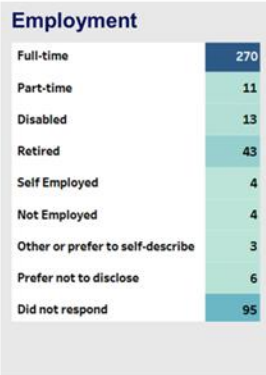
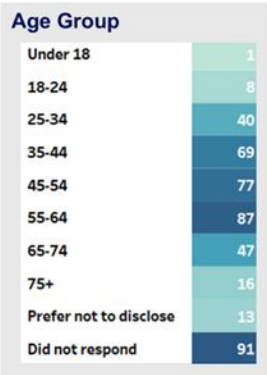


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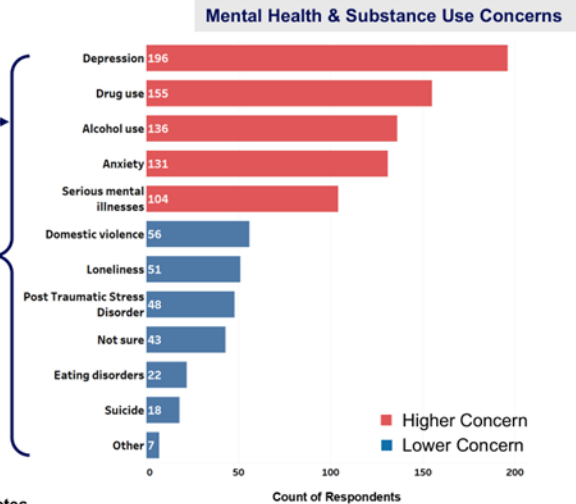
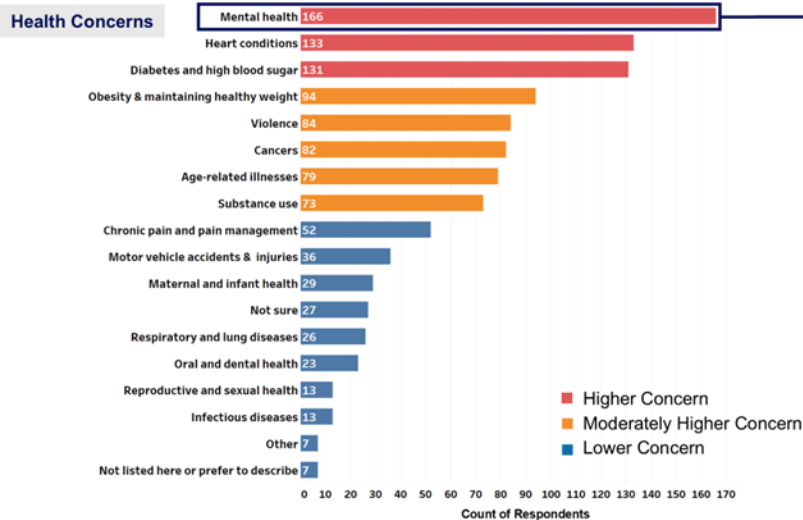
# Who responded to the survey?



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

449  
Total Respondents in North County

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



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

449  
Total Respondents in North 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, **chronic pain and pain management** were identified as a top concern by respondents who are Black or African American or another race. Additionally, **environmental health** was identified as a top concern by respondents of another race.

Health Concerns by Race

Higher Concern  
Moderately Higher Concern

Top Concerns	All Respondents n=449	White n=159	Black or African American n=150	Another Race* n=14	Did not respond or prefer not to disclose n=126
1	Mental health	Mental health	Diabetes	Substance use	Mental health
2	Heart conditions	Heart conditions	Heart conditions	Obesity	Obesity
3	Diabetes	Age-related illnesses	Mental health	Heart conditions	Diabetes
4	Obesity	Violence	Obesity	Age-related illnesses	Substance use
5	Violence	Diabetes	Cancers	Mental health	Heart conditions
6	Cancers	Cancers	Violence	Violence	Age-related illnesses
7	Age-related illnesses	Obesity	<b>Chronic pain and pain management</b>	<b>Chronic pain and pain management</b>	Cancers
8	Substance use	Substance use	Substance use	<b>Environmental health*</b>	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 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. Conditions related to environmental health was described by at least two respondents in open-ended responses.

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

The table below details the top mental health and substance use concerns among respondents by race. Most of the top concerns remained consistent across groups with some differences in the order of concerns. Notably, **eating disorders** were identified as a top concern among respondents of another race, and among this same group, **Post Traumatic Stress Disorder** ranked much higher in the order of top concerns.

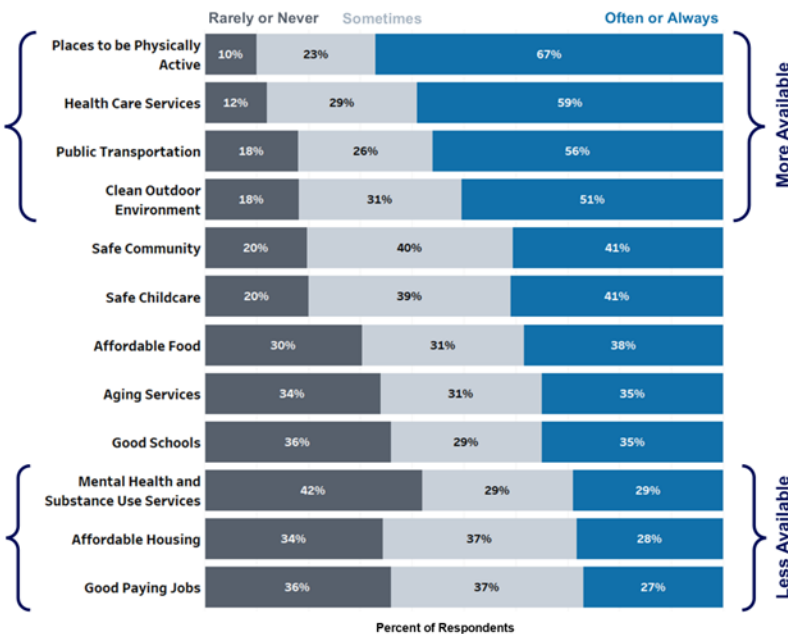
Mental Health & Substance Use Concerns by Race

■ Higher Concern  
■ Lower Concern

Top Concerns	All Respondents n=449	White n=159	Black or African American n=150	Another Race* n=14	Did not respond or prefer not to disclose n=126
1	Depression	Depression	Depression	Post Traumatic Stress Disorder	Drug use
2	Drug use	Anxiety	Drug use	Depression	Depression
3	Alcohol use	Alcohol use	Alcohol use	Anxiety	Alcohol use
4	Anxiety	Drug use	Serious mental illnesses	Serious mental illnesses	Serious mental illnesses
5	Serious mental illnesses	Serious mental illnesses	Anxiety	Loneliness	Anxiety
6	Domestic violence	Domestic violence	Domestic violence	<b>Eating disorders</b>	<b>Not sure</b>
7	Loneliness	Loneliness	Post Traumatic Stress Disorder	Drug use	Post Traumatic Stress Disorder
8	Post Traumatic Stress Disorder	<b>Not sure</b>	Loneliness	Alcohol use	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.

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



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

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

Mental health and substance use services, affordable housing, and good paying jobs, were reported to be less available, with less than 30% indicating that the resources were often or always available in their community.

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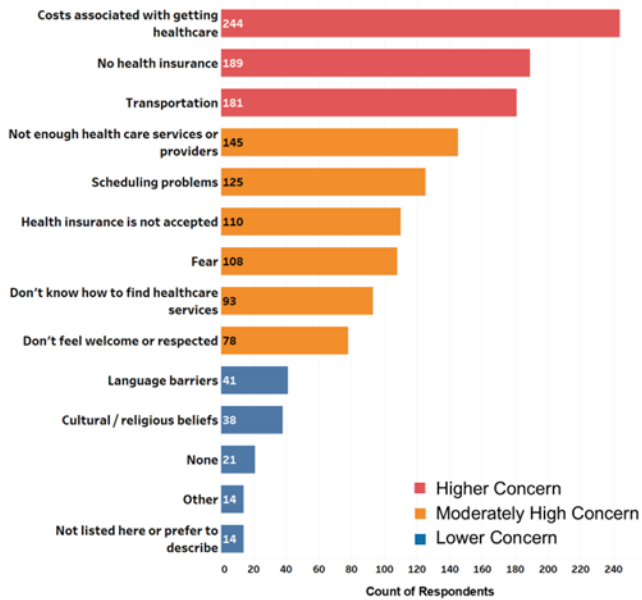


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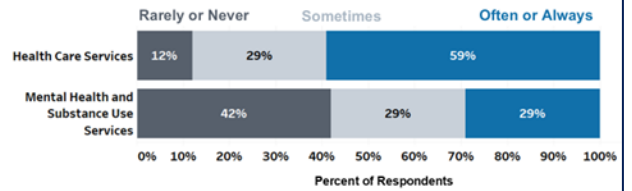
Barriers to Health Care Access



More than fifty percent (59%) of community members who responded to the survey indicated that health care services were often or always available in North County. Only 29% indicated that mental health and substance use services had good availability.

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

Health Care Service Availability



Notes

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## Appendix G: Community Leader Conversation Participants

Christian Hospital: Community Leader Conversation Participants			
Organization	First Name	Last Name	Title
A Red Circle	Emma	Crocker	Program Manager for Food & Nutrition
ALIVE – Alternatives to Living In Violent Environments	Melissa	Francisco	Volunteer/Outreach Coordinator
ALIVE – Alternatives to Living In Violent Environments	Tirsa	Woodson	Director of Advocacy
ArchCity Defenders, Inc.	Amanda Rae	Gardner	Social Work Pilot Coordinator
ArchCity Defenders, Inc.	Morgan	Martin	Case Manager
ArchCity Defenders, Inc.	Tiara	Gore	Case Manager
Beyond Housing	Chris	Krehmeyer	President & CEO
Bullet Related Injury Clinic / The T	LJ	Punch	Bullet Related Injury Clinic / TheR
Community Impact Network	Ailey	Pope	Vice President of Service
Da Hood Connect	Shavanna	Spratt	Owner
Deaconess Foundation	Bethany	Johnson-Javois	President & CEO
Epworth Drop-In Center	Mary	Saunders	Program Manager of Street Outreach
Fit & Food Connection	Megan	Sobolewski	Program Associate
Generate Health	Rose	Anderson-Rice	Chief Executive Officer
iFM Community Medicine	Flannery	Harman	Community Engagement & Evaluation Manager and Community Health Worker
iFM Community Medicine	Teresa	DuMaine	Nurse Practitioner
International Institute of St. Louis	Maxwell	Kelly	Community Support Manager
North County Inc.	Rebecca	Zoll	President/CEO
Operation Food Search Inc	Melissa	Wissler	Chief Program Officer
PreventEd	Courtney	Hinton	Community Engagement and Strategy
St. Louis Community Foundation	Elizabeth	George	Director of Community Investment
St. Louis County Health Department	Ruband	Mahmood	Community Health Assessment Coordinator
St. Louis County Health Department	Will	Bogan III	Business Manager
The Salvation Army	LaKeysha	Fields	Regional Social Services Director
United Way of Greater St. Louis	Julia	Fuller	Portfolio 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** | Beyond Housing – July 16, 2024 – 25 participants
- **Community Members** | St. Louis Oasis – October 16, 2024 – 12 participants
- **Community Members** | Beyond Housing – October 29, 2024 – 5 participants

### Community Leader Conversation on Health Needs

#### Mental Health

- Mental health is a top priority in North County, especially among communities of color
- Many communities in North County experience stress, trauma, and insufficient mental health resources
- Stigma and limited access to culturally competent care exacerbate disparities in mental health needs
- Mental health care needs to be normalized and integrated into community care
- Mobile mental health care services are recommended to meet community where they are

#### Substance Use

- Substance use is another top priority and often co-occurs with mental health issues
- Community members face similar barriers to seeking and accessing care for substance use needs (i.e., stigma, lack of culturally competent care)

### Community Leader Conversation on Health Resources

#### Health, Mental Health and Substance Use Services

- Access to health care remains an issue in North County
- Specific barriers include: Long appointment wait times, a lack of urgent care, specialty care, and hospitals located within close proximity to where community members live, inadequate insurance coverage, and difficulty navigating a complex health care system
- More culturally competent health care is needed
- Health literacy is also needed to help patients understand their treatment plans and feel empowered to manage their health
- Historical experiences of systemic neglect, racism, and poor communication have led to high levels of mistrust between marginalized communities and health care institutions
- Trust needs to be rebuilt through sustained, transparent engagement where hospitals demonstrate accountability, show measurable progress in addressing community concerns, and involve community members in decision-making
- Health care systems need to commit to long-term, transparent engagement with communities
- Mobile clinics and community-based health services are also recommended

- Engaging community health workers and trusted community leaders (e.g., clergy, grassroots organizers) were recommended to help bridge the trust gap, especially for communities that face transportation, language, and health literacy barriers

### **Affordable Housing**

- Housing instability is a major social determinant of health that affects health outcomes
- Health care systems need to integrate social determinants of health into strategic planning and service delivery and advocate for policies that improve social conditions, including access to affordable housing

### **Affordable, Healthy Food**

- Food insecurity is a major social determinant of health that affects health outcomes
- Improving health literacy is needed to help community members understand healthy eating options
- Health care systems need to partner with trusted community organizations to offer culturally relevant health education workshops on nutrition and managing chronic conditions

### **Public Transportation**

- Transportation is a major social determinant of health that affects health outcomes
- Community members face long commutes and inadequate transit options to access health care and other services
- Health care systems should integrate social determinants of health into strategic planning and service delivery and advocate for policies that improve social conditions, including access to public transportation

## **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 and those who live in communities with limited access to mental health services
- 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

### **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

### **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

## Community Member Conversation on Health Resources

### 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

### Affordable, Healthy Food

- Food accessibility is a major concern and affects community health
- Many community members have limited nutritious food options
- Access to grocery stores that offer fresh, affordable produce and community gardens are needed
- Community-centered events and educational opportunities that support food-related needs are needed

### 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
- Health care systems need to leverage existing community / peer support networks to ensure that information and resources are shared across neighborhoods and communities

### Public Transportation

- Transportation is a significant barrier for accessing health care, especially for older adults and for those who have to travel outside of their community to access health care facilities
- Some communities offer transportation services, but access is limited and inconsistent across the region
- Gaps in transportation are a barrier to attending routine health appointments and can delay necessary care
- 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
- Financial challenges, including high co-pays and medication costs, are barriers to receiving care
- Health care costs force community members to make difficult decisions about whether to buy medication, groceries, or other essential needs
- Several community members experience feeling dismissed or not heard by healthcare providers, which leads to distrust and reluctance to seek care
- There is a need for healthcare providers who are culturally competent and actively listen to their patients
- Beyond Housing was identified as an important, supportive resource for community health
- Health care systems need to build on community organizations' efforts and provide consistent, community-based opportunities to receive health care at schools and community centers

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

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

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

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

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

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

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

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

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

Please share any questions or thoughts.

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

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

## Appendix J: Hospital Community Health Needs Selection Team

Christian Hospital 2025 Community Health Needs Selection Team Attendees 05/30/2025			
Last Name	First Name	Title	Department
Beldner	Brad	Director, Finance & Support Services	Fin Ops - CHN , BJSP, PWHC
Cheung	Necole	Foundation Director	General Admin-Fund Raising
Douglas	Connie	Practitioner, Nurse	CHAPS Transition to Wellness
Drake	Paul	Manager, Community Health / Community Health Improvement Lead	Community Health Access Program (CHAP)
Johnson	Charles	Director, Patient Care Operations	Nursing Administration
Lorch	Christina	Manager, Safety and Regulatory	Clin Reg & Accreditation
McCoy	Alisha	Director, Case Management / Community Health Improvement Lead	Case Management
Onifade	Moyosore	Physician, ED	Medical Affairs
Patel	Hiral	Manager, Project	Executive Administration
Session	Lashonda	Director, Business/Service Line Dev & Phys Services	Physician Practice Development
Sparks	Rachel	Director, Quality	QSIP (Qual, Safety & IP)
Strauther	Marcus	Strategist, Marketing - SR	MC-Hospital Marketing
Walter	Mika	Director, Patient Care Services / ACNO	Nursing 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 and gave each one a score. The score was used to identify several elevated health needs for each hospital’s needs selection team to consider and discuss.

## Data Sources Used

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

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

## How we Sorted Each Need

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

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

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

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

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

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

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

