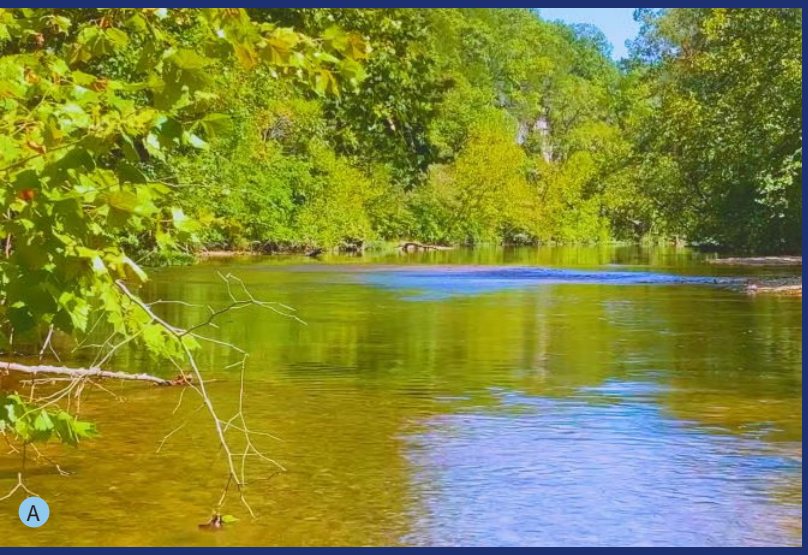
2025-2028 Community Health Needs Assessment and Improvement Plan



BJC HealthCare
Missouri Baptist
Sullivan Hospital

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

A Message from Bob Cannon, President, BJC HealthCare, and Lisa Lochner, President, Missouri Baptist Sullivan 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 Missouri Baptist Sullivan 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 Missouri Baptist Sullivan Hospital, we are committing to focused efforts around mental health and substance use, and obesity and maintaining healthy weight. These priorities were carefully determined through conversations with community members and leaders across the region, as well as a community health needs survey, public health data, and hospital data. Taken together, they reflect our shared vision for meaningful, measurable improvements in community health.

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

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

Sincerely,

Bob Cannon
President, BJC HealthCare

Lisa Lochner, MBA
President, Missouri Baptist Sullivan 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.

BJC HealthCare

Purpose

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

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

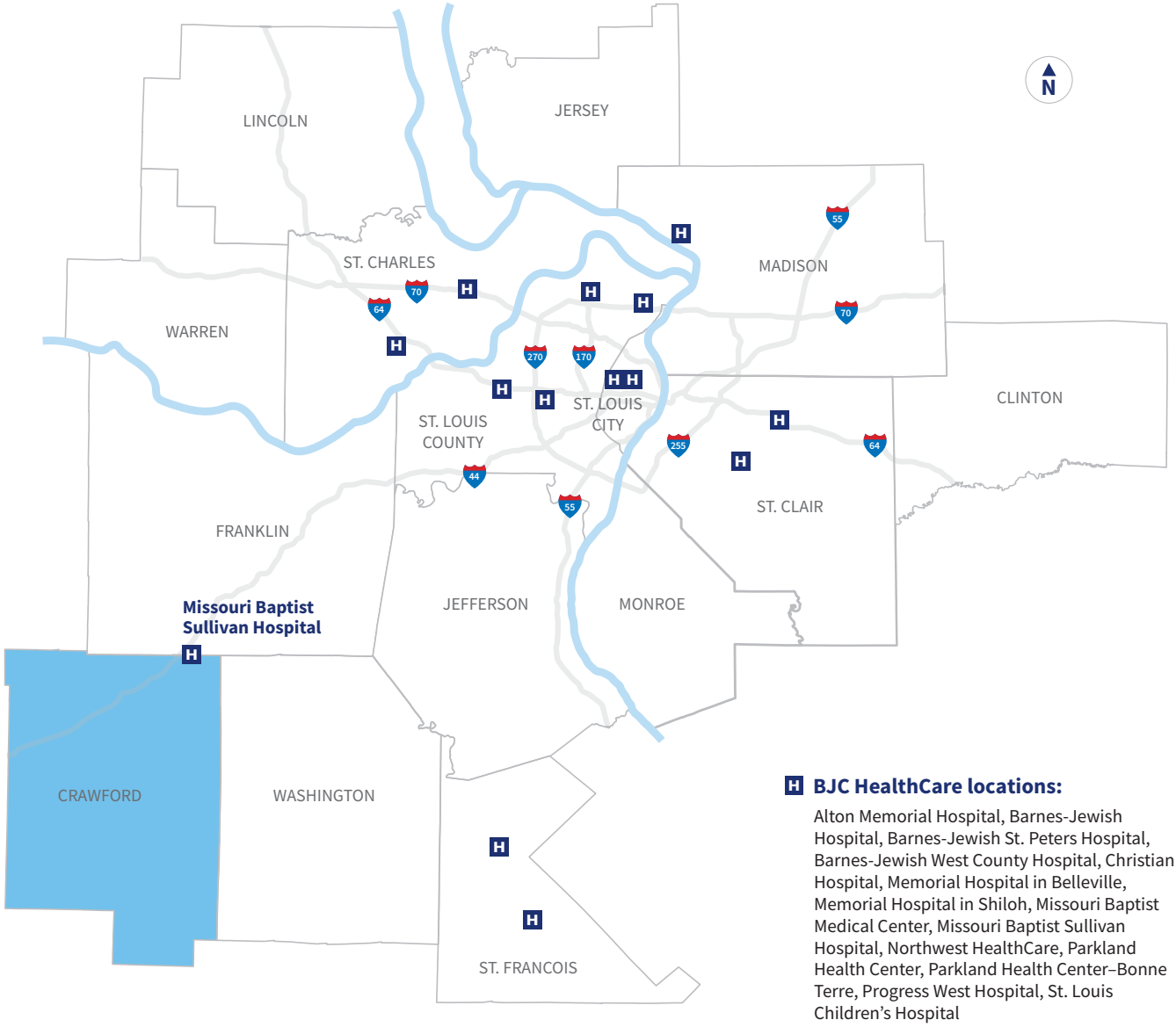
All nonprofit hospitals, including all BJC HealthCare hospitals, are required to do a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community of focus. 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. These plans set specific goals and actions to improve health needs in the community. In this report, we will share how we found out about health needs in the Missouri Baptist Sullivan Hospital community and chose which health needs to work on. Then, we will talk about our goals and plans for building a healthier community.

Missouri Baptist Sullivan Hospital and the Community We Serve

The Missouri Baptist Sullivan Hospital Community Health Needs Assessment is primarily focused on **Crawford County, Missouri**. Missouri Baptist Sullivan is a critical access hospital that provides exceptional inpatient and outpatient care to residents in Crawford, Franklin, and Washington counties.

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



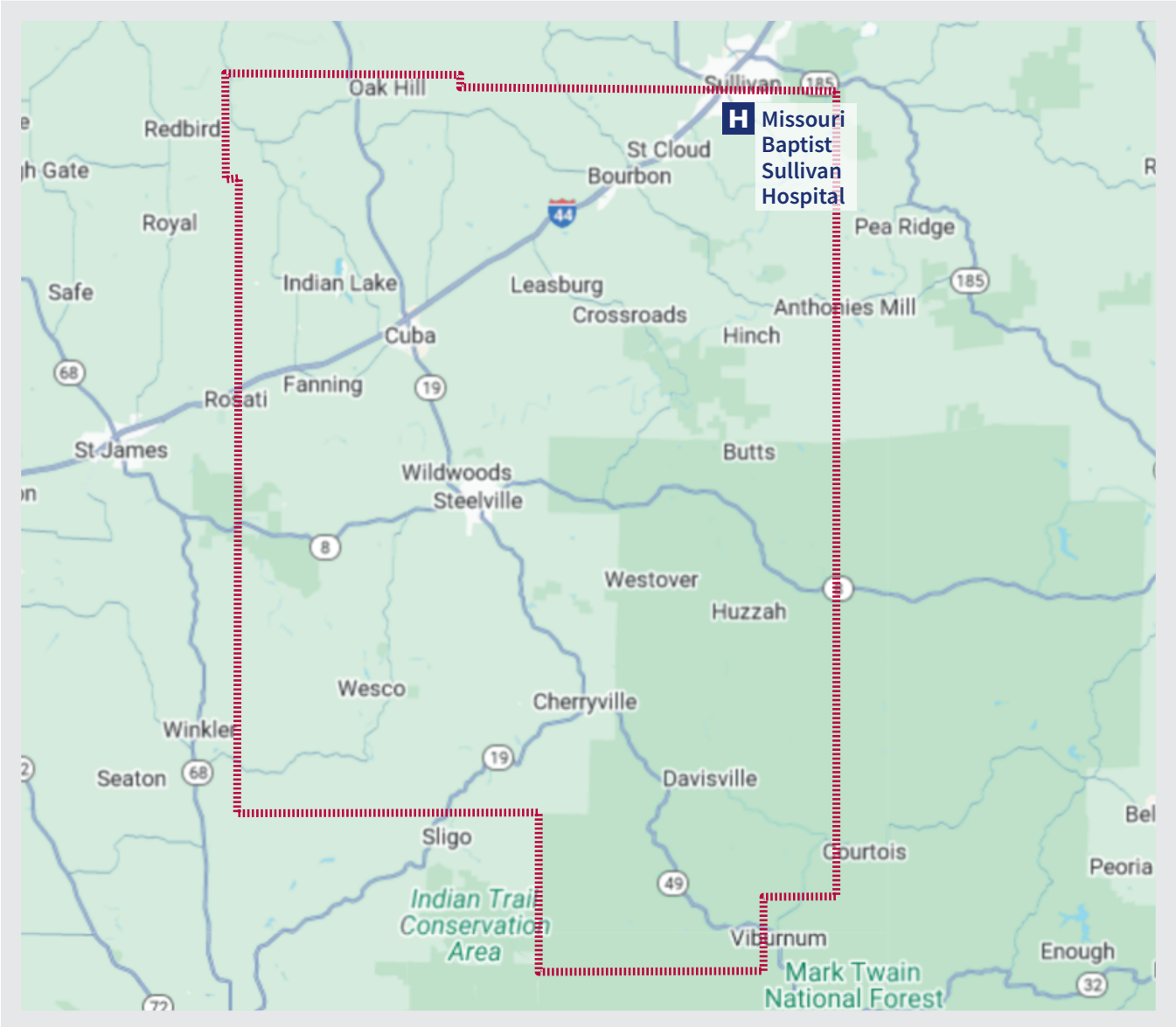
BJC HealthCare locations:

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

Since 2003, Missouri Baptist Sullivan has improved its facility and expanded its services, including a state-of-the-art Emergency Department, modern childbirth center, critical care unit, multi-room surgical suite, expanded cardiac rehabilitation services, therapy and rehab department, an **award-winning wound care center** with hyperbaric chambers, and a cancer center. A 25,000-square-foot medical office building provides offices for primary care providers and visiting medical and surgical specialists from the St. Louis area.

Missouri Baptist Sullivan collaborates with the Sullivan, Spring Bluff, and Bourbon School Districts. We place a nurse on each of the school campuses and a certified athletic trainer on the Sullivan campus. The hospital also has four rural health clinics, providing high-quality health care to surrounding communities.

Missouri Baptist Sullivan Hospital Community Health Needs Assessment service area close-up



Over the years, Missouri Baptist Sullivan has given back to the community in many ways. In 2023, the hospital provided **$6.4 million** in community benefit. This total includes:

- $2.8 million in **services that fill gaps** in health care access for the community
- $2.7 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- $0.6 million in **unreimbursed care** for people with Medicaid and Medicare
- $0.2 million in **programs that bring health resources and education** to the community

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

Missouri Baptist Sullivan has dedicated staff who provide care for many community members. The team includes 480 employees and 602 medical staff who practice at our hospital. In 2024, we cared for 2,251 inpatient admissions, 863 outpatient surgeries, and 18,688 Emergency Department visits. See more details in the graphic below.

Missouri Baptist Sullivan Hospital by the Numbers

480
Total Employees

602
Medical Staff

$69.3
Million Net Revenue (2023)

35
Staffed Beds

2,251
Inpatient Admissions

863
Outpatient Surgeries

18,688
Emergency Department Visits

246
Deliveries

About **23,000 people** call Crawford County home.[1] The county is a rural area.[1] Most of the people who live in Crawford County are white, and about one in five residents are older than 65 years.[1] The life expectancy for Crawford County residents is about 71 years.[2] The life expectancy for all Missouri residents is 75 years.[2]

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

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

About 1 in 5 Crawford County households spend more than 30% of their income on housing costs like rent or mortgages.[1] When housing is expensive, it can be hard to meet other needs, like food or transportation.

In Crawford County, **most residents have a high school degree**.[1] High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in Crawford County is about $56,345 per year.[1] This is lower than the median state household income.[1]

About one in six children in Crawford County live in poverty.[1] This is the same as the state of Missouri.[1]

Community Feature: Onondaga Cave State Park

Onondaga Cave can be found in Onondaga State Park, located along the Meramec River.[3] The cave has been designated as a National Natural Landmark because of the large number of beautiful stalactites, stalagmites, cave coral, and other mineral deposits.[3] John Eaton and Charles Christopher first explored the cave in 1886.[3] It became a popular place to visit in 1904, when St. Louis hosted the World's Fair.[3] During the summer, the park hosts nature programs for visitors to learn more about the cave and take a tour.[3] If visitors do not want to go in the cave, there are plenty of activities above ground.[3] They can enjoy scenic picnic areas, miles of hiking trails, and canoeing in the Meramec River.[3]

Onondaga Cave State Park, Leasburg, Missouri

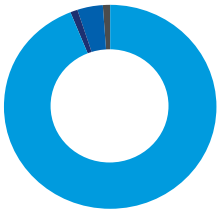
Missouri Baptist Sullivan Hospital Community Characteristics

Crawford County

Population
22,890

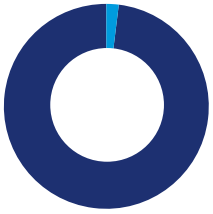
Land Area
744 sq. mi.

Race



94% White
1% Black
4% 2 or more races
1% Other*

Ethnicity



2% Hispanic/ Latino
98% Not Hispanic/ Latino

Most people have at least a high school education

Crawford Co.	Missouri
85%	92%

Life Expectancy

Crawford Co.	Missouri
71	75

The median household income in Crawford County is lower than in the state of Missouri

Crawford Co.	Missouri
$56,345	$68,920

About half as many people spend more than 30% of their income on housing than in the state of Missouri

Crawford Co.	Missouri
21%	42%

Poverty rates among children in Crawford County are the same as in the state of Missouri

Crawford Co.	Missouri
16%	16%

People over 65

Crawford Co.	Missouri
21%	18%

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

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

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

Where We've Been…

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

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

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

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

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

Missouri Baptist Sullivan Hospital Community Health Needs and Goals from 2022–2025

In our last Community Health Needs Assessment at Missouri Baptist Sullivan Hospital, we learned that diabetes and heart health were some of the top health concerns in Crawford County. We also wanted to improve the lives of residents of nearby Franklin County. For each health need, we set a goal and made a plan to reach the goal.

Diabetes

Goal: Reduce the negative impacts of diabetes. Improve the quality of life for everyone who has or is at risk for diabetes.

Heart Health

Goal: Improve heart health and quality of life for everyone in Crawford and Franklin counties who has or is at risk for heart disease. Improve prevention, detection, and access to treatment for people who are at risk of heart attack and stroke.

Heart Health

Goal: Increase early identification and treatment of heart attacks and strokes. Prevent future heart problems.

Diabetes

Our Strategy ▸

We wanted to **screen more adults for diabetes**. We identified patients who were at risk of developing diabetes. We screened them for elevated glucose. We also tested their **HbA1c** levels. These screenings took place at Missouri Baptist Sullivan, local businesses, and community events. We used the results of these tests to determine if a patient was at risk for diabetes. If an individual was at risk for diabetes, they were connected to education programs and community resources. We also provided health coaching services via emails and phone calls. We wanted to increase detection of prediabetes for people living in Crawford and Franklin counties by 10%. We also wanted to improve how they described their quality of life by 10%.

An **HbA1C** test measures your average blood glucose, or blood sugar, over the past two to three months.[4] The results from the test can be used to screen for diabetes.[4]

We tracked how many screenings we did for patients. We wanted Missouri Baptist Sullivan nurses, dietitians, and other trained staff to screen 50 adults in 2023 and 100 adults each following year.

We also wanted to **provide education to people with diabetes**. We wanted to connect more patients to Outpatient Nutrition Services and other community resources. These resources provide formal diabetes education programs. We tracked how many people we referred to these resources.

Our Progress ▸

In 2023, we completed 80 glucose and HbA1C screenings. In 2024, we completed 98 glucose and HbA1C screenings. Some of these screenings happened at health fairs and other community events.

While we did not have the resources to track every person who received formal diabetes education, we know that we increased diabetes education in our community. A nutritionist provided education at community events and at individual appointments.

Heart Health

Our Strategy ▸

We wanted to **improve heart health** for community members. We also wanted to **improve their quality of life**. We set out to do a broad range of activities. First, we wanted to prevent heart disease. We did this by providing education about heart health and heart-healthy eating at community events.

Second, we wanted to screen for heart disease. This meant working with patients who did not know whether they have heart disease. We tested for conditions like high blood pressure. We also tested cholesterol and blood glucose levels.

Finally, for patients who screened positive for heart disease risk factors, we wanted to connect them to care. We connected these patients to nutrition and bariatric (weight loss) services. We also provided patients with education about risk factors, heart health, and stroke.

Our Progress ▸

In 2023, we completed cholesterol, blood glucose, and blood pressure screenings for 80 people. In 2024, we completed these screenings for 98 people. We offered screenings at health fairs and community events and gave people the opportunity to follow up with a provider.

We did not have the resources to track how many patients were connected to care.

A nutritionist also provided education. We provided other resources too, like support groups, newsletters, and educational Facebook posts.

Where We Are Today…

2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of the Crawford 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 Crawford 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 Crawford 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 Crawford County. 114 community members completed the survey. See more details in Appendix B and Appendix C.

The top concerns among community members were mental health, substance use, and age-related illnesses. Specifically, mental health challenges like drug use, depression, and alcohol use were concerns for the community.

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

COMMUNITY SURVEY

Top 6 Health Problems

1. Mental health
2. Substance use
3. Age-related illnesses
4. Heart conditions
5. Obesity and maintaining healthy weight (tie)
5. Diabetes and high blood sugar (tie)

Top 5 Mental Health Concerns

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

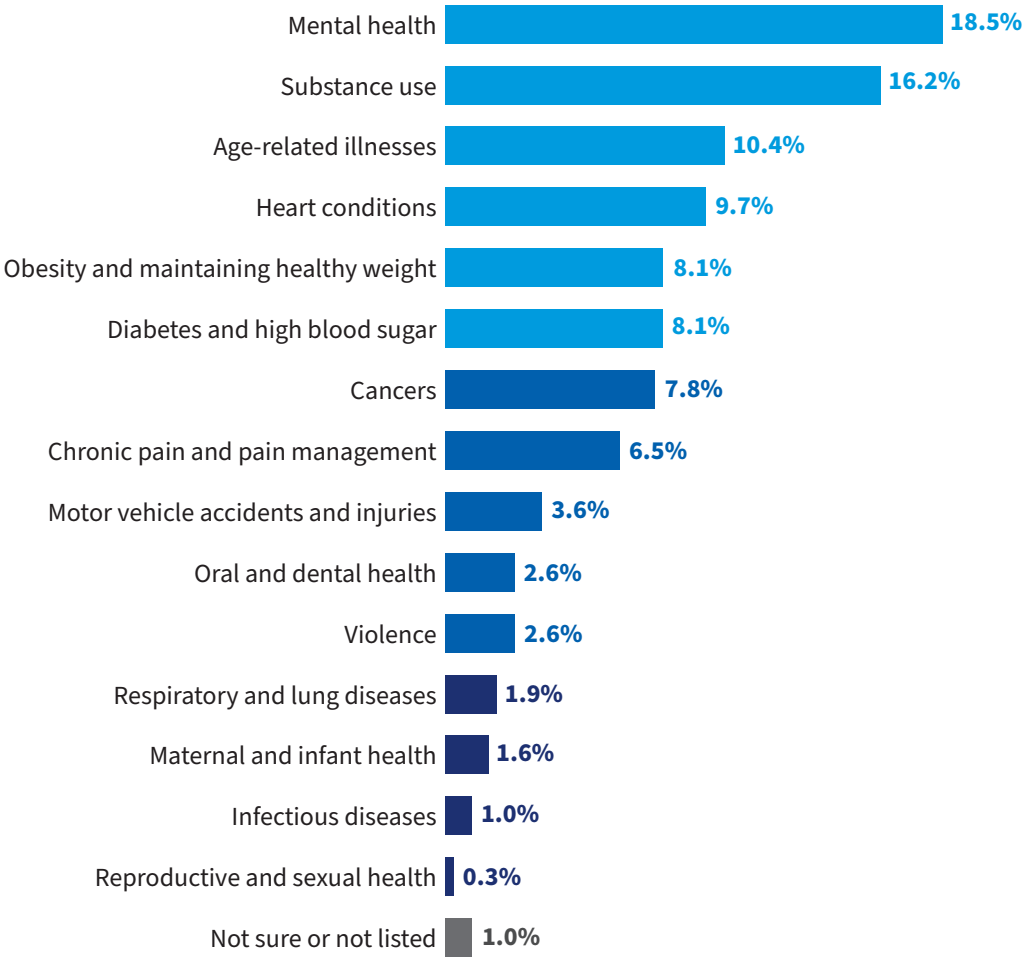
Top 5 Barriers to Care

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

Top 5 Community Resource Needs

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

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 Crawford County by using Conduent's Healthy Communities Institute (HCI) online tool. We use the HCI tool to explore **large amounts of information on community health**.

The HCI tool includes more than 100 social, economic, and health measurements. HCI has information from national and local sources, like the National Cancer Institute, 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 Crawford County with other communities, national goals from Healthy People 2030, and past community health information.

The top health needs from HCI were alcohol and drug use, cancer, and prevention and safety. The top social determinants of health needs were education, community (like the use of public transportation and access to the internet), and environmental health. See more details in the list on the right.

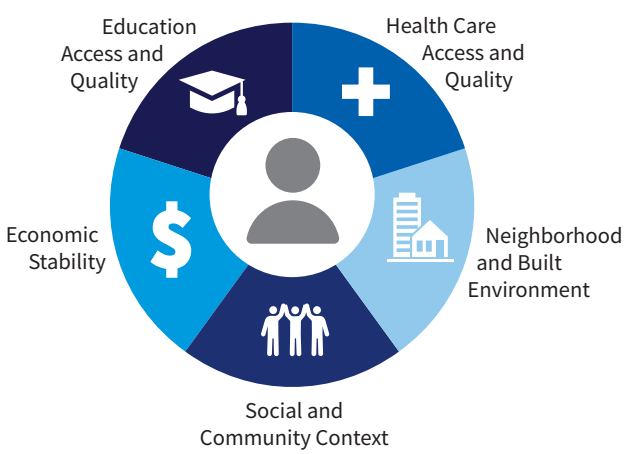
COMMUNITY INFORMATION

Top 5 Health Problems

1. Alcohol and drug use
2. Cancer
3. Prevention and safety
4. Mental health and mental disorders
5. Older adults

Top 4 Most Needed Social Determinants of Health

1. Education
2. Community
3. Environmental health
4. Economy



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 Sullivan Fire Protection District Station 5. 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, substance use, and obesity and maintaining healthy weight. They thought these health needs were the most important to focus on.

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

Lisa Lochner, president of Missouri Baptist Sullivan Hospital, speaking at Community Leader Conversation at Sullivan Fire Protection District Station 5, Sullivan, Missouri

COMMUNITY LEADER CONVERSATIONS

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

Discussed Community Health Needs

- Mental health
- Substance use
- Obesity and maintaining healthy weight

Discussed Community Health Resources

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

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 Grace United Methodist Church. We asked community members which health needs were the most important to them. Community members discussed mental health, substance use, age-related illnesses, and others.

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

Grace United Methodist Church in Sullivan, 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
- Substance use
- Age-related illnesses
- Heart conditions
- Diabetes and high blood sugar
- Infectious diseases

Discussed Community Health Resources

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

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 Missouri Baptist Sullivan 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 Missouri Baptist Sullivan, 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 6 Health Conditions

1. Hypertension
2. Diabetes
3. Substance use disorder
4. Tobacco use
5. Fibromyalgia, chronic pain, and fatigue (tie)
5. Mental health (tie)

Hospital Team Survey

Missouri Baptist Sullivan 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 Missouri Baptist Sullivan CHNA team took a survey about local health needs. Team members were most concerned about mental health, substance use, and obesity and maintaining healthy weight. See more details in the list below.

HOSPITAL TEAM SURVEY

Top 6 Community Health Needs

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

Top 5 Most Needed Community Health Resources

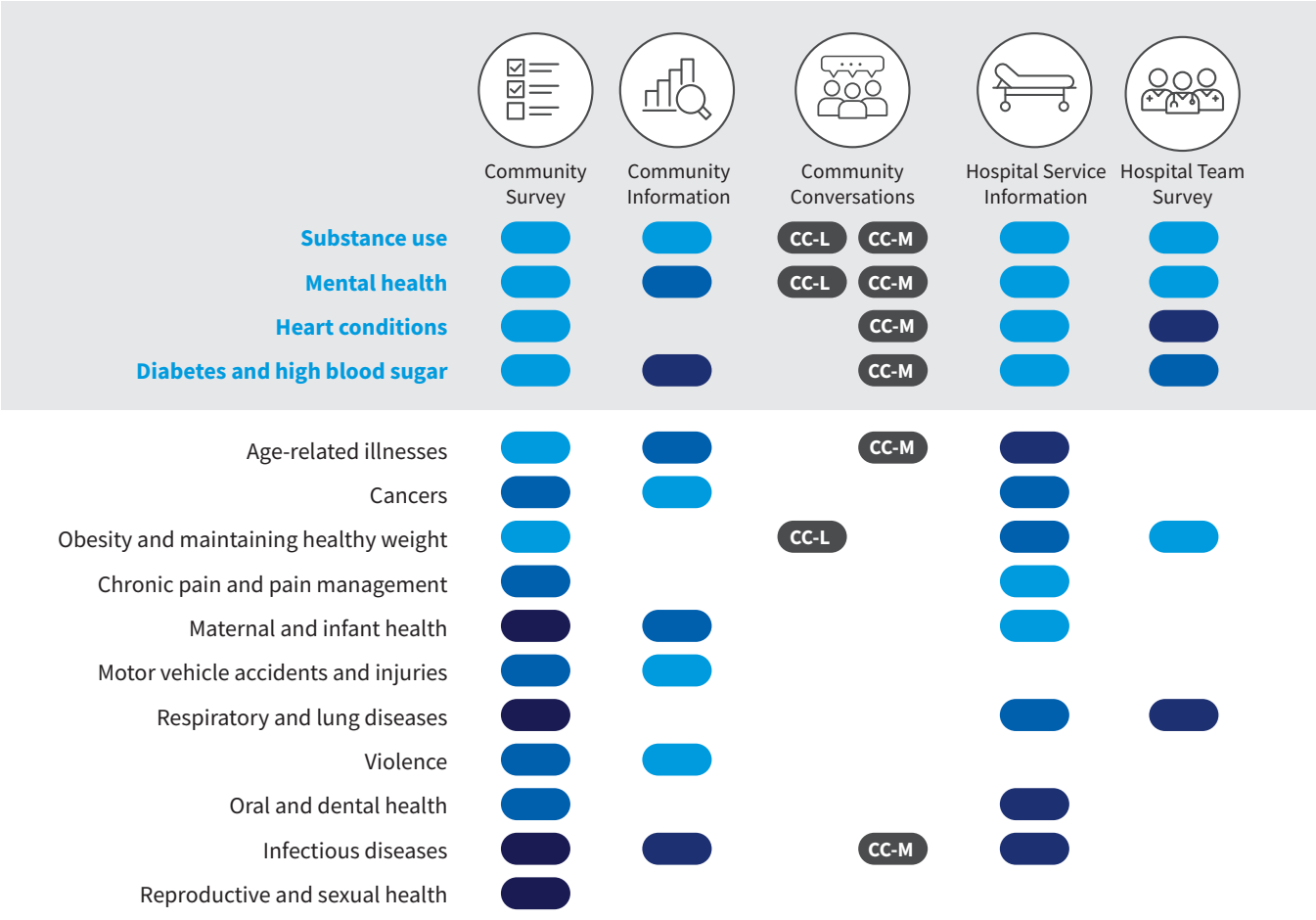
1. Public transportation
2. Affordable, healthy food (tie)
2. Good paying jobs (tie)
2. Mental health and substance use services (tie)
2. Affordable housing (tie)

What We Learned: Our Selected Health Needs

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

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

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



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

How the Needs Were Selected

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

Hospital Team Conversation

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

Hospital team group discussion

Health Needs We Will Prioritize in This CHIP

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

We decided to combine mental health and substance use into one health need because they are closely connected to each other. This health need is **mental health** with a focus on substance use. With our current resources, we think we can address both mental health and substance use. We already have a medical stabilization clinic that works very well for our patients who need mental health or substance use support. We are also connected to regional resources like BJC Behavioral Health. And by improving mental health, our other health need—obesity and maintaining weight—could be improved as well.

Heart conditions and diabetes and high blood sugar are also important to our community and hospital staff. These health conditions are closely related. We decided to combine heart conditions and diabetes and high blood sugar into one health need. This need is obesity and maintaining healthy weight. By focusing on **obesity and maintaining healthy weight**, we can also improve heart conditions and diabetes and high blood sugar. We can also use the resources we already have to improve obesity and maintaining healthy weight. We have resources like a bariatric weight loss program, a walking track, and educators.

A Closer Look at Our Prioritized Needs

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

Mental Health

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

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

People with serious mental health conditions are **more likely to die from violence** like homicide, suicide, and accidents.[5] They are also more likely to die from **chronic conditions**, like cardiovascular disease and respiratory diseases.[5] By prioritizing mental health and substance use, we can impact other health conditions, too.

About one in four adults in Crawford County have had depression.[6] In the United States, about one in five adults have had depression.[6]

One part of mental health is suicide. About 3 in 10,000 people die from suicide in Crawford County.[6] In Missouri, about 2 in 10,000 people die from suicide.[6] These numbers on deaths take into account the impact of age on illness.

In Crawford County,

1 in 5 adults

have been diagnosed with depression

which is more than in the nation

Crawford Co.	U.S.
25%	21%

SOURCE: Conduent Healthy Communities Institute

Older people are more likely to die from suicide.[7] For this reason, when talking about death from suicide, we have to consider the impact of age on deaths. When data sources have been **adjusted for age**, this means they have used math to take into account deaths across other age groups. When we adjust for age, we can compare death rates across younger and older communities.

Obesity and Maintaining Healthy Weight

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

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

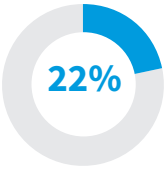
These factors are **affected by social determinants of health** that make it easier or harder to be healthy. These determinants can include walkable neighborhoods and education.[8]

Obesity is linked to long-term health conditions like heart conditions, diabetes, and cancers.[9] About one in five people in Crawford County get little to no physical activity.[6] This means that many adults in the county are more likely to develop long-term health conditions.

In Crawford County, about

1 in 5 adults

get little or no exercise



SOURCE: Conduent Healthy Communities Institute

BMI, or body mass index, is based on a person's weight and height.[10] BMI is measured by dividing a person's weight by their height.[10] Some BMIs can put people at higher risk of health problems, like high blood pressure and high cholesterol.[10]

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 two pages for our 2026–2028 Community Health Improvement Plan.

CHNA Health Need:
Mental Health

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

Category: *Health education*

INITIATIVE: Establish a partnership with area schools and pilot programming to increase awareness, promote education, and improve skills related to coping and mental health.

MEASURES:
- Establishment of resources and partners
- # of schools engaged
- #/type of programs and services delivered
- # of students reached
- % of students who report program-related improvements (TBD)

Category: *Health education*

INITIATIVE: Establish and pilot a weekly wellness initiative at the hospital that provides opportunities for community members to exercise and learn healthy physical and mental habits both in person and through flyers, email, and social media.

MEASURES:
- Establishment of resources and collaborators
- #/type of wellness sessions and resources provided
- # of participants reached
- % of participants who report improvements in healthy habits
- % of participants who report increase in knowledge related to mental health

CHNA Health Need:
Obesity and Maintaining Healthy Weight

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

Category: *Health education*

INITIATIVE: Establish a partnership with area schools and pilot programming to increase awareness, promote education, and improve physical activity among youth.

MEASURES:
- Establishment of resources and partners
- # of schools engaged
- #/type of programs and services delivered
- # of students reached
- % of students who report program-related improvements

Category: *Health education*

INITIATIVE: Establish and pilot a weekly wellness initiative at the hospital that provides opportunities for community members to exercise and learn healthy physical habits both in person and through flyers, email, and social media.

MEASURES:
- Establishment of resources and collaborators
- #/type of wellness sessions and resources provided
- # of participants reached
- % of participants who report improvements in healthy habits
- % of participants who report increase in knowledge related to obesity and the impact that diet and exercise have on health

What Comes Next

Looking Forward

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

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

Appendix A: Community Demographics

Demographics of Crawford and Missouri		
	Crawford	Missouri
POPULATION		
Population 2020	23,984	6,124,160
Population 2023 (estimate)	22,890	6,196,156
Population 2024 (estimate)	23,819	6,245,466
Population, Percent change - 2023 (estimate) to 2024 (estimate)	4.1	0.8
AGE		
Persons Under 5 Years, Percent, 2023	5.8	5.5
Persons Under 18 Years, Percent, 2023	22.3	22.1
Persons 65 Years and over, Percent, 2023	20.7	18.4
GENDER		
Female Persons, Percent, 2024	49.9	50.7
Male Persons, Percent, 2024	50.1	49.3
RACE/ETHNICITY		
White alone, Percent, 2024	92.0	77.6
White alone, not Hispanic or Latino, Percent, 2023	92.9	76.5
African American alone, Percent, 2024	0.9	10.5
Hispanic or Latino, Percent, 2024	3.0	5.6
Two or More Races, Percent, 2024	5.0	7.3
American Indian and Alaska Native alone, Percent, 2024	0.4	0.3
Asian alone, Percent, 2024	0.1	2.3
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.2	0.1
LANGUAGE		
Foreign Born Persons, Percent, 2019-2023	1.6	4.9
HOUSING		
Housing Units, 2019-2023	11,423	2,809,501
Homeownership Rate, Percent, 2019-2023	72.4	67.9
Median House Value, Dollars, 2024	219,400	254,400
FAMILIES & LIVING ARRANGEMENTS		
Households, 2019-2023	9,468	2,563,244
Persons per Household, 2019-2023	2.4	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	1.4	6.6
EDUCATION		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	84.9	92.0
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	17.5	33.5
INCOME		
Median Household Income, Dollars, 2024	60,056	71,589
Per Capita Income in past 12 months (in dollars), 2023	31,502	38,497
People Living Below Poverty Level, Percent, 2023	13.6	12.0

Appendix B: Community Survey Tool

St. Louis Community Health Needs Assessment

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

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

Tell Us About Your Community

1. **What is your home ZIP code?**
   Enter the five-digit ZIP code of the address where you live: _____

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

2. **Thinking about the community where you live, how available are the following resources?**
   For each resource below, choose a number from 1 to 5, where 1 means *Never available*, and 5 means *Always available*. If you do not know, choose *Not sure*.

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

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

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

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

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

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

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

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

5. **Thinking about the community where you live, which barriers prevent access to heath care?**
   Select all that apply.

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

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

6. **Thinking about <u>yourself or other adults</u> in the community where you live, what are the <u>top three</u> mental health and substance use problems?**
   Choose **<u>three</u>** items from the list that are a concern for **<u>yourself or other adults</u>** in your community.

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

7. **Thinking about <u>your or other children</u> in the community where you live, what are the <u>top three</u> mental health and substance use problems?**
   Choose **<u>three</u>** items from the list that are a concern for **<u>your or other children</u>** in your community.

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

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

Tell Us About You

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

8. **What is your age group?**
   Choose one answer.
- ☐ Under 18
- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75+
- ☐ Prefer not to disclose

9. **Which of the following best describes you?**
   Choose all that apply.
- ☐ Woman
- ☐ Man
- ☐ Genderqueer
- ☐ Transgender/Trans woman
- ☐ Transgender/Trans man
- ☐ Non-binary
- ☐ Other or prefer to self-describe: _____
- ☐ Prefer not to disclose

10. **Which of the following best describes you?**
    Listed in alphabetical order. Choose all that apply.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African

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

11. Which of the following best describes you?

Choose one answer.

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Prefer not to disclose

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

Choose one answer.

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

13. Which languages do you speak at home?

Choose all that apply.

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

14. What best describes your employment status?

Choose one answer.

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

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

Choose one answer.

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

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

Thank you for your time and input!

Appendix C: Community Survey Respondents Demographics

In Crawford County, Missouri, 114 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 1 to 89. On average, about 10% of participants did not answer the optional demographic questions. Among those who did respond, most were between 55 and 64 years old (25%), women (69%), White (83%), non-Hispanic (66%), and primarily English-speaking at home (89%). Many held advanced degrees such as a Master's, Professional, or Doctorate degree (24%), were employed full time (57%), and reported a household income between $100,000 and $149,999 (18%).

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

BJC HealthCare
Missouri Baptist
Sullivan Hospital

Franklin County & Crawford County

Key Survey Findings

BJC HealthCare Mercy SSMHealth. St. Luke's

2024 Community Health Needs Assessment Survey

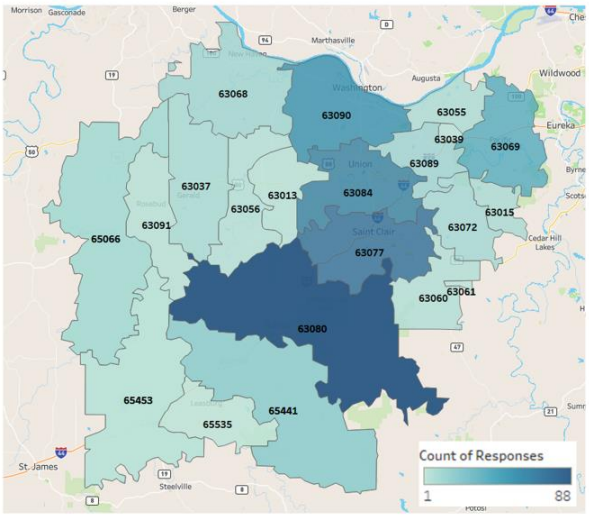
Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

456
Total Respondents in Franklin & Crawford Counties

In Franklin and Crawford Counties, 456 community members responded to the community health needs survey. The number of survey respondents in Franklin and Crawford County ZIP codes ranged between 1 and 88.

Survey Respondents by ZIP code



Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

456
Total Respondents in Franklin & Crawford Counties

Over 15% of respondents in Franklin and Crawford Counties did not complete the optional demographic survey questions (non-respondents range from n=72 to 149, depending on the question).

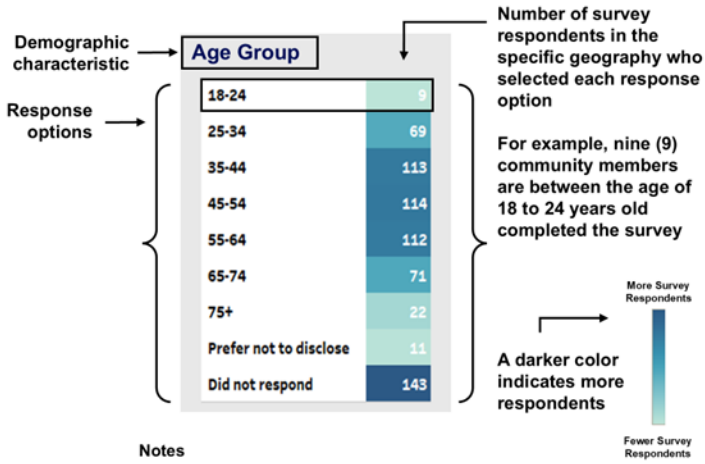
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=456).

Most respondents:

- Are between the age of 35 and 64 years old (57%)
- Are women (67%)
- Are White (78%)
- Are non-Hispanic (63%)
- Speak English at home (83%)
- Have a master's, professional, or doctorate degree (20%)
- Are employed full time (49%)
- Have a household income between $10,000 and $24,999 (15%)

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

Example: Survey Respondents by Age Group

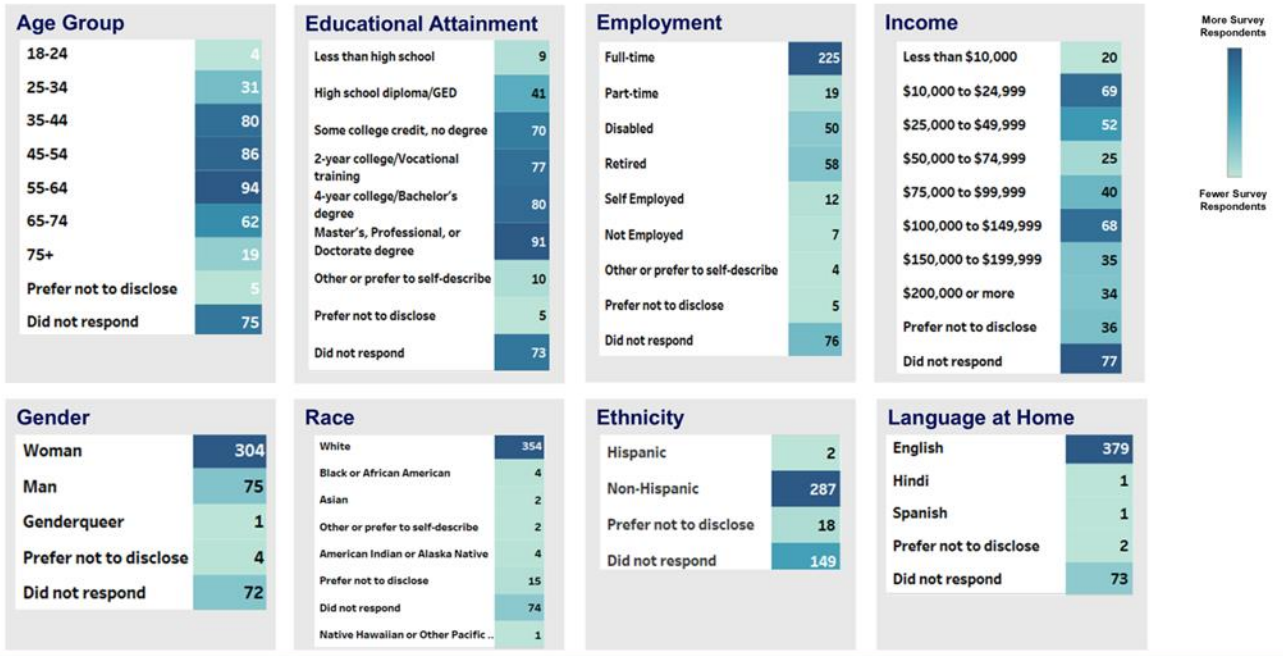


Notes

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

456
Total Respondents in Franklin & Crawford Counties



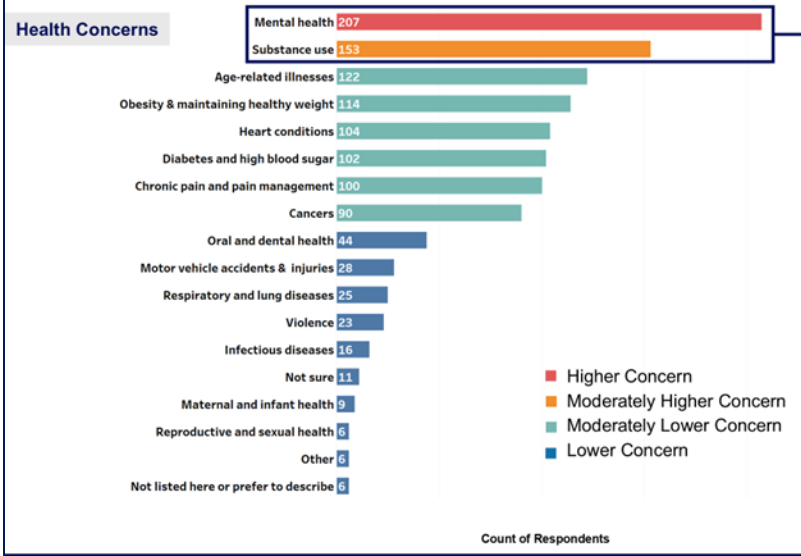
2024 Community Health Needs Assessment Survey

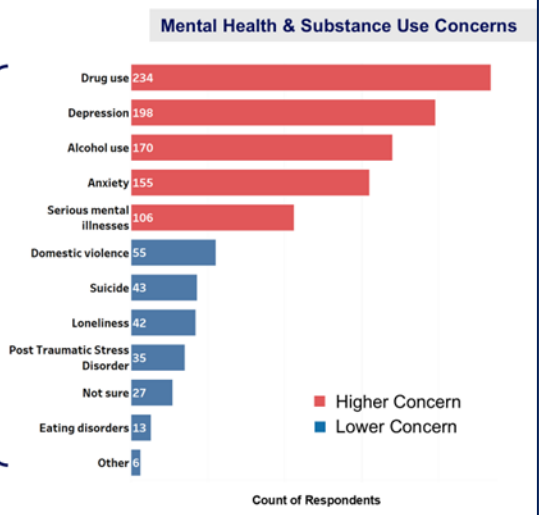
Preliminary survey data through June 2024 presented to community leaders

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

456 Total Respondents in Franklin & Crawford Counties

Community members identified mental health, substance use, age-related illnesses, and obesity as the top health concerns in Franklin and Crawford Counties. Among mental health and substance use-related needs, drug use, depression, alcohol use, and anxiety are top of mind for community members.





Notes

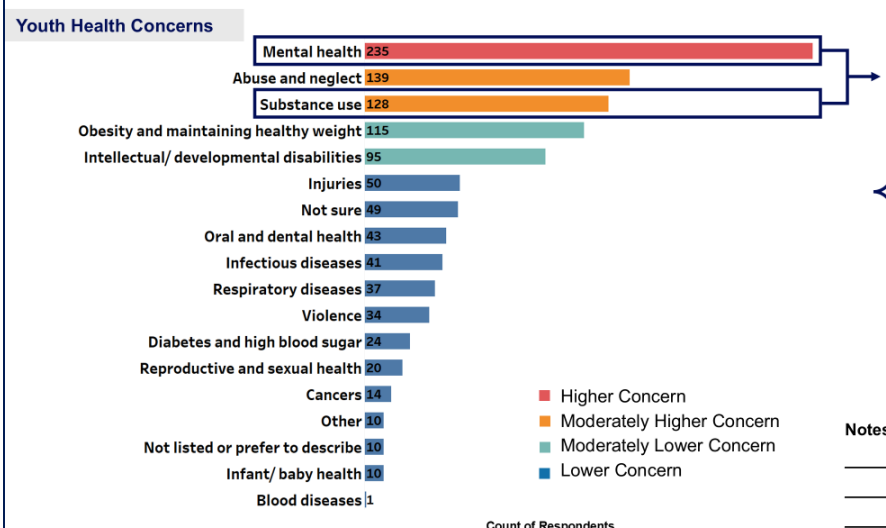
2024 Community Health Needs Assessment Survey

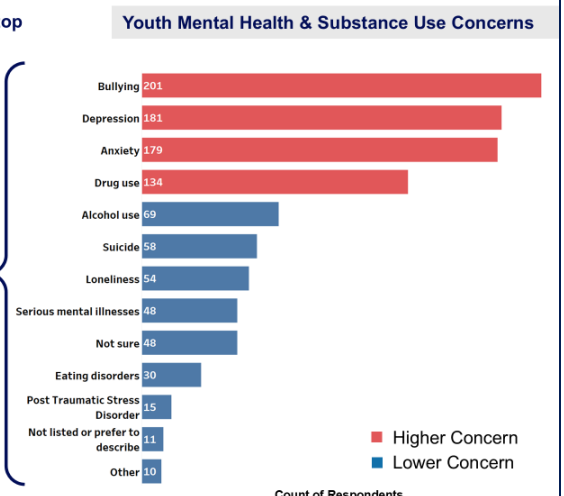
Preliminary survey data through June 2024 presented to community leaders*

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

456 Total Respondents in Franklin & Crawford Counties

Community members identified mental health, abuse and neglect, substance use, and obesity as the top health concerns for children and youth in Franklin and Crawford Counties. Among mental health and substance use-related needs, bullying, depression, anxiety, and drug use are top of mind.





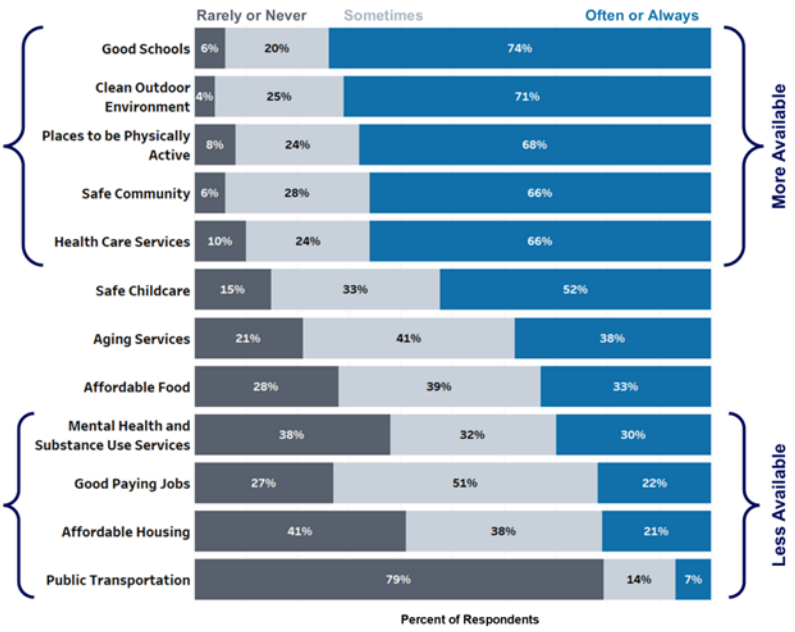
Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders*

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

456 Total Respondents in Franklin & Crawford Counties



Community members rated the availability of several resources in Franklin and Crawford Counties.

Good schools, clean outdoor environment, places to be physically active, safe community, and health care services were rated as being more available, with over 65% of respondents indicating that the resources were often or always available in their community.

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

Notes

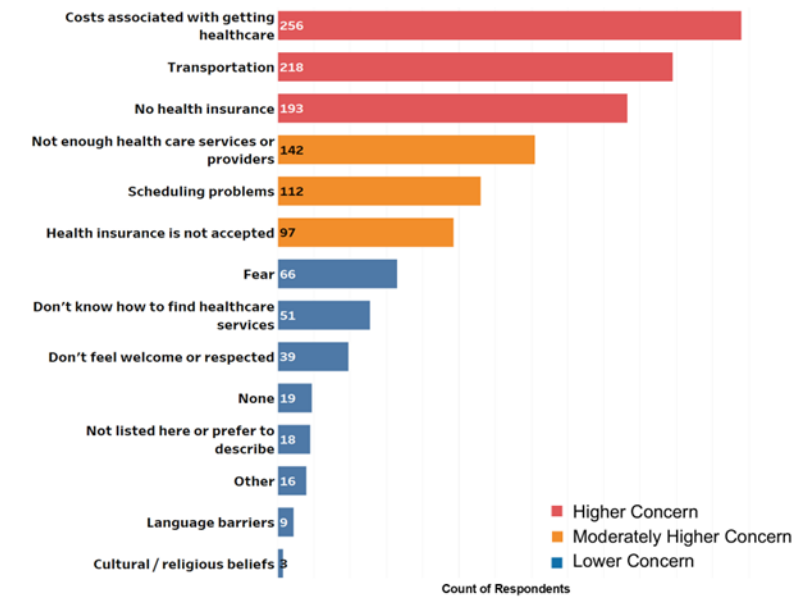
2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

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

456 Total Respondents in Franklin & Crawford Counties

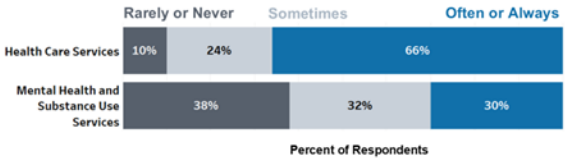
Barriers to Health Care Access



Sixty-six percent (66%) of community members who responded to the survey indicated that health care services were often or always available in Franklin and Crawford Counties. Only 30% indicated that mental health and substance use services had good availability.

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

Health Care Service Availability



Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

Appendix G: Community Leader Conversation Participants

Missouri Baptist Sullivan Hospital: Community Leader Conversation Participants			
Organization	**First Name**	**Last Name**	**Title**
Carl Duff Ministries: House of Hope	Carl	Duff	Founder
Crawford County Health Department	Amanda	Ramstein	Registered Nurse
Franklin County Health Department	Tony	Buel	Health Department Director
Franklin County Community Resource Board	Danielle	Louis	Chief Program Director
Grace United Methodist Church	Susan	Youmans	Pastor
Hope Ranch of Missouri	Jennifer	Hope	Executive Director
Life House Youth Center	Jennifer	Massie-Fadler	Executive Director
Life House Youth Center	Kayla	Watters	Operations Manager
Lowes Landscaping	Erik	Lowes	Owner
Mission Volunteer / Homeless Task Force	Marcie	Michel	Volunteer
Realtor / Heath Fairs	Kelly	Johnston	Owner
Russell House	Jessica	Hanner	Crawford County Outreach
Russell House	Shelley	Swearingin	Outreach Director
Sullivan C-2 School District	Matt	Peregoy	Superintendent
Sullivan PD	Patrick	Johnson	Chief

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** | Sullivan Fire House – October 29, 2024 – 15 participants
- **Community Members** | Grace United Methodist Church – December 12, 2024 – 12 participants

Community Leader Conversation on Health Needs

Mental Health

- Mental health – stigma and trust are the biggest issues
- Mental health is high/a concern in the community
- Anxiety for children is a problem

Substance Use

- Substance us drives the communicable disease outbreaks in the community
- Substance use is high/a concern in the community

Obesity and Maintaining Healthy Weight

- Obesity and lack of nutrition is a serous issue for youth and adults

Community Leader Conversation on Health Resources

Public Transportation

- Transportation is a very serious struggle
- EZMO Transportation offers transportation to doctors appointments, grocery shopping, etc.

Mental Health and Substance Use Services

- Need inpatient drug treatment resources

Affordable Housing

- Enforcement of housing quality/safety is nonexistent.
- Hotels are operating as long-term housing due to a lack of other affordable options

Affordable, Healthy Food

- Meals on wheels is no longer delivering to Senior center

Community Member Conversation on Health Needs

Mental Health

- Mental health
- Stigma around mental health
- Mental disability
- Increase in worry and stress
- Seniors have depression and loneliness
- PTSD
- People are more depressed

Substance Use

- Individuals are turning to alcohol and other substances
- Addiction

Age-Related Illnesses

- Seniors have depression and loneliness

Heart Conditions

- Increased blood pressure

Diabetes and High Blood Sugar

- Diabetes seen as a health concern

Infectious Diseases

- Need access to clean needles, safe injection sites to help the health of those with substance use disorder and stop the spread of diseases

Community Member Conversation on Health Resources

Public Transportation

- There is a lack of public transportation
- EZMO transportation app is available to help with transportation
- Medicaid transportation is getting better
    - Also seen as unreliable
- Taxis are available
- MTM Transportation covers Medicare and other insurances for transportation

Mental Health and Substance Use Services

- Mental health impedes access to work
- Compass Health Network

- Getting help for mental health is taking longer than before
- There are sober living places available

Affordable Housing

- Homelessness for seniors
- No affordable housing
- Shelters are limited

Affordable, Healthy Food

- There is a lack of access to healthy foods

Safe Childcare

- Lifehouse Center is an under advertised resource

Safe Community

- Need places for the homeless to go
- Housing seen as unsafe
- Grace's Place Crisis Nursery is a resource to help parents
- Library is seen as a resource in the community

Places to be Physically Active

- Clean parks

Good Schools

- Education is the key

Health Care Services

- Long wait times to see a provider
- Distance and general access is a major challenge
- Hard for older adults to get access to technology and make appointments
- It takes to long to get an appointment

Appendix I: Hospital Team Survey

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

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

Tell Us About Your Community

1. **Which hospital do you represent?**
   Enter the name of the hospital where you primarily work:_____

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

2. **Thinking about the community that your hospital serves, how available are the following resources?**
   For each resource below, choose a number from 1 to 5, where 1 means *Never available*, and 5 means *Always available*. If you do not know, choose *Not sure*.

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

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

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

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

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

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

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

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

Thank you for your time and input!

Appendix J: Hospital Community Health Needs Selection Team

Missouri Baptist Sullivan Hospital 2025 Community Health Needs Selection Team Attendees 05/12/2025			
Last Name	**First Name**	**Title**	**Department**
Alfermann	Tiffanie	Manager, Patient Care - IV	Med/Surg
Bliss	Nichole	Manager, Patient Care - IV	Emergency Room
Heine	Blyss	Strategist Marketing	MC-Hospital Marketing
Jeffrey	Christopher	Manager, Social Work	Case Management / Social Services
Koons	Michelle	Manager, Patient Care - IIII	Post Partum
Manoogian	Karyn	Manager, Finance	Finance Operations
Searcy	Lisa	Manager, Risk & Compliance	Risk & Compliance
Steinbach	Wendy	Community Health Worker	Social Services
Voss	Tiffany	Practitioner, Nurse	MBSH Medical Clinic
Wildhaber	Amy	Director, Operations & Support Services / Community Health Improvement Lead	General Administration

Appendix K: Elevated Health Needs Ranking Process

Our Goal

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

Data Sources Used

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

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

How we Sorted Each Need

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

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

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

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

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

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

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