2025-2028 Community Health Needs Assessment and Improvement Plan

BJC HealthCare
Memorial Hospital

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

A Message from Bob Cannon, President, BJC HealthCare, and Deborah Graves, President, Memorial Hospital

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

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

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

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

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

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

Sincerely,

Bob Cannon
President, BJC HealthCare

Deborah Graves
President, Memorial Hospital

Table of Contents

About BJC HealthCare

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

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

BJC HealthCare

Purpose

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

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

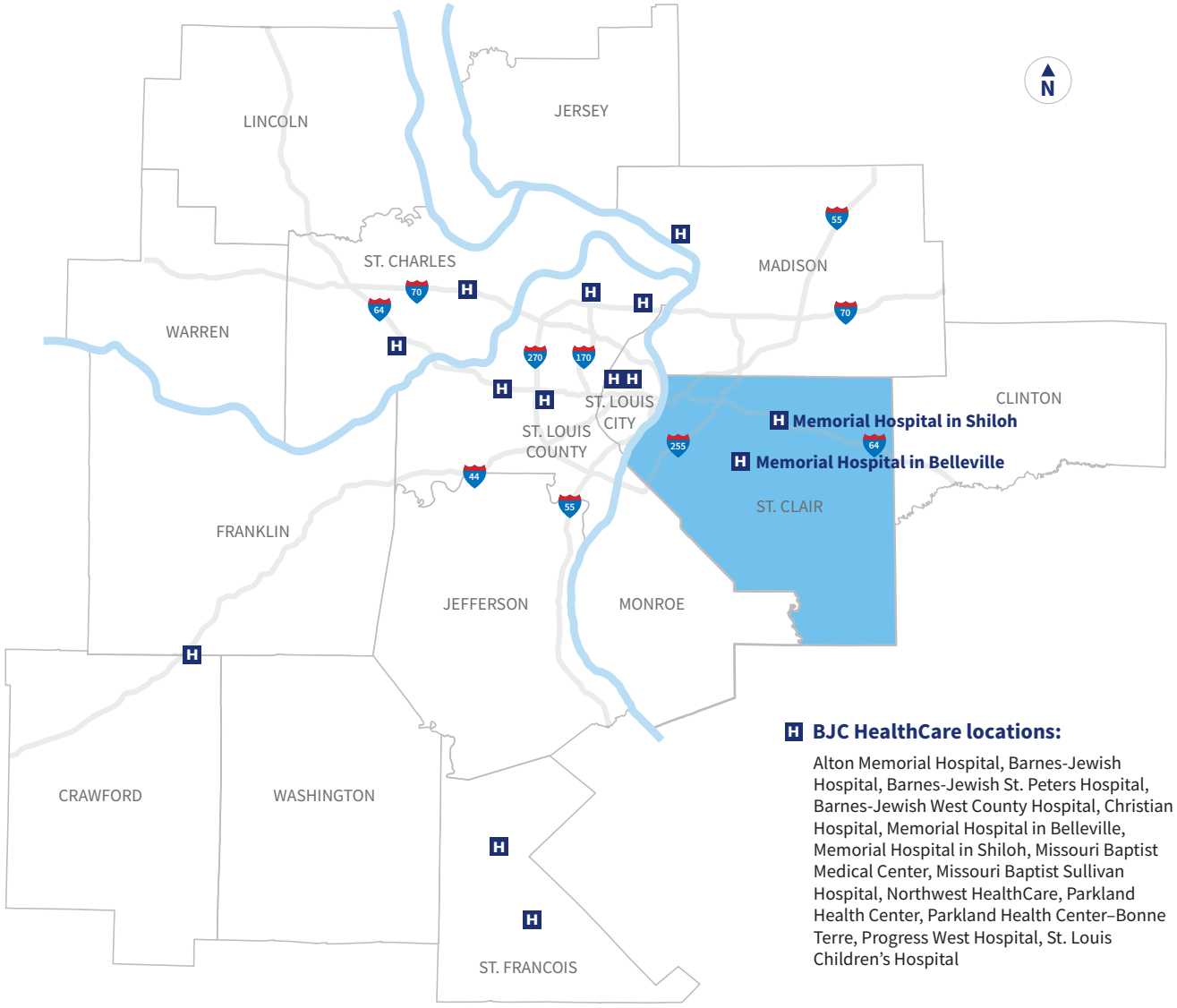
All nonprofit hospitals, including all BJC HealthCare hospitals, are required to do a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community of focus.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

Memorial Hospital Belleville & Shiloh and the Community We Serve

The Memorial Hospital Belleville & Shiloh Community Health Needs Assessment is focused on **St. Clair County, Illinois**. There are two Memorial Hospital locations. One is in Belleville, Illinois, and the other is in Shiloh, Illinois. Memorial Hospital Belleville & Shiloh is the largest health care provider in the region. Both locations are Magnet®-recognized hospitals, the highest achievement for excellent nursing.

Memorial Hospital in Belleville and **Memorial Hospital in Shiloh** are parts of the larger BJC service area, which includes health care locations across the St. Louis region.



The **Belleville location** is an acute care hospital. This means it provides short-term medical treatments. Short-term care includes:

- Emergency and intensive care
- Diagnosis and treatment of injury and illness
- Surgery and short-term recovery

This location also has a complete rehabilitation program and the Memorial Care Center, which is a short-term rehabilitation center for older adults.

The **Shiloh location** has a 24/7 Emergency Department in addition to medical, surgical, and diagnostic services. This location is home to the only Siteman Cancer Center location in Illinois. The Siteman Cancer Center is a **nationally recognized leader for cancer care**. The Memorial Family Care Birthing Center provides a family-centered birthing experience and specialized emergency care services for pregnant people and newborns.

Memorial Hospital in Belleville and **Memorial Hospital in Shiloh** Community Health Needs Assessment service area close-up

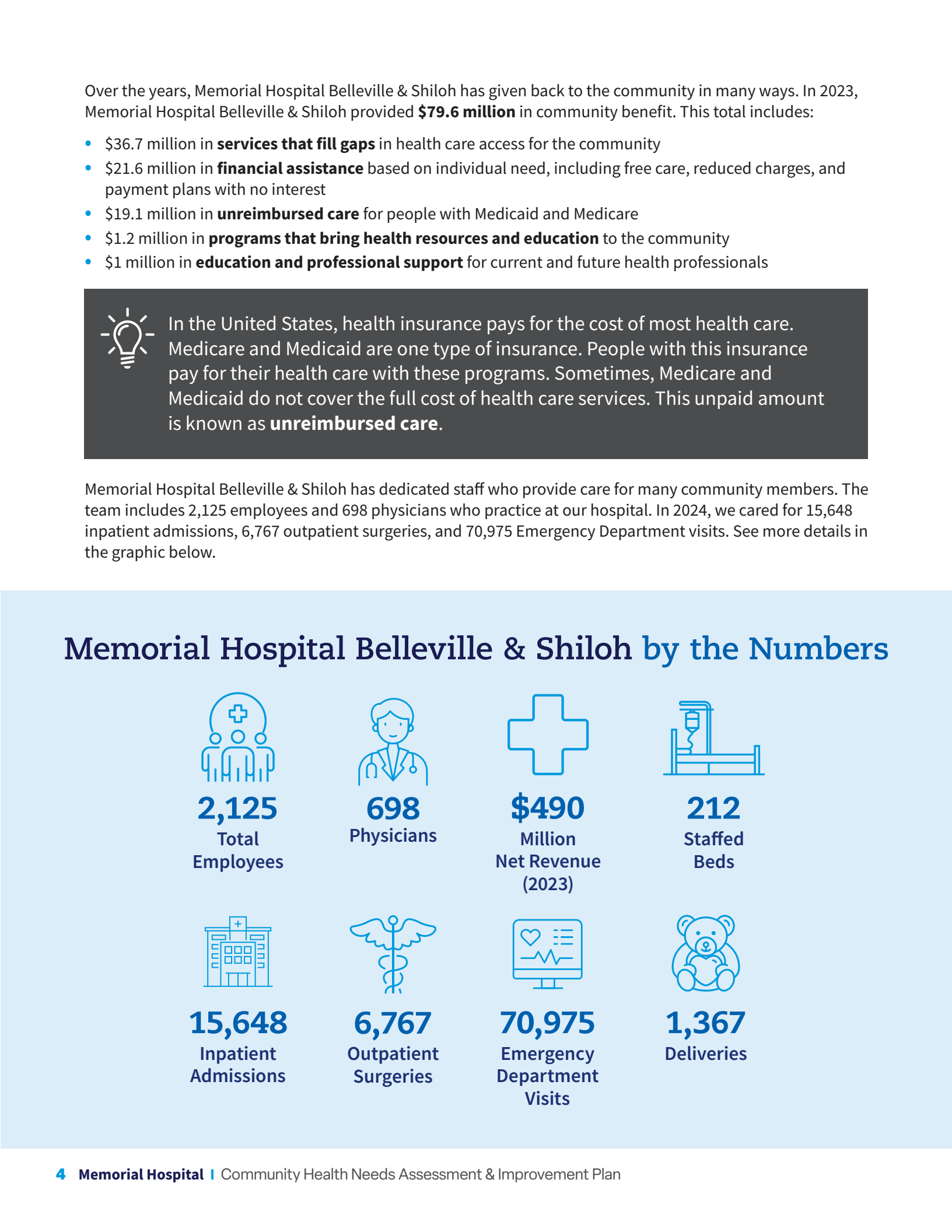
Over the years, Memorial Hospital Belleville & Shiloh has given back to the community in many ways. In 2023, Memorial Hospital Belleville & Shiloh provided **$79.6 million** in community benefit. This total includes:

- $36.7 million in **services that fill gaps** in health care access for the community
- $21.6 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- $19.1 million in **unreimbursed care** for people with Medicaid and Medicare
- $1.2 million in **programs that bring health resources and education** to the community
- $1 million in **education and professional support** for current and future health professionals

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**.

Memorial Hospital Belleville & Shiloh has dedicated staff who provide care for many community members. The team includes 2,125 employees and 698 physicians who practice at our hospital. In 2024, we cared for 15,648 inpatient admissions, 6,767 outpatient surgeries, and 70,975 Emergency Department visits. See more details in the graphic below.

Memorial Hospital Belleville & Shiloh by the Numbers



About **250,000 people** call St. Clair County home.[1] The county is not as crowded as an urban area, but not as spread out as a rural one.[1] More than half of the people who live in St. Clair County are white, and about one in five residents are older than 65 years.[1] The life expectancy for St. Clair County residents is about 74 years, which is about four years less than the life expectancy for all Illinois residents.[2]

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

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

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

In St. Clair County, **nearly all residents have a high school degree**.[1] High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in St. Clair County is about $70,000 per year.[1] This is lower than the median state household income.[1]

About one in five children in St. Clair County live in poverty.[1] This is more than in Illinois, where one in seven children live in poverty.[1]

Community Feature: Scott Air Force Base

Scott Air Force Base is located in St. Clair County, near Belleville. Scott Air Force Base is one of the oldest, continuous Air Force installations in the United States.[3] It first opened in 1917, when pilots and crews were being trained for World War I.[4] During World War II, Scott Air Force Base trained students in communications and radio operations.[4] Today, it is home to the 37th Air Mobility Wing, the 618th AOC (TACC), the 18th Air Force, Air Mobility Command, and the United States Transportation Command.[4] Scott Air Force Base employs 13,100 people and is the largest employer in southwest Illinois.[5] Scott Air Force Base has an economic impact on the community of $3 billion.[5]

Scott Air Force Base, Scott AFB, Illinois

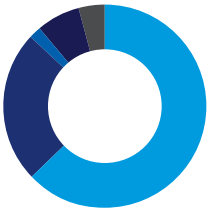
Memorial Hospital Belleville & Shiloh
Community Characteristics

St. Clair County

Population
254,777

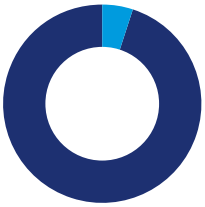
Land Area
658 sq. mi.

Race



61% White
28% Black
2% Asian
7% 2 or more races
2% Other*

Ethnicity



5% Hispanic/ Latino
95% Not Hispanic/ Latino

Most people have at least a high school education

St. Clair Co.	Illinois
93%	90%

Life Expectancy

St. Clair Co.	Illinois
74	78

The median household income in St. Clair County is somewhat lower than for the state of Illinois

St. Clair Co.	Illinois
$70,178	$81,702

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

St. Clair Co.	Illinois
44%	44%

Poverty rates among children in St. Clair County are higher than in the state of Illinois

St. Clair Co.	Illinois
19%	15%

People over 65

St. Clair Co.	Illinois
17%	17%

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.

Memorial Hospital Belleville & Shiloh Community Health Needs and Goals from 2022–2025

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

Mental Health

Goal: Fund programs and services that address mental and behavioral health in elementary and middle schools located in Memorial's primary service area.

Maternal and Infant Health

Goal: Reduce infant mortality and improve disparity in infant mortality by reducing unsafe sleep deaths.

Substance Use Disorder

Goal: Prevent individual relapse of substance use disorder in St. Clair County.

Mental Health

Our Strategy ▸

We wanted to address mental and behavioral health in St. Clair County residents. We planned to do this in many ways.

First, we wanted to **support programs that address students' mental and behavioral health**. Memorial Foundation funded Social Emotional Learning programs. These programs were in elementary and middle schools in St. Clair County and some neighboring communities. Social Emotional Learning programs teach young people how to manage their feelings, make decisions, and build healthy relationships.[6]

Second, we wanted to **support community organizations that focus on mental health**. We worked with Memorial Foundation to fund these community organizations. We planned to specifically support community programs that focus on mental and emotional health. We also planned to expand the reach of our relationships. We wanted to find organizations with missions and visions that fit with Memorial Foundation's strategic plan.

Third, we wanted to stay in touch with the organizations and programs we supported. We planned to document and **report on the progress of each organization** every year.

Our Progress ▸

Memorial Foundation **gave funding to six nearby school districts for Social Emotional Learning programs**. With this funding, elementary and middle schools were able to:

- Buy materials and tools to teach Social Emotional Learning
- Host a Girls Empowerment event, which included self-care, bonding, and conversations about confidence, leadership, and personal growth
- Develop and decorate a sensory room, which is a comfortable space to help people calm down
- Work with organizations to offer private counseling
- Plan and provide self-care opportunities for school staff

Memorial Hospital Belleville & Shiloh also **funded two community organizations: Metro East Every Survivor Counts and Heartlinks Grief Center**.

At Metro East Every Survivor Counts, the funding was used for:

- Counseling for survivors of sexual assault
- Medical or legal support for survivors of sexual assault
- Community education about preventing sexual assault

At Heartlinks Grief Center, the funding was used for:

- Counseling, especially for trauma
- Support groups and workshops on suicide loss in offices, schools, and the community
- Suicide prevention programs and support for people impacted by suicide

Memorial Hospital Belleville & Shiloh also supported staff through the **Employee Annual Wellness Program**. Memorial Foundation gathered information from these funded programs to track progress.

Maternal and Infant Health

Our Strategy ▸

We wanted to **reduce unsafe sleep deaths**. We thought teaching families about safe sleep practices could help prevent unsafe sleep deaths. We planned to help St. Clair County families improve their knowledge of safe sleep during their time at Memorial Hospital. We planned to:

- Educate staff on safe sleep
- Find out which families need a safe sleep place for their baby
- Educate those families about safe sleep
- Give those families portable cribs when they leave the hospital

We wanted to ensure this plan improved knowledge of safe sleeping. We planned to give families a test before and after we taught them about safe sleeping. By comparing the test scores, we would see if there was a change in knowledge of safe sleep. We wanted families to improve their knowledge of safe sleep by 10%.

Our Progress ▸

In 2023, our team gave out 37 portable cribs. In 2024, our team gave out 14 portable cribs. The families who got these cribs also met with a social worker to discuss and find resources for any of their other health needs. During their hospital stay, these parents learned about safe sleep from hospital staff and watched a video about safe sleep.

Substance Use

Our Strategy ▸

Substance use disorder is a difficult condition to manage. Maintaining sobriety can be challenging. We wanted to prevent substance use relapse for St. Clair County residents. We thought connecting patients to support may help **prevent substance use relapse**.

We planned to connect patients with substance use disorder to peer recovery specialists. Our peer recovery specialists are people who have been successful in substance use recovery. They are trained and certified to help others in recovery.

We planned to connect our patients to more support in many ways. First, we needed to identify which patients could benefit from support. We identified patients in our Emergency Departments with substance use disorder. Then, we planned for social workers to meet with the patients and provide more support. This included sharing information about our Peer Recovery Program and giving them community resources. On the weekends and at times when social workers were not present, nurses recorded which patients came to the Emergency Department with substance use disorder. That way, our social workers could follow up with our patients within one or two days. Our social workers planned to reach out for follow-up care up to three times. During these conversations, our social workers planned to explain our Peer Recovery Program to our patients with substance use disorder.

If patients agreed to join the program, our social workers would connect patients to peer recovery specialists. Social workers could also directly refer patients to rehabilitation programs if patients asked for it.

We planned to connect at least 50% of our patients with substance use disorder to a peer recovery specialist. We wanted at least 5% of these patients to maintain their sobriety after working with the peer recovery specialists for one year.

Our Progress ▸

The Peer Recovery Specialist program became the Memorial Hospital Belleville & Shiloh Medical Stabilization program. This program started in October 2023 to support adults with substance use disorders. The Medical Stabilization team includes peer recovery specialists, nurses, and physicians.

In 2024, **the Medical Stabilization program helped 844 patients**. The team worked with patients at their hospital bedsides, in the Emergency Department, and over the phone. Of the 844 patients, 100 were admitted to the hospital for **detoxification**, or detox. They were not referred for treatment after their hospital stay. 129 came in for detox and then were referred to a treatment program.

Detoxification, or detox, is the process of removing a substance like alcohol or opioids from your body. Health care professionals can help people go through detox safely.

Peer recovery specialists consulted with 344 people. They visited the hospital beds of patients with a substance use concern and another medical need.

There were 82 substance use support visits to patients in the Emergency Department.

Where We Are Today…

2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of the St. Clair 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. Clair 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. Clair 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. See more details in Appendix B and Appendix C.

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. Clair County. 274 community members completed the survey.

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

We learned that costs, not enough providers, and scheduling problems were serious challenges to getting care. The community needs more affordable housing, mental health care, and good paying jobs. See more details in the list on the right.

COMMUNITY SURVEY

Top 5 Health Problems

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

Top 5 Mental Health Concerns

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

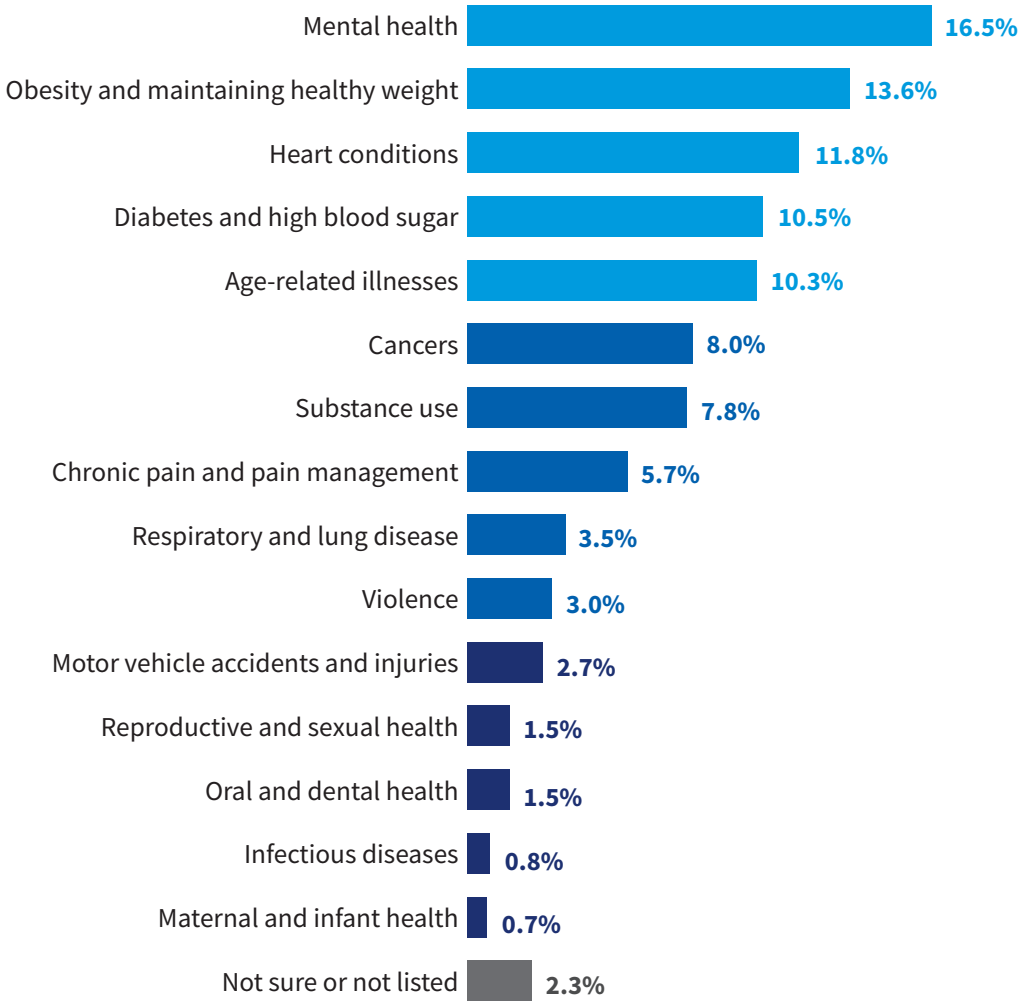
Top 5 Barriers to Care

1. Costs
2. Not enough services or providers
3. Scheduling problems
4. Health insurance is not accepted
5. Transportation

Top 5 Community Resource Needs

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

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



Community Information

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

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

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

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

We used HCI's Data Scoring Tool to compare St. Clair County with other communities, national goals from Healthy People 2030, and past community health information.

The top health needs from HCI were heart disease and stroke, sexually transmitted infections, and prevention of and safety from violence. The top social determinants of health needs were physical activity, community (like the use of public transportation and access to the internet), and economy (like poverty and employment rates). See more details in the list on the right.

COMMUNITY INFORMATION

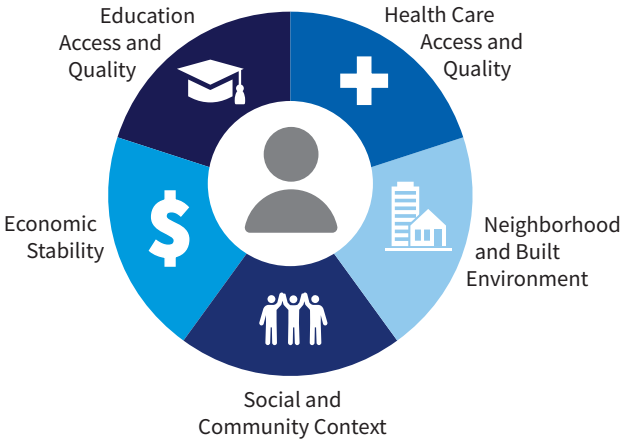
Top 5 Health Problems

1. Heart disease and stroke
2. Sexually transmitted infections
3. Prevention and safety
4. Maternal, fetal, and infant health
5. Cancer

Top 5 Most Needed Social Determinants of Health

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

Social Determinants of Health



Community Conversations

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

Community Leaders

We invited many community leaders to meetings at Shiloh Church. 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, obesity and maintaining healthy weight, heart conditions, diabetes and high blood sugar, and others. They thought these health needs were the most important to focus on.

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

Deborah Graves, president of Memorial Hospital, speaking at Community Leader Conversation at Shiloh Church, Shiloh, Illinois

COMMUNITY LEADER CONVERSATIONS

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

Discussed Community Health Needs

- Mental health
- Obesity and maintaining healthy weight
- Heart conditions
- Diabetes and high blood sugar
- Age-related illnesses
- Substance use
- Infectious diseases
- Maternal infant health

Discussed Community Health Resources

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

Community Members

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

We spoke with many community members in meetings at Downtown Belleville YMCA. We asked community members which health needs were the most important to them. Community members discussed mental health, obesity and maintaining healthy weight, heart conditions, diabetes and high blood sugar, and others.

We then asked community members which community resources were most needed. They discussed affordable housing; good paying jobs; affordable, healthy food; health care services; and others. See more details in the list on the right.

Downtown Belleville YMCA, Belleville, Illinois, where conversations with community members took place

COMMUNITY MEMBER CONVERSATIONS

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

Discussed Community Health Needs

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

Discussed Community Health Resources

- Affordable housing
- Good paying jobs
- Affordable, healthy food
- Health care services
- Clean outdoor environment
- 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 Memorial Hospital Belleville & Shiloh. 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 Memorial, the most common reasons patients visit the hospital are for hypertension, diabetes, and cancer. See more details in the list below.

HOSPITAL SERVICE INFORMATION

Top 5 Health Conditions

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

Hospital Team Survey

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

HOSPITAL TEAM SURVEY

Top 5 Community Health Needs

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

Top 5 Most Needed Community Health Resources

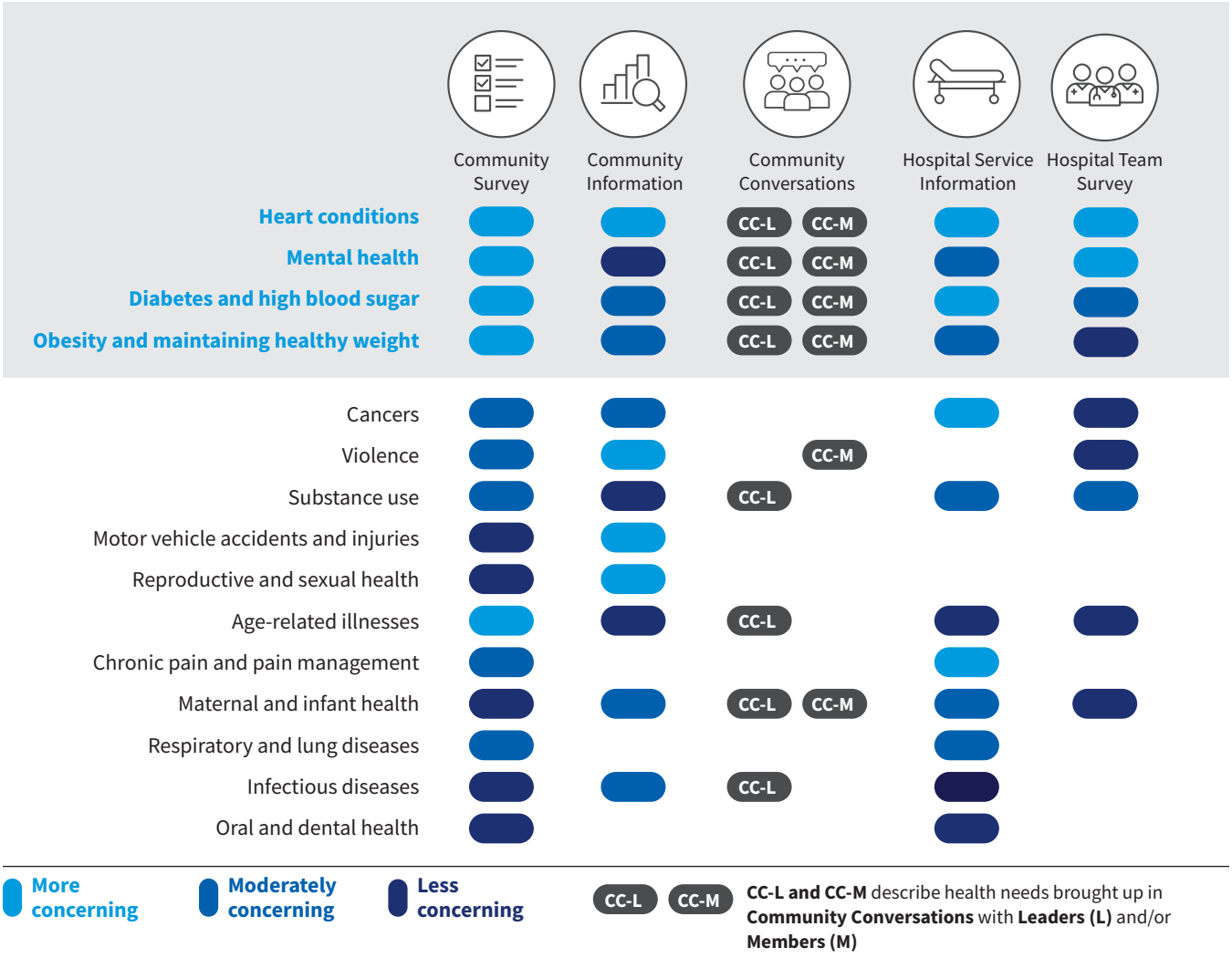
1. Public transportation (tie)
1. Mental health and substance use services (tie)
1. Affordable housing (tie)
2. Aging services (tie)
2. Good paying jobs (tie)

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 Memorial Hospital Belleville & Shiloh. These needs are **heart conditions**, **mental health**, **diabetes and high blood sugar**, and **obesity and maintaining healthy weight**. 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 Memorial Hospital Belleville & Shiloh community**.



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

How the Needs Were Selected

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

Health Needs We Will Not Prioritize in This CHIP

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

Hospital Team Conversation

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

We decided not to focus on heart conditions because they are often caused by other health issues, like diabetes and obesity. We wanted to support heart health by focusing on these causes.

We decided not to prioritize mental health because we don't have enough mental health care providers in the area right now. This is an important need, but our team feels we need a stronger foundation. To help with this, Memorial Foundation will offer mental health-focused grants as part of its 2026–2027 plan. We also plan to help involve social workers in schools. We are connected to regional mental health resources like BJC Behavioral Health. While we work on increasing mental health resources in our community, we wanted to choose needs we can improve in the next three years.

Health Needs We Will Prioritize in This CHIP

Maternal and infant health was not in the top-ranked needs, but our team decided to prioritize it for two reasons. First, we know we have programs and resources that can help in this area. For example, we have recently expanded substance use treatment teams to our pregnancy and childbirth department (obstetrics). We also have access to resources and programs to help with safe sleep, breastfeeding, and social support.

Second, we know that all surveys can have limitations because of who does or does not participate. We were concerned that our survey may have missed some residents of child-bearing age. We wanted to make sure their needs were still included. Each time we conduct a Community Health Needs Assessment, we try to expand the number and kinds of people who take our survey. We will continue to work on improving the reach of our survey in the future.

We also decided to prioritize **obesity and maintaining a healthy weight** and **diabetes and high blood sugar**. These were both in the top-ranked health concerns. Both needs are current community problems and focus areas for Memorial Hospital Belleville & Shiloh. They can also both be addressed by healthy lifestyle strategies.

A Closer Look at Our Prioritized Needs

We decided to prioritize obesity and maintaining healthy weight, diabetes and high blood sugar, and maternal and infant health. This is how we define these concerns.

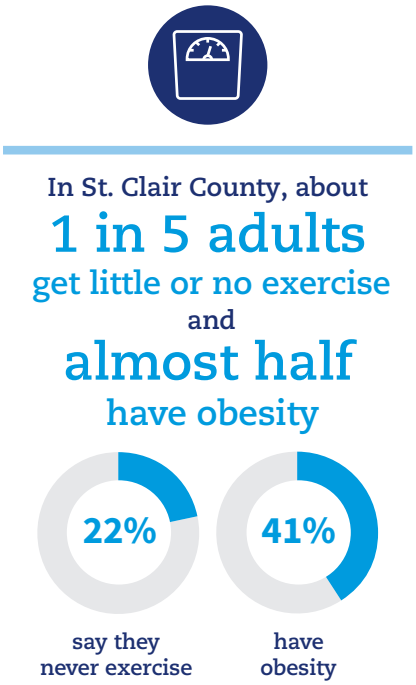
Obesity and Maintaining Healthy Weight

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

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

Many of these factors are **affected by social determinants of health** that make it easier or harder to be healthy. These determinants can include walkable neighborhoods and education.[7]

Obesity is linked to long-term health conditions like heart conditions, diabetes, and cancers.[8] About 4 in 10 adults in St. Clair County have obesity.[9]



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]

Diabetes and High Blood Sugar

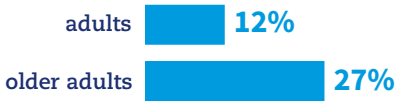
Diabetes is a metabolic condition that affects how the body uses food for energy.[11] There are three types of diabetes:

- **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.[11] 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.[11] These changes include exercising more and eating healthy foods.

In St. Clair County, about 1 in 10 adults over 20 years old have diabetes.[9] This is more than most other counties in Illinois.[9]

In St. Clair County, about
1 in 10 adults
and more than
1 in 4 older adults
have diabetes



SOURCE: Conduent Healthy Communities Institute

Maternal and Infant Health

Maternal and infant health cover many areas of health. It includes:

- Preterm birth, which is giving birth at fewer than 37 weeks
- Diabetes, high blood pressure, and other pregnancy complications
- Substance use during pregnancy
- Postpartum depression
- Infant illness or death

Babies who are born too early or with low birth weight are **more likely to have breathing problems, developmental delays, vision problems, and other health issues** as children and as adults.[12,13]

About 1 in 10 babies in St. Clair County have low birth weight, which is about the same as both Illinois and U.S.[9] About 1 in 10 babies in the county are born too early, which is the same as in Illinois.[9]

About 9 for every 1,000 babies born die before the age of 1 in St. Clair County, compared to about 6 for every 1,000 in the state.[9]

In St. Clair County, about
1 in 10 babies
have low birth weight,
more than in the
state of Illinois or the nation

St. Clair Co.	Illinois	U.S.
12%	9%	9%

SOURCE: Conduent Healthy Communities Institute

Where We're Going

2026–2028 Community Health Improvement Plan (CHIP)

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

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

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

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

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

CHNA Health Need:
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: Partner with School Outreach and Youth Development to provide education for healthy eating and healthy lifestyle.

MEASURES:
- # /type of classes offered
- # of students served
- % of students reporting knowledge change

Category: *Capacity building*

INITIATIVE: Collaborate with community to install and maintain a Storybook Walk, an outdoor activity that combines reading and exercise by posting pages of a children's book along a path, allowing families to read the story together as they walk.

MEASURES:
- # of Storybook Walks developed

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: Reduce 30-day readmission rates for patients with Type 2 diabetes on Medicaid who have been connected to a community health worker. The community health worker will link these patients who have social determinants of health needs to community resource providers.

MEASURES:
- # of social determinants of health needs referrals created
- # of patients connected to a community health worker
- % change in 30-day readmission rate for patients with Type 2 diabetes

CHNA Health Need:
Maternal and Infant Health

Goal: Increase access to education and connections to supportive care to improve maternal and infant health outcomes

Category: *Connection to resources*

INITIATIVE: Provide mothers with education and resources to ensure a safe sleep environment for their infants by providing pack-n-plays to those mothers identified as lacking safe sleep resources upon discharge.

MEASURES:
- % of patients identified as lacking safe sleep resources that are provided pack-n-plays
- # of patients receiving pack-n-plays

Category: *Health education*

INITIATIVE: Provide prenatal, in-hospital, and post-discharge lactation support to improve exclusive breastfeeding rates among new mothers.

MEASURES:
- % of mothers planning to exclusively breastfeed
- # of mothers planning to exclusively breastfeed
- % of mothers that planned to and are exclusively breastfeeding at discharge

What Comes Next

Looking Forward

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

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

References

1. Social Explorer Tables: ACS 2023 (5-Year Estimates). Suitland, MD: U.S. Census Bureau; 2023. Accessed July 31, 2025. https://www.socialexplorer.com/tables/ACS2023_5yr/R13882959.

2. County Health Rankings & Roadmaps. Accessed July 29, 2025. https://www.countyhealthrankings.org.

3. City of Belleville. *Scott Air Force Base*. YouTube. Published November 3, 2020. Accessed October 14, 2025. https://www.youtube.com/watch?v=-vLao9sB8cU.

4. Scott Air Force Base history. Scott Air Force Base. Updated May 2017. Accessed October 14, 2025. https://www.scott.af.mil/About-Us/Fact-Sheets/Display/Article/159788/scott-air-force-base-history/.

5. 375th AMW mission. Scott Air Force Base. Accessed October 14, 2025. https://www.scott.af.mil/About-Us/.

6. Fundamentals of SEL. Collaborative for Academic, Social, and Emotional Learning (CASEL). Accessed July 30, 2025. https://casel.org/fundamentals-of-sel/.

7. Javed Z, Valero-Elizondo J, Maqsood M, et al. Social determinants of health and obesity: findings from a national study of US adults. *Obesity*. 2022;30(2):491-502. doi: 10.1002/oby.23336.

8. Sarma S, Sockalingam S, Dash S. Obesity as a multisystem disease: trends in obesity rates and obesity-related complications. *Diabetes, Obesity and Metabolism*. 2021;23(S1):3-16. doi: 10.1111/dom.14290.

9. Data Scoring Tool. Conduent Healthy Communities Institute (2025). Memorial Hospital. March 10, 2025. https://admin-memhosp.thehcn.net/login.

10. About body mass index (BMI). Centers for Disease Control and Prevention. May 20, 2024. Accessed August 18, 2025. https://www.cdc.gov/bmi/about/index.html.

11. Diabetes basics. Centers for Disease Control and Prevention. July 19, 2024. Accessed July 25, 2025. https://www.cdc.gov/diabetes/about/index.html.

12. Jańczewska I, Wierzba J, Jańczewska A, Szczurek-Gierczak M, Domżalska-Popadiuk I. Prematurity and low birth weight and their impact on childhood growth patterns and the risk of long-term cardiovascular sequelae. *Children*. 2023;10(10):1599. doi: 10.3390/children10101599.

13. Grillo M, Mariani G, Ferraris J. Prematurity and low birth weight in neonates as a risk factor for obesity, hypertension, and chronic kidney disease in pediatric and adult age. *Frontiers in Medicine*. 2022;8. doi: 10.3389/fmed.2021.769734.

Photo Credits

A. Main Street, Belleville, IL. artistmac. Retrieved from https://www.flickr.com/photos/26329029@N06/14817168788/.

B. Scott Air Force Base. SSGT Chad R. Gann, USAF. Retrieved from https://commons.wikimedia.org/w/index.php?curid=889601.

C. Downtown Belleville YMCA. Retrieved from https://maps.app.goo.gl/kq6SbFu9iPp1zmDq7.

Appendices

Appendix A: Community Demographics

Demographics of St. Clair and Illinois		
	St. Clair	Illinois
POPULATION		
Population 2020	261,186	12,716,164
Population 2023 (estimate)	251,018	12,549,689
Population 2024 (estimate)	251,149	12,710,158
Population, Percent change - 2023 (estimate) to 2024 (estimate)	0.1	1.3
AGE		
Persons Under 5 Years, Percent, 2024	5.0	5.2
Persons Under 18 Years, Percent, 2024	22.3	21.2
Persons 65 Years and over, Percent, 2024	18.4	17.9
GENDER		
Female Persons, Percent, 2024	51.6	50.6
Male Persons, Percent, 2024	48.4	49.4
RACE/ETHNICITY		
White alone, Percent, 2024	59.8	60.2
White alone, not Hispanic or Latino, Percent, 2024	59.0	57.1
African American alone, Percent, 2024	28.5	13.2
Hispanic or Latino, Percent, 2024	5.3	19.4
Two or More Races, Percent, 2024	7.6	10.7
American Indian and Alaska Native alone, Percent, 2024	0.2	0.8
Asian alone, Percent, 2024	2.0	6.4
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.0	0.0
LANGUAGE		
Foreign Born Persons, Percent, 2024	3.6	15.4
HOUSING		
Housing Units, 2024	116,644	5,482,133
Homeownership Rate, Percent, 2024	68.7	67.6
Median House Value, Dollars, 2024	202,200	280,700
FAMILIES & LIVING ARRANGEMENTS		
Households, 2024	103,038	5,105,448
Persons per Household, 2024	2.4	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	4.8	24.5
EDUCATION		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	94.0	90.7
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	34.2	39.2
INCOME		
Median Household Income, Dollars, 2024	79,292	83,211
Per Capita Income in past 12 months (in dollars), 2024	41,134	46,937
People Living Below Poverty Level, Percent, 2024	11.8	11.6

Appendix B: Community Survey Tool

St. Louis Community Health Needs Assessment

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

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

Tell Us About Your Community

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

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

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

	1	2	3	4	5	
	Never	**Rarely**	**Sometimes**	**Often**	**Always**	**Not sure**
Safe childcare	☐	☐	☐	☐	☐	☐
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 <u>yourself or other adults</u> in the community where you live, what are the <u>top three</u> health problems?**

   Choose **<u>three</u>** items from the list that are a concern for **<u>yourself or other adults</u>** 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 <u>your or other children</u> in the community where you live, what are the <u>top three</u> health problems?**

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

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

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

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

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

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

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

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

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

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

Tell Us About You

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

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

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

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

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

11. Which of the following best describes you?

Choose one answer.

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

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

Choose one answer.

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

13. Which languages do you speak at home?

Choose all that apply.

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

14. What best describes your employment status?

Choose one answer.

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

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

Choose one answer.

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

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

Thank you for your time and input!

Appendix C: Community Survey Respondents Demographics

In St. Clair County, 274 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 1 to 33. On average, about 27% of participants did not answer the optional demographic questions. Among those who did respond, most were between 55 and 64 years old (21%), women (60%), White (57%), non-Hispanic (61%), and primarily English-speaking at home (72%). Many held advanced degrees such as a master's, professional, or doctorate degree (27%), were employed full time (56%), and reported a household income between $50,000 and $74,999 (14%).

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 | Encompass Health
The Rehabilitation Institute of Southern Illinois

BJC HealthCare Memorial Hospital

St. Clair 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

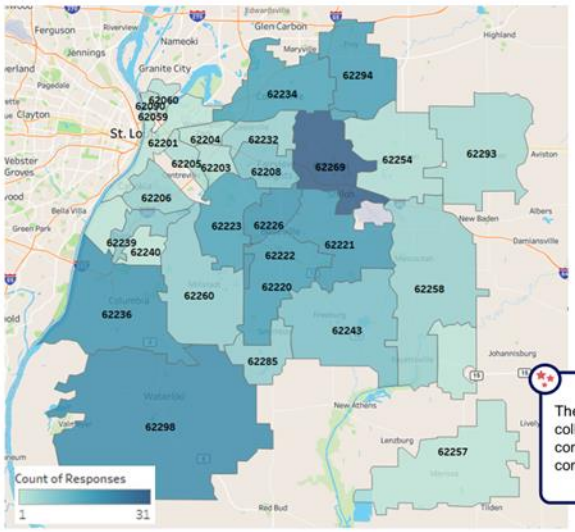
---

1 Who responded to the survey?

258
Total Respondents in St. Clair County

In St. Clair County, 258 community members responded to the community health needs survey. The number of survey respondents in St. Clair County ZIP codes ranged between 1 and 31.

Survey Respondents by ZIP code



Background & Context

In 2023, several partners (listed below) collaborated on a Community Health Needs Assessment to identify and prioritize community health needs in St. Clair County. As part of this process, feedback was collected from over 400 community members through an online survey.

Points of alignment and difference in key findings from the 2023 and 2024 surveys are noted on each slide – look for the star icon!

2023 CHNA Partner Agencies:
- St. Clair County Health Department
- East Side Health District
- BJC HealthCare (Memorial Hospital)
- Hospital Sisters Health System (St. Elizabeth's Hospital)

The 2023 St. Clair County CHNA survey collected responses from over 400 community members across several communities.

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

258 Total Respondents in St. Clair County

Over 20% of respondents in St. Clair County did not complete the optional demographic survey questions (non-respondents range from n=62 to 83, depending on the question).

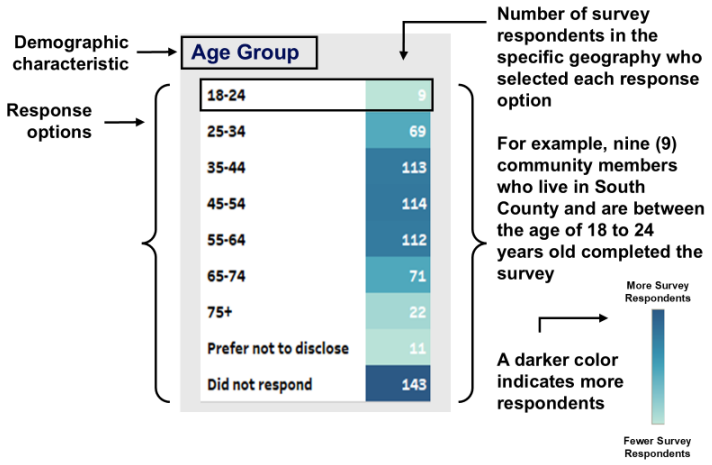
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=258).

Most respondents:

- Are between the age of 45 and 64 years old (40%)
- Are women (62%)
- Are White (60%)
- Are non-Hispanic (63%)
- Speak English at home (76%)
- Have a master's, professional, or doctorate degree (28%)
- Are employed full time (57%)
- Have a household income between $50,000 and $74,999 (14%)

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

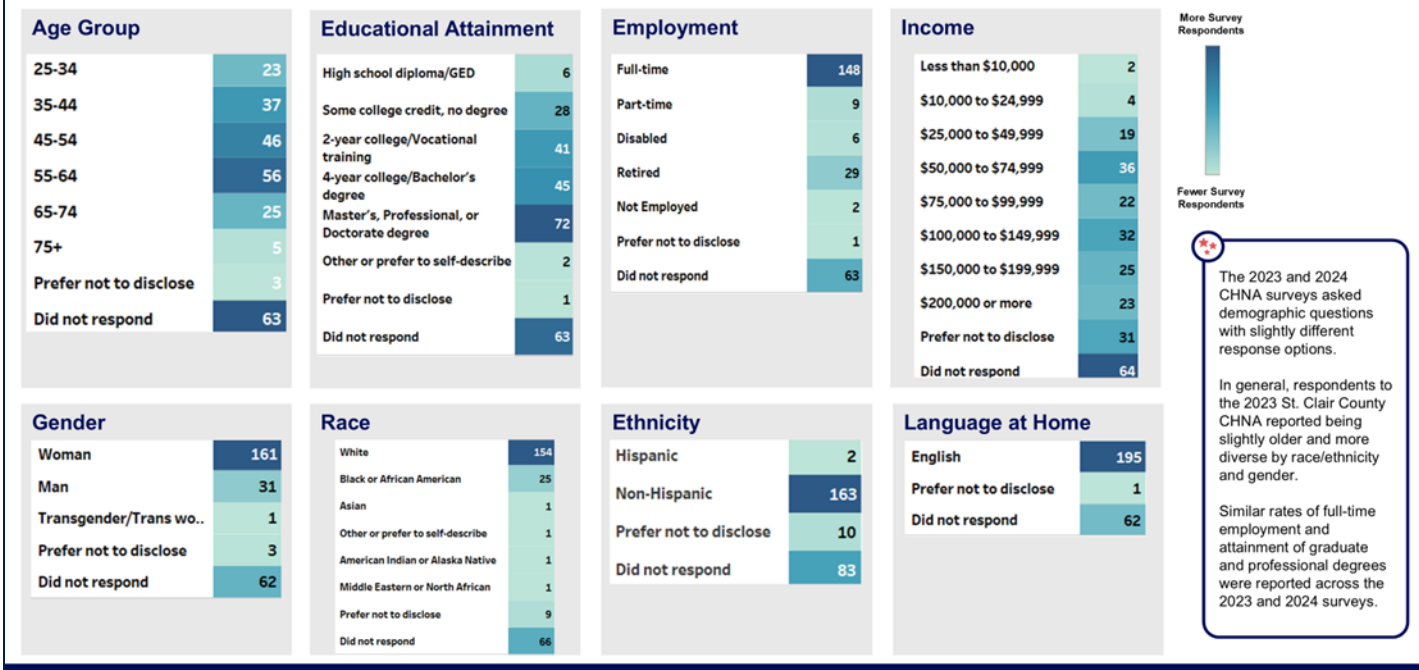
Example: Survey Respondents by Age Group



Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

258 Total Respondents in St. Clair County



2024 Community Health Needs Assessment Survey

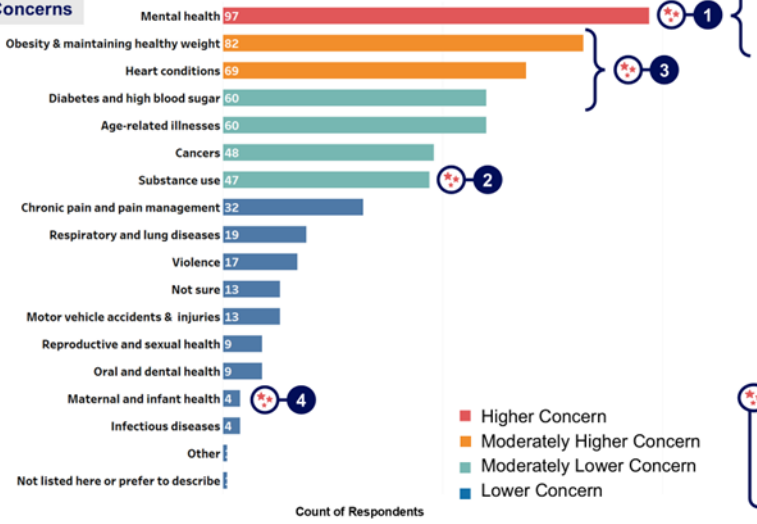
Preliminary survey data through June 2024 presented to community leaders*

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.)

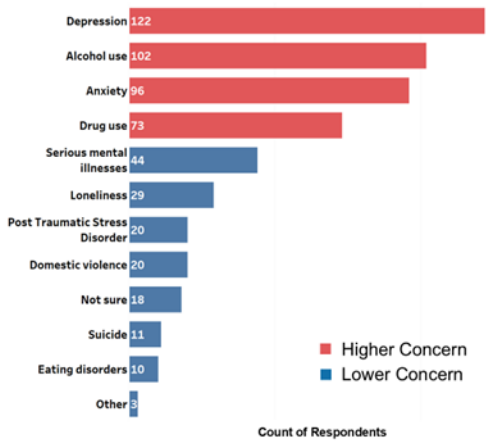
258 Total Respondents in St. Clair County

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

Health Concerns



Mental Health & Substance Use Concerns



The top 3 health concerns among residents who responded to the 2023 St. Clair County CHNA survey were: **mental health**, **behavioral health**, and **chronic disease**. In addition, Health Care Commission partner agencies identified **maternal and infant health** as a priority.

2024 Community Health Needs Assessment Survey

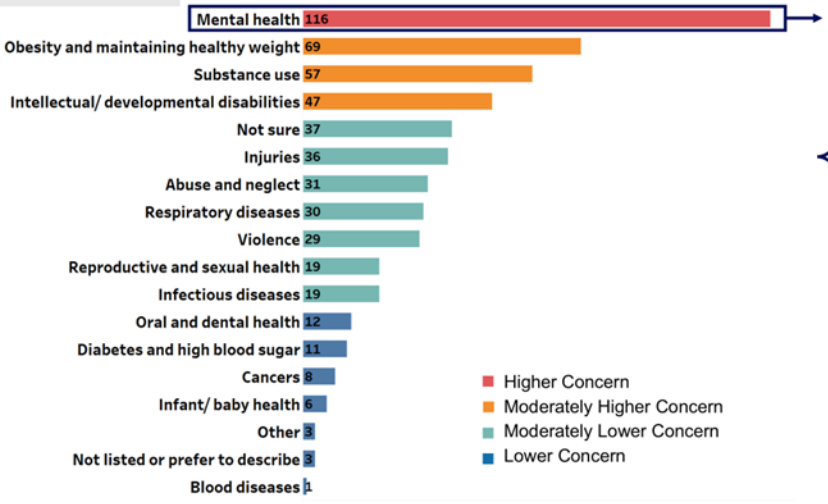
Preliminary survey data through June 2024 presented to community leaders

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.)

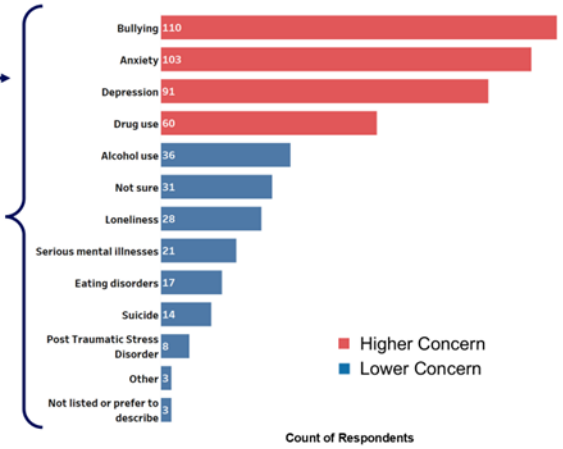
258 Total Respondents in St. Clair County

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

Youth Health Concerns



Youth Mental Health & Substance Use Concerns



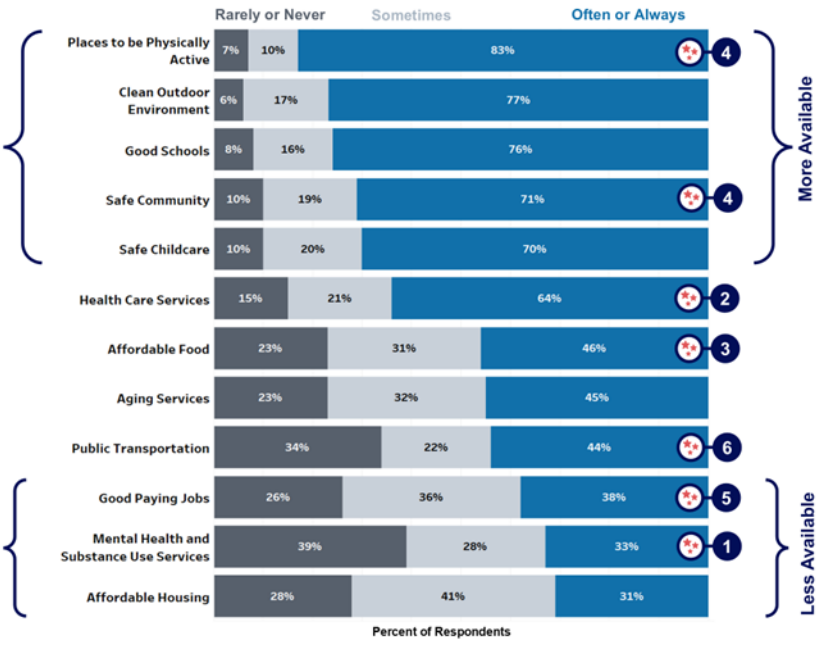
Specific health concerns among children and youth were not identified during the 2023 St. Clair County CHNA.

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?

258 Total Respondents in St. Clair County



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

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

Affordable housing, mental health and substance use services, and good paying jobs were reported to be less available, with less than 40% indicating that the resources were often or always available in their community.

Respondents to the 2023 St. Clair County CHNA survey were asked to identify the services needed to improve the health of their community. The services that were most frequently selected by residents included:

- Mental health and substance use services
- Health care services, including wellness and free health screenings
- Healthier food options and grocery stores
- Safe places to walk and play
- Job opportunities
- Transportation

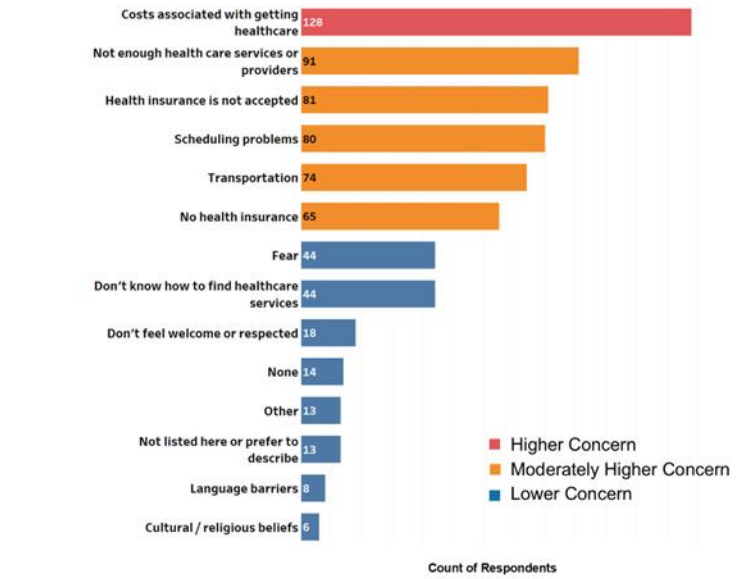
2024 Community Health Needs Assessment Survey

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?

258 Total Respondents in St. Clair County

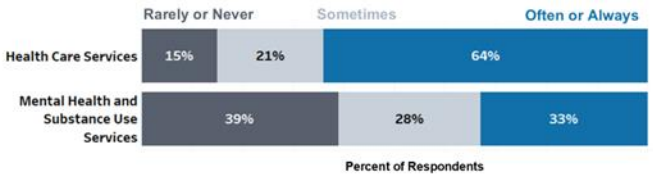
Barriers to Health Care Access



Sixty-four percent (64%) of community members who responded to the survey indicated that health care services were often or always available in St. Clair. Only 33% indicated that mental health and substance use services had good availability.

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

Health Care Service Availability



Specific barriers to accessing health care were not identified during the 2023 St. Clair County CHNA.

Respondents were asked about their personal health insurance status and where they go for routine healthcare. Only 2% indicated that they did not have health insurance, and most (83%) reporting visiting a doctor's office.

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

Appendix G: Community Leader Conversation Participants

Memorial Hospital Belleville and Shiloh: Community Leader Conversation Participants			
Organization	**First Name**	**Last Name**	**Title**
Champion Consulting	Amy	Champion Hilmes	Clinical Counselor
Chestnut Health Systems	Elizabeth	McQuaid	Alliance Lead
City of Belleville	Patty	Gregory	Mayor
City of O'Fallon	Walter	Denton	City Administrator
Downtown Belleville YMCA	Jennie	Alberts	Executive Director
East Side Health District	Angela	Clark	Director of Nursing
East Side Health District	Linda	Joiner	Health Education Program Manager
Encompass Health	Cassidy	Hoelscher	Chief Executive Officer
Family Hospice of Belleville	Matthew	Brauss	Executive Director
Home Instead	Cindy	Hill	Home Care Consultant
Hospital Sisters Health System (HSHS)	Alex	Schneider	Community Health Outreach Specialist
P&O Care	Dan	Luitjohan	Clinical Manager
P&O Care	Kim	Smith	Clinical Liaison
Shiloh Church	Ken	Hutchens	Directing Pastor
Southwestern Illinois College Programs and Services for Older Adults	Carla	Boswell	PSOP Site Manager
St. Clair County Health Department	Aldara	Henderson	Systems Quality Manager
St. Clair County Mental Health Board	Jane	Nesbit	Executive Director
University of Illinois Extension	Rima	Abusaid	SNAP Education Educator

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** | Shiloh Church – October 24, 2024 – 18 participants
- **Community Members** | Downtown Belleville YMCA – December 18, 2024 – 11 participants

Community Leader Conversation on Health Needs

Mental Health

- Long wait times for psychologists and psychiatrists
- Overall shortage of mental-health physicians
- Increased visibility of mental-health needs after COVID
- Higher stress, anxiety, depression linked to media and social media
- Mental-health concerns are most prominent among young and middle-aged adults
- Desire for greater HSO investment in mental-health initiatives
- No local in-patient mental-health or substance-use treatment options (nearest are St. Louis or Springfield)

Obesity and Maintaining Healthy Weight

- High rates of obesity, diabetes, and heart conditions linked to limited access to healthy foods
- Concern that affordable healthy food remains limited
- “Food as medicine” initiatives are still emerging, but stakeholders interested in seeing data on progress
- Diabetes and transitional care programs see spikes in admissions tied to end-of-month reliance on food pantries
- Challenges with food pantries such as regulations required for fresh food and staffing shortages

Heart Conditions

- High burden of chronic conditions like heart disease and diabetes
- Lack of cardiologists and diabetes specialists
- Diabetes and High Blood Pressure
- High burden of chronic conditions like heart disease and diabetes
- Lack of cardiologists and diabetes specialists
- Request for dedicated Diabetes and Hypertension clinics

Age-Related Illnesses

- Need for more dementia care resources
- Lack of caregiver support
- Age-related illnesses are under-represented in available services

Substance Use

- Stress from media/social media contributing to anxiety, depression, and drug use
- No local in-patient options for mental-health or substance-use treatment
- Long wait times (up to months) for substance-use treatment
- Substance use ranked #2 concern among high school students
- Adults also report ongoing alcohol and drug issues
- Alcohol/drug use seen as coping mechanisms

Infectious Diseases

- Infectious disease ranked very low concern
- COVID exposed gaps in services and system weaknesses
- COVID lockdown increased mental-health challenges

Maternal and Infant Health

- Survey ranked maternal/child health lower than expected
- Often raised in importance by professionals, less so by community members
- Illinois has high infant and maternal mortality rates
- May become a higher-priority issue again in 2024 due to political environment

Community Leader Conversation on Health Resources

Affordable Housing

- YMCA serving many residents experiencing homelessness
- Housing is a high need among individuals with mental-health or developmental challenges

Mental Health and Substance Use Services

- Strong need for more mental-health resources, especially for youth and teens
- COVID lockdown worsened mental-health issues
- No local in-patient mental-health or substance-use treatment options
- Long wait times for substance-use treatment
- Interest in models like PECaD to reduce behavioral-health disparities
- Desire to reduce stigma and make mental-health conversations more common
- Hope for more funding and investment from HSOs

Good Paying Jobs

- Lack of good-paying jobs
- Many people cannot take time off work to seek care
- Health often deprioritized because missing work means losing pay

Public Transportation

- Major barrier for accessing care

- Long travel times on public transit
- Difficulty getting to Memorial without reliable transportation
- Need for shuttles and better bus/metro stop infrastructure (ex. benches)
- Some counties offer transportation tokens, but community awareness is low
- Virtual options could help address transportation barriers

Affordable, Healthy Food

- Limited access to healthy food contributes to obesity, heart disease, and diabetes
- Food-as-medicine approaches still developing
- End-of-month reliance on food pantries leads to poorer food choices
- Pantries face challenges, such as limited refrigeration, regulations, staffing shortages
- Last year's survey ranked affordable food higher than this year

Health Care Services

- Not enough providers, especially those accepting Medicaid
- Need for local specialists so residents don't have to travel to St. Louis
- Community interest in opening Diabetes and Hypertension clinics

Safe Childcare

- Childcare barriers affect patients' ability to attend appointments
- Requests to bring children to medical visits reflect lack of options

Good Schools

- For youth, mental health ranked #1 concern; substance use ranked #2
- Desire for more partnerships with schools, churches, and community groups
- Interest in expanding SEL programs in schools

Community Member Conversation on Health Needs

Mental Health

- Connection between homelessness and drug use
- Lack of homeless shelters in the area

Obesity and Maintaining Healthy Weight

- Heavy presence of unhealthy, greasy fast-food options (especially in East St. Louis)
- Limited access to fresh produce and prevalence of food deserts
- Healthy restaurant options are more expensive
- Cost of food is too high
- Desire for community gardens and higher-quality pantry options like meat and vegetables
- Interest in health fairs and healthy living promotion

Heart Conditions

- High blood pressure and diabetes tied to unhealthy food environments
- Poor nutrition and food deserts as drivers of chronic disease
- Healthy options are too expensive

Diabetes and High Blood Pressure

- High blood pressure and diabetes tied to unhealthy food environments
- Poor nutrition and food deserts as drivers of chronic disease
- Healthy options are too expensive

Violence

- Some areas in East St. Louis described as unsafe
- Need for stronger security presence (especially around 25th Street)
- Some community outreach efforts already in place, but gaps remain

Maternal and Infant Health

- Concerns about limited or lower-quality OBGYN care

Community Member Conversation on Health Resources

Affordable Housing

- Need more resources for people experiencing homelessness
- No homeless shelters on the Bellville side of the river
- Shelters available for women, but not for men
- Visible homelessness around community locations (ex. near the Y)

Good Paying Jobs

- Many residents working 2–3 jobs and still struggling
- Multiple jobs leave no time to navigate systems or access services

Affordable Healthy Food

- Limited access to healthy food and fresh produce
- High cost of healthy options
- Food deserts in marginalized communities
- Cheaper unhealthy foods lead to poor diet, especially for children
- Interest in community gardens (ex. garden at the Y)
- Pantries exist, such as at the YMCA and churches, but may not fully meet nutritional needs
- Local rules, such as no chickens or livestock, limit ability to grow or produce food at home

Health Care Services

- Desire for free screenings brought into the community
- Need for one-on-one crisis counseling resources
- Interest in more access to home-health testing/services

- Want more promotion of health fairs and healthy living activities

Clean Outdoor Environment

- Desire for clean faucet water

Places To Be Physically Active

- Want better access to parks, walking areas, and hiking options
- Walking is not accessible in many parts of St. Clair County
- Parking challenges limit use of some recreational spaces

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

Memorial Hospital Belleville - Shiloh 2025 Community Health Needs Selection Team Attendees 04/04/2025			
Last Name	**First Name**	**Title**	**Department**
Altland	Lisa	Director, Emergency Services	Nursing Administration
Graves	Deb	President	Executive Administration
Harriss	Dionne	Manager, Finance	Finance Operations
Jennings	Elizabeth	Manager, Foundation & Development	General Administration - Fund Raising
Journagan	Kevin	VP, Chief Medical Officer	Executive Administration
Neidrauer	Elizabeth	Strategist, Marketing - SR	Hospital Marketing
Perulfi	Shelley	VP, Chief Nurse Officer	Executive Administration
Schrage	Danielle	Manager, Case Coordination	Case Management
Seiber	Theresa	Performance Improvement Manager - SR	Operational Excellence
Stephens	Donna	Director, Acute & Critical Care	Nursing Administration
Stewart	Doug	Manager, Spiritual Care Services / Community Health Improvement Lead	Pastoral Care

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			