

# 2025-2028 Community Health Needs Assessment and Improvement Plan





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

## A Message from Bob Cannon, President, BJC HealthCare, and Annette Schnabel, President, Parkland Health Center

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

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

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

Sincerely,



**Bob Cannon**  
President, BJC HealthCare



**Annette Schnabel**  
President, Parkland Health Center

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# About BJC HealthCare

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

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



## Purpose

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

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

All nonprofit hospitals, including all BJC HealthCare hospitals, are required to complete a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community of focus. While BJC hospitals serve lots of communities, for our CHNA we define our community as the county in which the hospital sits.

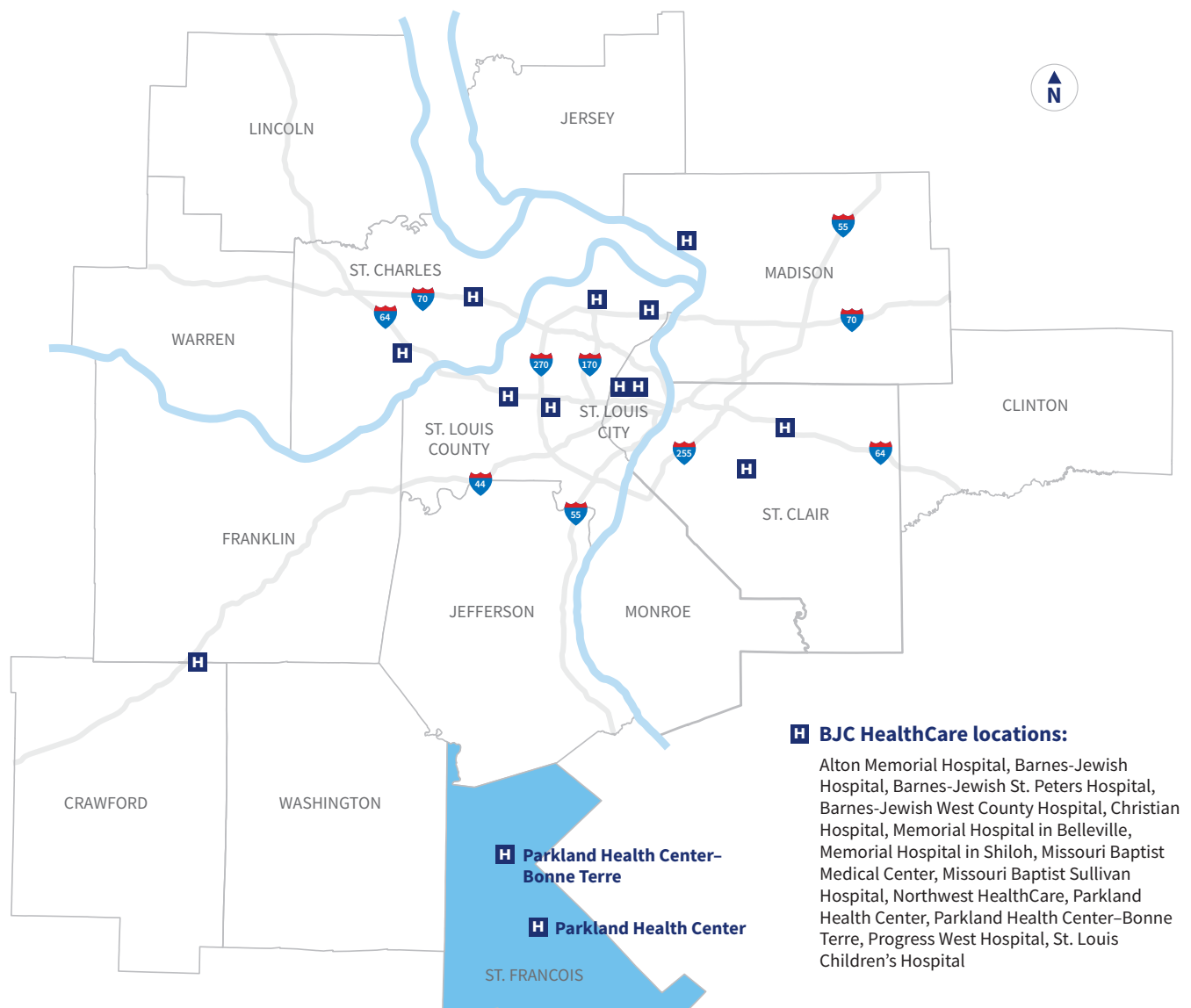
When their CHNAs are complete, hospitals create Community Health Improvement Plans (CHIPs). These plans set specific goals and actions to improve health needs in the community. In this report, we will share how we learned about health needs in the Parkland Health Center community and chose which health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

# Parkland Health Center and the Community We Serve

The Parkland Health Center Community Health Needs Assessment is focused on **St. Francois County, Missouri**.

Parkland Farmington is a full-service acute care hospital, with inpatient, outpatient, and clinic services. This location offers inpatient care, surgery, intensive care, obstetrics (pregnancy and childbirth), and emergency services. It also offers outpatient services that include oncology, an infusion center, a cardiac catheterization lab, a wound care clinic, and a cardio-pulmonary rehabilitation center.

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

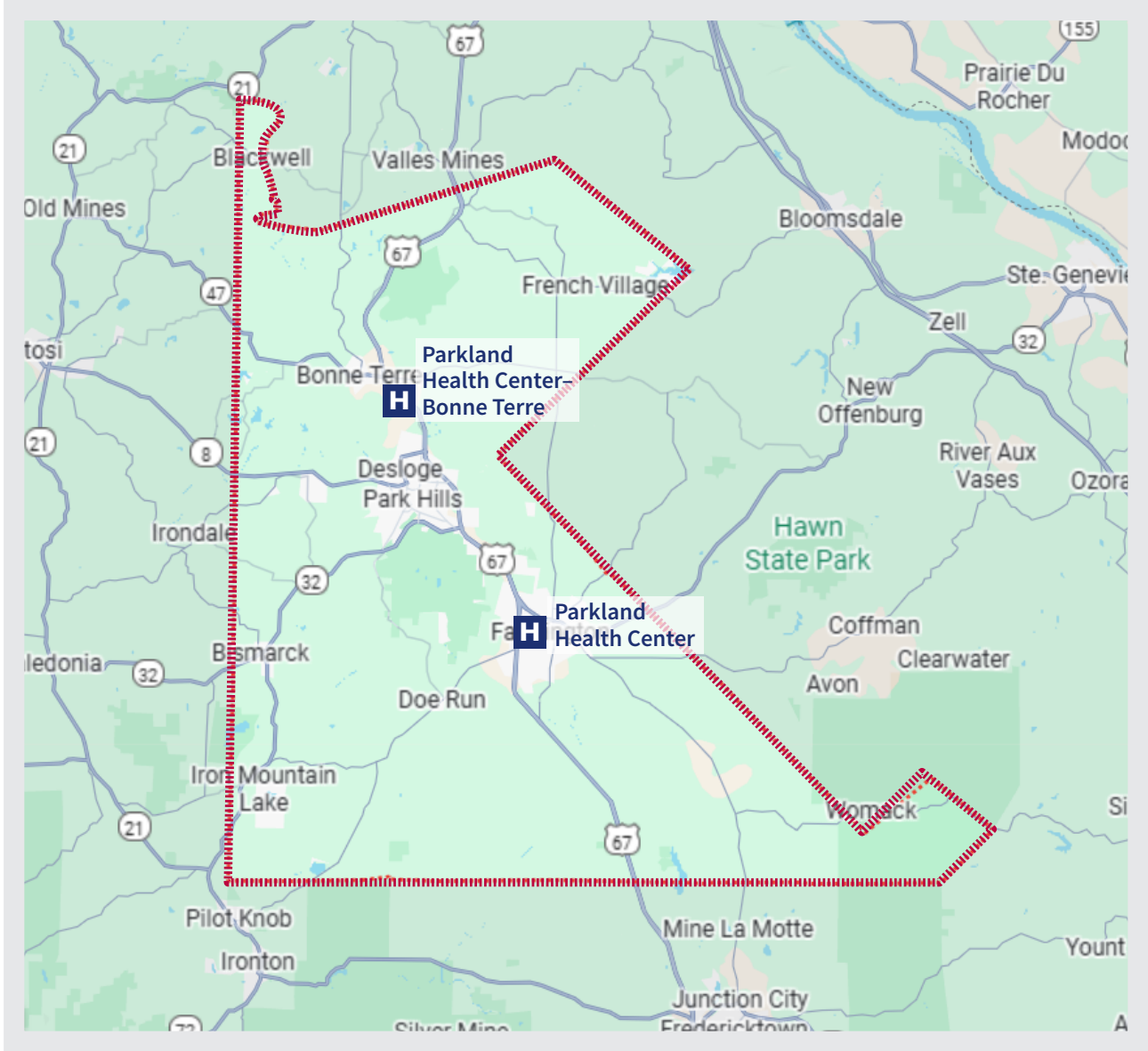


Parkland Bonne Terre is a Rural Emergency Hospital, and it provides emergency services, observation care, outpatient services, and has a provider clinic. This location was the first rural emergency hospital in the state.

We also have rural health clinics that offer primary care, obstetrician care, and pediatric care.

Parkland was named a **2025 High Performing Hospital for Maternity Care** by *U.S. News & World Report*. Parkland's obstetrics care has been recognized by the Centers for Medicare & Medicaid Services as a Birthing-Friendly hospital.

**Parkland Health Center** Community Health Needs Assessment service area close-up



Over the years, Parkland has given back to the community in many ways. In 2023, Parkland provided **\$16.8 million** in community benefit. This total includes:

- \$11.2 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- \$4.1 million in **unreimbursed care** for people with Medicaid and Medicare
- \$1.2 million in **services that fill gaps** in health care access for the community
- \$0.3 million in **programs that bring health resources and education** to the community



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

Parkland has dedicated staff who provide care for many community members. The team includes 679 employees and 377 physicians who practice at our hospital. In 2024, we cared for 4,324 inpatient admissions, 4,616 outpatient surgeries, and 39,579 Emergency Department visits. See more details in the graphic below.

## Parkland Health Center by the Numbers



**679**

Total  
Employees



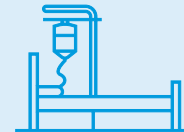
**377**

Physicians



**\$104**

Million  
Net Revenue  
(2023)



**104**

Staffed  
Beds



**4,324**

Inpatient  
Admissions



**4,616**

Outpatient  
Surgeries



**39,579**

Emergency  
Department  
Visits



**517**

Deliveries

About **67,000 people** call St. Francois County home.<sup>1</sup> The county is a rural area.<sup>1</sup> Most of the people who live in St. Francois County are white, and about one in six residents are older than 65 years.<sup>1</sup> The life expectancy for St. Francois County residents is about 72 years, which is about three years less than the life expectancy for all Missouri residents.<sup>2</sup>

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

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

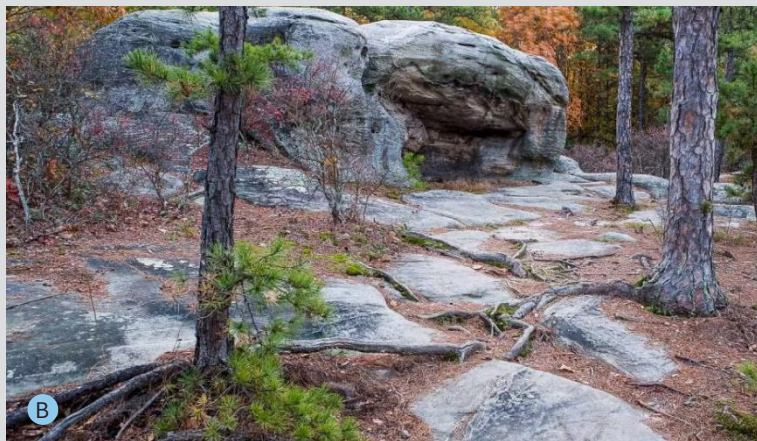
Almost half of all St. Francois County households spend more than 30% of their income on housing costs like rent or mortgages.<sup>1</sup> When housing is expensive, it can be hard to meet other needs, like food or transportation.

In St. Francois County, **most residents have a high school degree.**<sup>1</sup> High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in St. Francois County is about \$55,000 per year.<sup>1</sup> This is lower than the median state household income.<sup>1</sup>

About one in six children in St. Francois County live in poverty.<sup>1</sup> This is about the same as children across the state of Missouri.<sup>1</sup>

## Community Feature: Pickle Springs Natural Area


Our community has many places to enjoy nature, including Pickle Springs Natural Area. Pickle Springs has trails with views of cliffs, canyons, arches, and waterfalls.<sup>3</sup> The “Trail Through Time” features rocks and other sights that are over 500 million years old.<sup>4</sup> Pickle Springs is also home to many unique animals and plants, including 20 types of fish and 250 types of plants.<sup>3,5</sup> It is a great place for walking, hiking, and bird watching.




*Pickle Springs Natural Area, Farmington, Missouri*

# Parkland Health Center Community Characteristics

## St. Francois County

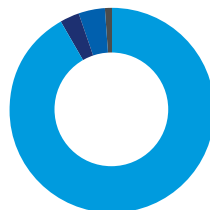


Population  
**66,864**



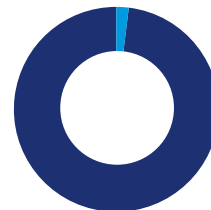
Land Area  
**452 sq. mi.**

## Race



**91%** White  
**3%** Black  
**4%** 2 or more races  
**1%** Other\*

## Ethnicity



**2%** Hispanic/Latino  
**98%** Not Hispanic/Latino

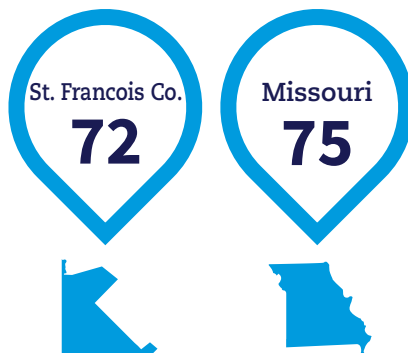



Most people have at least a high school education






St. Francois Co. **87%** Missouri **92%**

## Life Expectancy

The median household income in St. Francois County is lower than for the state of Missouri


St. Francois Co. **\$54,813** Missouri **\$68,920**





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




St. Francois Co. **40%** Missouri **42%**

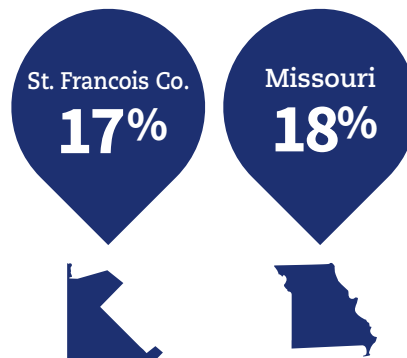


Poverty rates among children in St. Francois County are higher than in the state of Missouri

St. Francois Co. **18%** Missouri **16%**

## People over 65



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

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

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



# Where We've Been...

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

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.



# Parkland Health Center Community Health Needs and Goals from 2022–2025

In our last Community Health Needs Assessment at Parkland Health Center, we learned that mental health, substance use disorder, and diabetes were some of the top health concerns in St. Francois County. For each health need, we set a goal and made a plan to reach the goal.



## Mental Health and Substance Use Disorder

**Goal:** Increase the number of patients who attend referred counseling services at Southeast Missouri (SEMO) Behavioral Health and BJC Behavioral Health while being prescribed suboxone for substance use disorder from Parkland Health Center.



## Mental Health and Substance Use Disorder

**Goal:** Decrease the rate of infants delivered who test positive for drugs by using medication assisted treatment (MAT) for mothers during prenatal care.



## Diabetes

**Goal:** Increase the number of people with diabetes who receive formal education.

## Mental Health

### Our First Strategy ►

When we treat patients with mental health needs and substance use disorder, we often refer them to other clinics. At these clinics, they can receive counseling as part of their treatment. We wanted **more patients with mental health needs and substance use disorder in St. Francois County to access counseling.**

When we treated patients with these needs at BJC Medical Group, we gave them suboxone. Suboxone helps people with substance use disorder to stop misusing substances. Then, we referred these patients to BJC Behavioral Health and Southeast Missouri (SEMO) Behavioral Health. In these settings, patients can receive counseling and continue receiving suboxone.

We kept track of how many patients received suboxone at BJC Medical Group. After patients received suboxone, we taught them and their families about the importance of continuing treatment after starting suboxone. We also kept track of how many patients were referred to other clinics.

We started some new strategies to **help patients get treatment for mental health needs and substance use disorders**. We tracked our progress by looking at how many adults received services for mental health needs and substance use disorder. We wanted to increase the number of adults receiving services by 5% to 10% each year.

We also wanted patients to **reduce their substance misuse through counseling and treatment**. Our first goal was to help 5% of patients being treated for substance use disorder to decrease their substance misuse. Then, we wanted to help an additional 5% to 10% of patients each year to decrease their substance misuse.

### **Our Progress on Our First Strategy ▶**

From May to December 2023:

- 221 patients went to counseling at Southeast Missouri (SEMO) Behavioral Health.
- 91 went to a location other than SEMO.

In 2024 we met our goal:

- 268 patients went to counseling at SEMO Behavioral Health.
- 118 went to a location other than SEMO.

We are still working toward our 2025 goal. From January through March 2025:

- 41 patients went to counseling at SEMO Behavioral Health.
- 4 went to counseling at a location other than SEMO.

In the last two and a half years, 5% of patients have reduced their substance use. Many patients are still undergoing treatment and may still reduce their substance use.

### **Our Second Strategy ▶**

When pregnant patients use substances, those substances can affect their babies. These babies can test positive for drug use when they are born.

We wanted to **reduce how many babies are born that test positive for drug use**. To do this, we used medication assisted treatment (MAT). MAT is a way to treat substance use disorder.<sup>6</sup> MAT combines prescription medication with counseling and social support.<sup>6</sup> We prescribed buprenorphine as part of MAT to our pregnant patients.

We tracked how many providers prescribed MAT to pregnant people. We wanted providers to increase prescribing MAT during prenatal care and after babies are born. Our goal was for providers to increase prescribing to these patients by 50% in three years.

We wanted to **increase the number of providers who can prescribe medication assisted treatment (MAT)**. We helped certify new and current obstetrics (pregnancy and childbirth) providers to prescribe MAT. With more certified providers, more patients can receive MAT for drug use.

We also wanted to **increase services for pregnant people who had a positive drug screen**. We wanted to increase MAT services for these patients by 10% to 15% each year. We tracked how many patients delivered babies successfully after receiving MAT.

## Our Progress on Our Second Strategy ►

Between May and December 2023, we met our first goal:

- 50% more providers prescribed medication assisted treatment (MAT).
- Six mothers with substance use disorder were given Subutex (buprenorphine).
- All six mothers delivered healthy newborns.

In 2024, we met our second goal:

- Eight mothers with substance abuse disorder were given Subutex (buprenorphine).
- They all delivered healthy newborns.

We are still working toward our 2025 goal. From January through March 2025:

- Two mothers with active substance abuse disorder were given Subutex (buprenorphine).
- They both delivered healthy newborns.

## Diabetes

### Our Strategy ►

We wanted to improve the lives of people living with diabetes or prediabetes in St. Francois County. We thought offering **classes on topics about managing diabetes** would be helpful. We partnered with the St. Francois County Health Center to offer these classes. We wanted to increase the number of people living with diabetes who have had formal education about managing their diabetes. We wanted the number of people receiving education to increase by 10% every year.

We also wanted to educate people with prediabetes that are at a high risk for developing diabetes. We gave them the same test before and after the classes. We looked at the tests to see how their knowledge changed. We wanted people with prediabetes to increase their knowledge by 10% after every class.

We partnered with the St. Francois County Health Center to teach the classes. Diabetes educators from the health center and our registered dietitians taught the classes. The classes covered topics like diet and physical activity. Classes were offered for six weeks at a time. They were offered three to four times a year. Patients were referred to the classes by hospital providers.

### Our Progress ►

In 2023, the St. Francois County Health Center taught six classes. Eight people attended the classes. They tracked the results of the classes. The health center met its 2023 goal:

- The average test score before the class was 68%. After the class, the average test score was 94%.

In 2023, Parkland Health Center taught 6 classes and 46 people attended the classes. In 2024, we taught 6 classes and 63 people attended the classes. So far this year, we have taught 4 classes and 29 people have attended. Each year, we tracked the results of the classes. Each year, we met our goal:

- In 2023, the average test score before the class was 25%. After the class, the average test score was 90%.
- In 2024, the average test score before the class was 17%. After the class, the average test score was 80%.
- In 2025 so far, the average test score before the class has been 28%. After the class, the average test score has been 89%.

# Where We Are Today...

## 2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of the St. Francois 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. Francois 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. Francois County** to fill out our survey and share their thoughts. They could take the survey in English or Spanish. This was the first time we have offered the survey in Spanish. BJC HealthCare employees who live in the county could take the survey, too. We asked about:

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

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

We shared the survey online and in print. We used a QR code to share the survey more easily. Local community leaders and organizations helped us share the survey.

This included people from:

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

We also shared it at BJC hospitals, clinics, and community sites in St. Francois County. 405 community members completed the survey. See more details in Appendix B and Appendix C.

The top concerns among community members were mental health, substance use, and heart conditions. Specifically, mental health challenges like drug use, depression, and anxiety were concerns for the community.

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



### COMMUNITY SURVEY

#### Top 5 Health Problems

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

#### Top 5 Mental Health Concerns

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

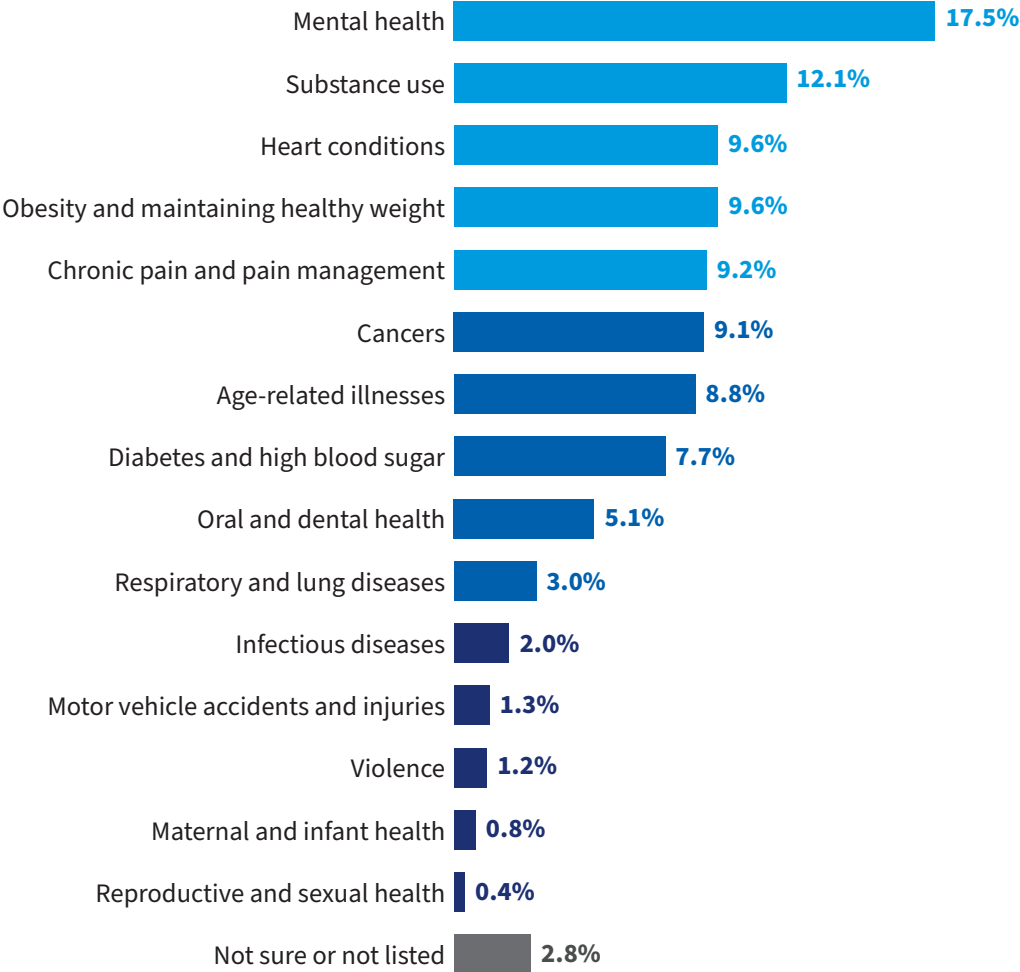
#### Top 5 Barriers to Care

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

#### Top 5 Community Resource Needs

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

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

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

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

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

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

The top health needs from HCI were mental health and mental disorders; cancer; and maternal, fetal, and infant health. The top social determinants of health needs were nutrition and healthy eating, economy (like poverty and employment rates), and community (like the use of public transportation and access to the internet). See more details in the list on the right.



## COMMUNITY INFORMATION

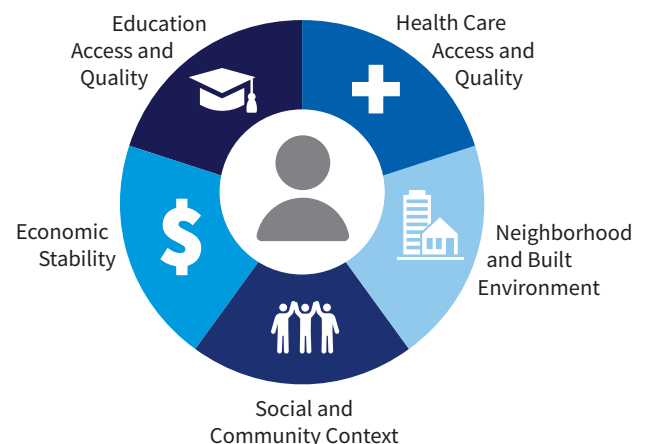
### Top 5 Health Problems

1. Mental health and mental disorders
2. Cancer
3. Maternal, fetal, and infant health
4. Prevention and safety
5. Immunizations and infectious diseases

### Top 5 Most Needed Social Determinants of Health

1. Nutrition and healthy eating
2. Economy
3. Community
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

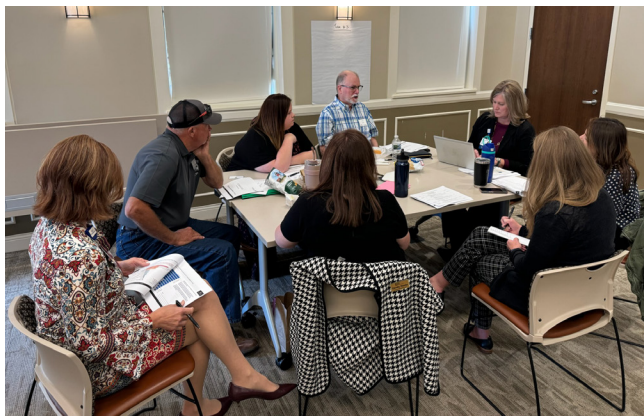
We invited many community leaders to meetings at Farmington Public Library. These leaders included:

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

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

Community leaders were concerned about mental health, substance use, chronic pain and pain management, and oral and dental health. They thought these health needs were the most important to focus on.

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



**Community Leader Conversation at Farmington Public Library**



### COMMUNITY LEADER CONVERSATIONS

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

#### Discussed Community Health Needs

- Mental health
- Substance use
- Chronic pain and pain management
- Oral and dental health

#### Discussed Community Health Resources

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

## Community Members

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

We spoke with community members at Farmington Public Library. We asked community members which health needs were the most important to them. Community members discussed mental health, substance use, obesity and maintaining healthy weight, and violence.

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



**Farmington Public Library in Farmington, Missouri, where conversations with community members and leaders took place**



## COMMUNITY MEMBER CONVERSATIONS

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

### Discussed Community Health Needs

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

### Discussed Community Health Resources

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

## 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 Parkland Health Center. 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 Parkland Health Center, the most common reasons patients visit the hospital are for hypertension, substance use disorder, and tobacco use. See more details in the list below.



### HOSPITAL SERVICE INFORMATION

#### Top 5 Health Conditions

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

## Hospital Team Survey

Parkland Health Center 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 Parkland CHNA team took a survey about local health needs. Team members were most concerned about mental health, substance use, and heart conditions. See more details in the list below.



### HOSPITAL TEAM SURVEY

#### Top 4 Community Health Needs

1. Mental health (tie)
1. Substance use (tie)
2. Heart conditions
3. Obesity and maintaining a healthy weight

#### Top 5 Most Needed Community Health Resources

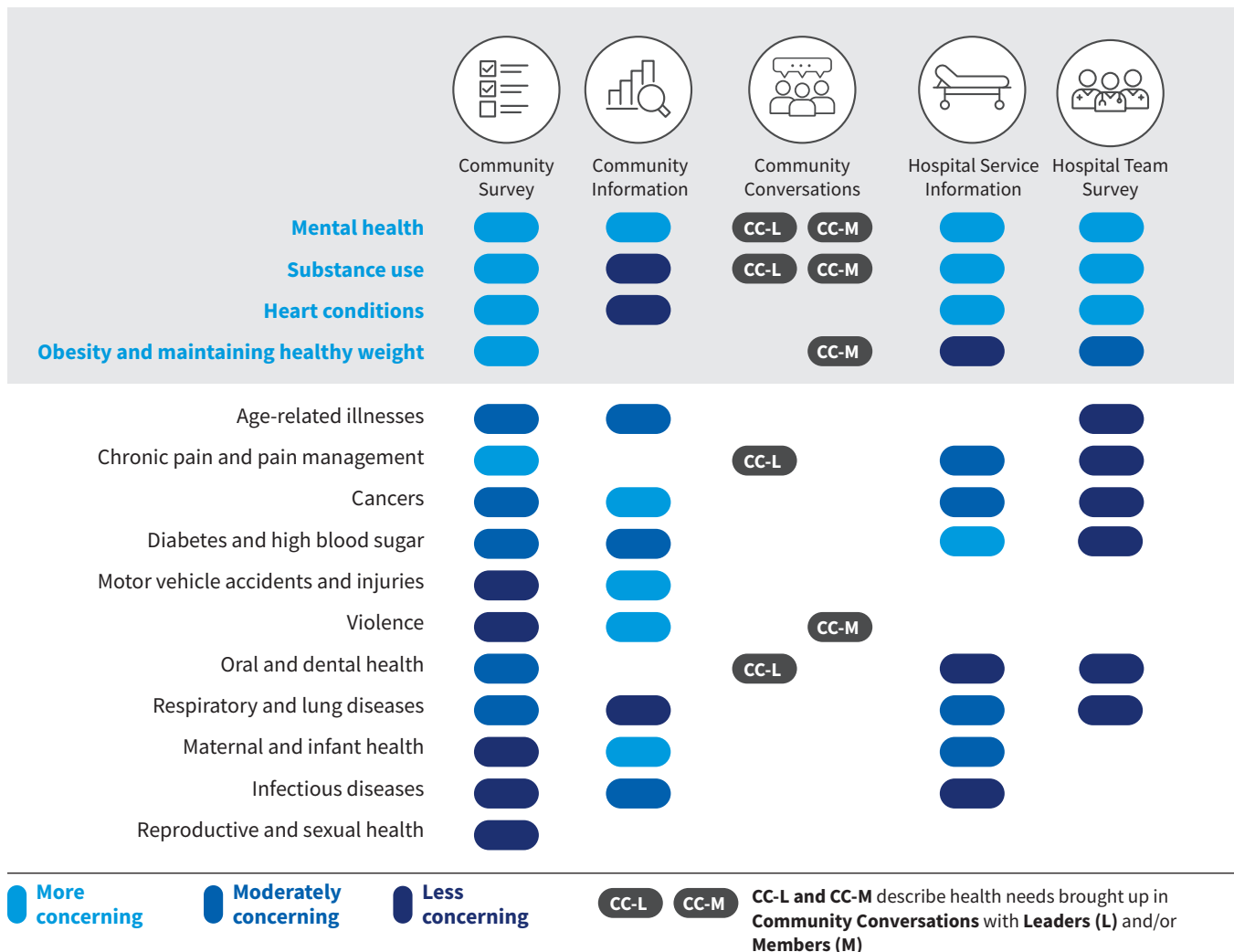
1. Public transportation (tie)
1. Affordable housing (tie)
1. Mental health and substance use services (tie)
2. Good paying jobs (tie)
2. Affordable, healthy food (tie)

# 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 Parkland Health Center. These needs are **mental health, substance use, heart conditions, 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 Parkland Health Center community**.



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

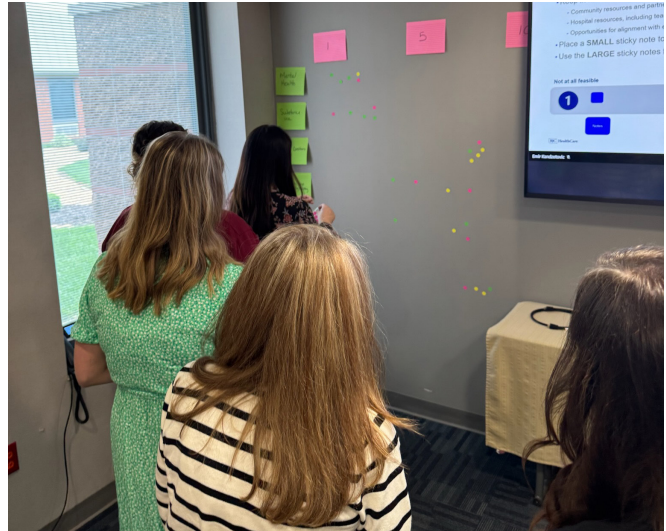
## How the Needs Were Selected

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

### Hospital Team Conversation



*Parkland Health Center President Annette Schnabel and other hospital team members (see list of team members in Appendix J)*



*Hospital team group activity*

## 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.

We decided not to prioritize mental health and substance use disorders. We are already making improvements in this area. We are connected to regional mental health resources like Telehealth Psychology and BJC Behavioral Health. We will continue to use our resources to improve these needs for our patients. We also decided not to directly prioritize heart conditions. We have resources to provide care for heart conditions. We will soon open a new building dedicated to heart health which will offer more resources to the community. We will address the causes of heart conditions by prioritizing obesity and maintaining healthy weight.

## Health Needs We Will Prioritize in This CHIP

We decided to prioritize **maternal and infant health**. We want to support infant health in our community, and we have many resources to support this work. We will prioritize maternal and infant health by focusing on prenatal care for pregnant patients. We currently work with the St. Francois Health Center, and we will continue to work to reduce substance use during pregnancy. We also decided to prioritize **obesity and maintaining healthy weight**. We decided this for a few reasons. First, we know this is an important health need for our community because of our Community Health Needs Assessment. Second, obesity and maintaining healthy weight are related to other health needs, like heart conditions. By working to improve obesity and maintaining healthy weight, we may improve other health needs, too.

## A Closer Look at Our Prioritized Needs

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

### Maternal and Infant Health

Maternal and infant health covers 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.<sup>7</sup>

About 1 in 10 babies in St. Francois County have low birth weight, and about the same number are born too early.<sup>8</sup> This is higher than in both the state of Missouri and the U.S.<sup>8</sup> This means babies born in St. Francois County may be more likely to have health problems than all Missouri or American babies.

In St. Francois County, for every 1,000 babies born, about seven die before their first birthday.<sup>8</sup> This is higher than the [Healthy People 2030](#) goal of no more than five deaths for every 1,000 babies born.<sup>9</sup>



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



St. Francois Co.  
**10%**



Missouri  
**9%**



U.S.  
**9%**

SOURCE: Conduent Healthy Communities Institute

## 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:

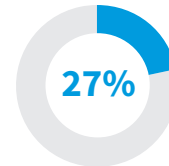
- Physical activity and safe places to do physical activity
- Access to healthy food
- Stress
- Genetics and family health history

Many of these factors are **affected by economic and social determinants of health** that make it easier or harder to be healthy. These can include walkable neighborhoods and education.<sup>10</sup>

Obesity is linked to long-term health conditions like heart conditions, diabetes, and cancers.<sup>11</sup> In St. Francois County, about one in four adults over 20 years old do little or no physical activity.<sup>8</sup> This means many adults in the county are more likely to develop long-term conditions.



In St. Francois County, about  
**1 in 4 adults**  
get little or no exercise



*SOURCE: Conduent Healthy Communities Institute*



**BMI**, or body mass index, is based on a person's weight and height.<sup>12</sup> BMI is measured by dividing a person's weight by their height.<sup>12</sup> Some BMIs can put people at higher risk of health problems, like high blood pressure and high cholesterol.<sup>12</sup>

# 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: Maternal and Infant Health

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

**Category:** *Connection to care*

**INITIATIVE:** Integrate doula services into prenatal, delivery, and postpartum care by collaborating with a doula organization to support patients through their birth journey. Adopt and utilize the doula documentation function in Epic to track doula involvement and outcomes for births.

- MEASURES:**
- # of partnerships established
  - # of trainings conducted
  - # of staff trained
  - % of births that use the doula documentation field

**INITIATIVE:** Increase awareness of doula services through staff training and patient education initiatives.

- MEASURES:**
- # of labor and delivery staff who complete the doula education training



## 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:** Collaborate with local school districts, pediatric providers, and dietitians to revise and deliver Parkland Health Center's My Body, My Health presentations.

- MEASURES:**
- # of school districts served
  - # of programs delivered
  - # of students reached

# What Comes Next

## Looking Forward

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



# Acknowledgments

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

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

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

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

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

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

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## Appendix A: Community Demographics

Demographics of St. Francois and Missouri		
	St. Francois	Missouri
<b>POPULATION</b>		
Population 2020	66,653	6,124,160
Population 2023 (estimate)	67,058	6,196,156
Population 2024 (estimate)	67,503	6,245,466
Population, Percent change - 2023 (estimate) to 2024 (estimate)	0.7	0.8
<b>AGE</b>		
Persons Under 5 Years, Percent, 2024	5.5	5.5
Persons Under 18 Years, Percent, 2024	20.7	21.9
Persons 65 Years and over, Percent, 2024	18.1	18.7
<b>GENDER</b>		
Female Persons, Percent, 2024	47.6	50.7
Male Persons, Percent, 2024	52.4	49.3
<b>RACE/ETHNICITY</b>		
White alone, Percent, 2024	88.5	77.6
White alone, not Hispanic or Latino, Percent, 2024	88.2	76.2
African American alone, Percent, 2024	2.7	10.5
Hispanic or Latino, Percent, 2024	2.1	5.6
Two or More Races, Percent, 2024	6.8	7.3
American Indian and Alaska Native alone, Percent, 2024	0.2	0.3
Asian alone, Percent, 2024	0.3	2.3
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.2	0.1
<b>LANGUAGE</b>		
Foreign Born Persons, Percent, 2024	0.2	4.9
<b>HOUSING</b>		
Housing Units, 2024	29,450	2,858,527
Homeownership Rate, Percent, 2024	68.2	68.6
Median House Value, Dollars, 2024	185,300	254,400
<b>FAMILIES &amp; LIVING ARRANGEMENTS</b>		
Households, 2024	27,304	2,563,244
Persons per Household, 2024	2.3	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	1.2	6.6
<b>EDUCATION</b>		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	88.9	92.0
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	20.2	33.5
<b>INCOME</b>		
Median Household Income, Dollars, 2024	55,350	71,589
Per Capita Income in past 12 months (in dollars), 2024	30,529	40,284
People Living Below Poverty Level, Percent, 2024	13.6	12.3

# Appendix B: Community Survey Tool

## St. Louis Community Health Needs Assessment

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

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

### Tell Us About Your Community

**1. What is your home ZIP code?**

Enter the five-digit ZIP code of the address where you live: \_\_\_\_\_

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

**2. Thinking about the community where you live, how available are the following resources?**

For each resource below, choose a number from 1 to 5, where 1 means *Never available*, and 5 means *Always available*. If you do not know, choose *Not sure*.

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

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

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

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

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

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

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

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

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

Select all that apply.

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

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

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

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

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

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

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

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

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

## Tell Us About You

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

### 8. What is your age group?

Choose one answer.

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

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

Choose all that apply.

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

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

Listed in alphabetical order. Choose all that apply.

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

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

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

Choose one answer.

- Hispanic
- Non-Hispanic
- Prefer not to disclose

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

Choose one answer.

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

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

Choose all that apply.

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

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

Choose one answer.

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

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

Choose one answer.

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

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

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

## Appendix C: Community Survey Respondents Demographics

In St. Francois County, Missouri, 405 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 1 to 209. Just over 21% of participants did not answer the optional demographic questions. Among those who did respond, most were between 45 and 54 years old (21%), women (67%), White (73%), non-Hispanic (61%), and primarily English-speaking at home (78%). Many held advanced degrees such as a master's, professional, or doctorate degree (18%), were employed full time (39%), and reported a household income between \$100,000 and \$149,999 (13%).

# Appendix D: Community Leader Conversation Guide

## Facilitation Guide: Stakeholder Conversations for the Community Health Needs Assessment

### 1. Welcome and Introductions

- a. Welcoming remarks
- b. Hospital leadership remarks (if applicable)
- c. Brief introduction to the session's objectives and structure.
- d. Explain current efforts (St. Louis Regional Collaborative – if applicable)
- e. Reference pre-event info that was shared via email-make mention of the CHNA handout/one-page
- f. Introductions of CHI members, their roles, and future/continued engagement

### 2. Presentation of Survey Process

- a. Share:
  - i. How the questions were developed, limitations
  - ii. Dissemination process/communication strategy
  - iii. Survey timeline
  - iv. High level, key themes and findings from the community survey.
- b. Provide high level overview of survey development and dissemination process. Speak briefly to the gaps/limitations/areas of opportunity, such as bolstering efforts to gain a stronger representative sample size.

### 3. Gallery Walk of Survey Data and Facilitated Discussion: Reaction to Survey Data

- a. If applicable - Introduce the gallery walk exercise and placement of foam boards. Ask individuals to mindfully walk through the survey visuals to reflect on the data presented, starting at any board they choose. Participants are free to use a sticky note to jot down reflections as they move around the room.  
\*If table groups get through this before time is called, they can move to the next section to prioritize needs.
- b. Discussion prompt questions:
  - i. *Does anything about the data surprise you?*
  - ii. *Based on the community you serve, is the survey data aligned with the identified needs of the community?*
  - iii. *Does it resonate with their experiences and awareness?*
  - iv. *What best practices/tactics have been implemented to capture underrepresented survey respondents?*
  - v. *What's missing?*

### 4. Prioritizing Community Health Needs

- a. Based on their understanding of survey data and their experiences serving & supporting community members, ask each participant to respond to the prompts:
  - i. *What do you feel are the most critical health needs?*
  - ii. *Considering Health-Related Social Needs (HRSN) and Social Determinants of Health (SDOH), how should hospitals prioritize these needs from a community health level?*

*iii. In what ways should community be embedded in this process?*

## **5. Capturing Ideas for Community Conversations**

- a. Purpose: Identify key topics and questions for community conversations.
- b. Discussion prompt questions:
  - i. What specific information should we seek from community members?*
  - ii. How can we ensure diverse and inclusive participation from all community segments?*
  - iii. Where would you like to see the HSO active in your community?*
  - iv. In what ways should community be embedded in this process?*

## **6. Brief recap and Next Steps**

- a. Recap from each table to entire group
- b. Final thoughts, reflections
  - i. What are you taking from this conversation?*
- c. Summary of key points from the discussion.
- d. Discuss next steps in the CHNA/CHIP process.
- e. Urge participants to take the Post-event survey before leaving the meeting. Share that we are in the process of planning community conversation invites with their communities. Invite them to share.

## **7. Closing Remarks and Adjournment**

- a. Express gratitude for stakeholder participation and valuable input.

# Appendix E: Community Member Conversation Guide

## Facilitation Guide: Community Conversations for the Community Health Needs Assessment

### 1. Welcome, Introduction, and Overview of Health Needs Assessment Process

- a. Explain the purpose of the conversation and how the input will be used.
- b. Be transparent and honest about where the Collaborative is in the CHNA process and the longer-term goals
- c. Note that there are opportunities to engage the community on the front end and ongoing basis moving forward.
- d. Introduce facilitators and any supporting staff. - Discuss CHNA data processes, including survey process, data highlights, gaps in data/responses, and secondary sources.
- e. Note that Community Conversations represent one way to gather more information that supports the CHNA.
- f. Review the expectations/outcomes from this meeting/process

### 2. Segment 1: Identifying Community Health Needs

- a. Opening Reflection:
  - i. *"To start, can you share what a healthy community looks like to you?"*
- b. Personal and Community Health Concerns:
  - i. *"What are the health issues or challenges you personally face, or that you see most often in your community?"*
- c. Impact of These Health Concerns:
  - i. *"How do these health issues affect your daily life or the well-being of your family and neighbors?"*
- d. Solutions Already in the Community:
  - i. *"What are some ways that people in your community are already trying to address these health concerns?"*

### 3. Segment 2: Barriers to Health

- a. Challenges to Accessing Care:
  - i. *"What gets in the way of you or others in your community getting the health care or services you need?"*
- b. Systems and Structures:
  - i. *"Are there particular systems or processes (like transportation, finances, or navigating healthcare) that make it harder to get care?"*
- c. Addressing Barriers:
  - i. *"What would make it easier for you or others to access the care you need? What changes would be most helpful?"*
- d. Building on Strengths:
  - i. *"What is working well right now? How can the healthcare system support and build on what's already helping in the community?"*

#### **4. Segment 3: Prioritizing Health Issues**

- a. Community Priorities:
  - i. *"Out of everything we've discussed, what health issues feel most urgent to you right now?"*
- b. Addressing the Most Critical Issues:
  - i. *"If we could work on just one issue today, what would it be, and what's one solution you think could make a real difference?"*
- c. Collaborative Solutions:
  - i. *"How can the healthcare system and the community work together to solve these issues? What role would you like to see the healthcare system play?"*
- d. Closing Reflection:
  - i. *"Before we finish, is there anything else you'd like to share—any other ideas or concerns we should consider as we move forward?"*

#### **5. Co-Creating Action Plans and Next Steps**

- a. Collective Action Discussion:
  - i. *"What actions can we take together to start addressing the top priority issue?"*
  - ii. *"Who needs to be involved in these efforts?"*
  - iii. *"What resources or support would be needed from the healthcare system?"*
- b. Closing Reflection and Commitments:
  - i. *"What is one commitment or idea you will take forward based on the discussion?"*

#### **6. Thank You and Closing Remarks**

- a. Thank participants for their time, input, and contributions to the discussion.
- b. Acknowledge the importance of their feedback in shaping the CHNA process.
- c. Reiterate the expectations/outcomes from this meeting/this process.
- d. Provide information on the next steps, how their input will be incorporated, and any opportunities for future involvement.
- e. Encourage participants to stay engaged and invite them to share any additional thoughts after the meeting if they wish.

# Appendix F: Community Leader Data Handout



## St. Francois County

### Key Survey Findings



2024 Community Health Needs Assessment Survey

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

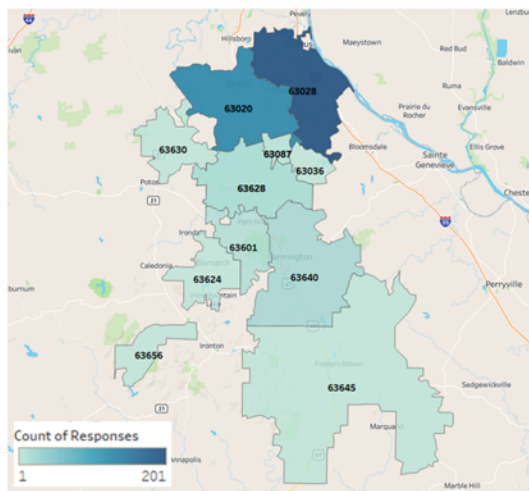
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### Who responded to the survey?

393  
Total Respondents in  
St. Francois County

In St. Francois County, 393 community members responded to the community health needs survey. The number of survey respondents in St. Francois ZIP codes ranged between 1 and 201.

#### Survey Respondents by ZIP code



#### Notes

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2024 Community Health Needs Assessment Survey

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

Over 19% of respondents in St. Francois County did not complete the optional demographic survey questions (non-respondents range from n=74 to 131, depending on the question).

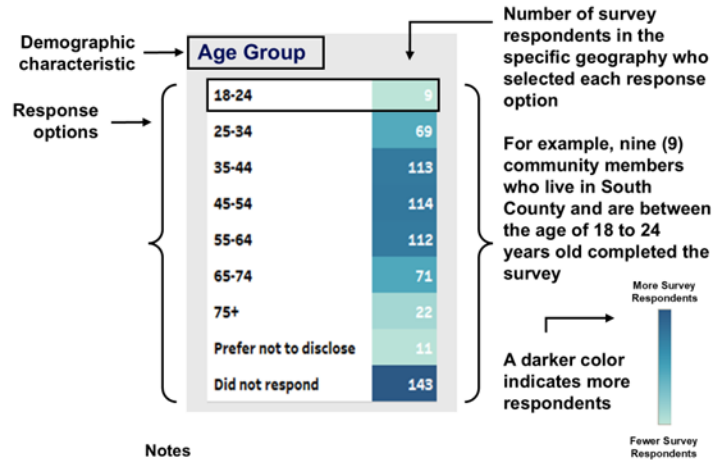
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=393).

**Most respondents:**

- Are between the age of 35 and 64 years old (57%)
- Are women (68%)
- Are White (74%)
- Are non-Hispanic (62%)
- Speak English at home (80%)
- Have a master's, professional, or doctorate degree (18%)
- Are employed full time (40%)
- Have a household income between \$100,000 and \$149,999 (13%)

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

Example: Survey Respondents by Age Group



Notes

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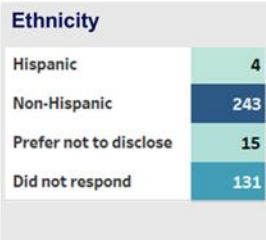
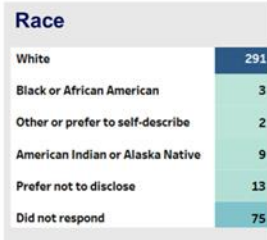
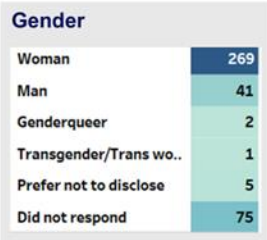
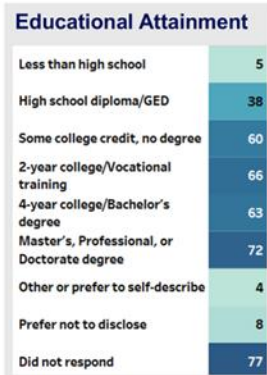
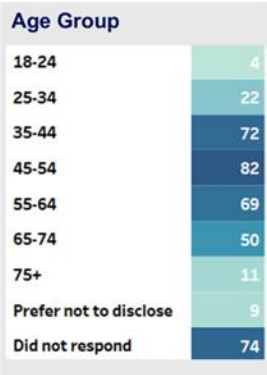
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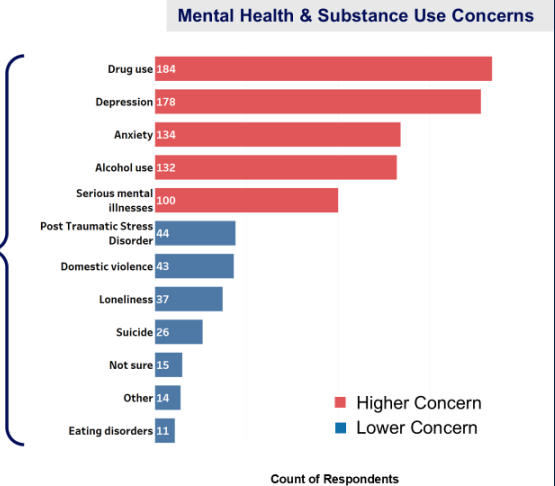
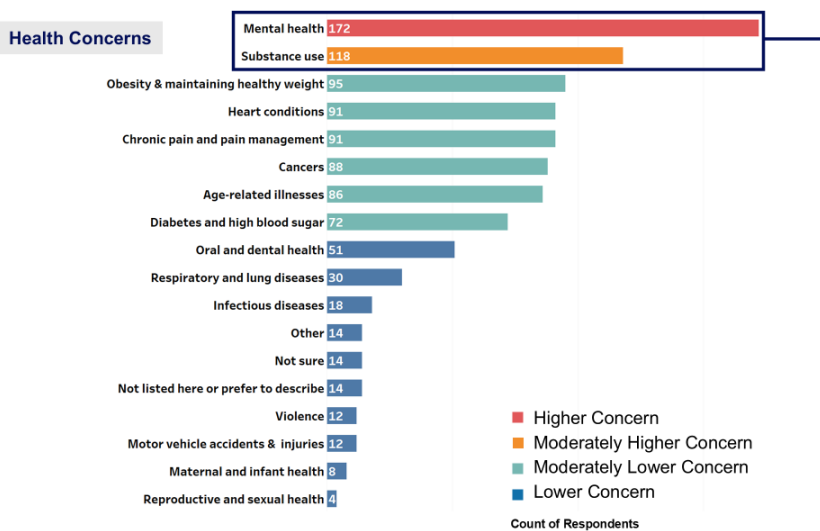
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## Thinking about yourself or other adults in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

393  
Total Respondents in St. Francois County

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



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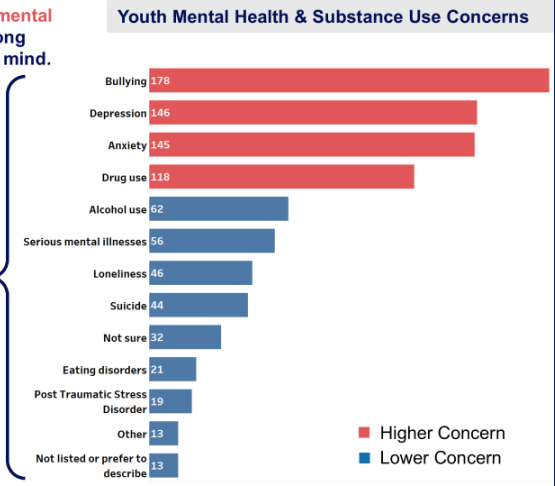
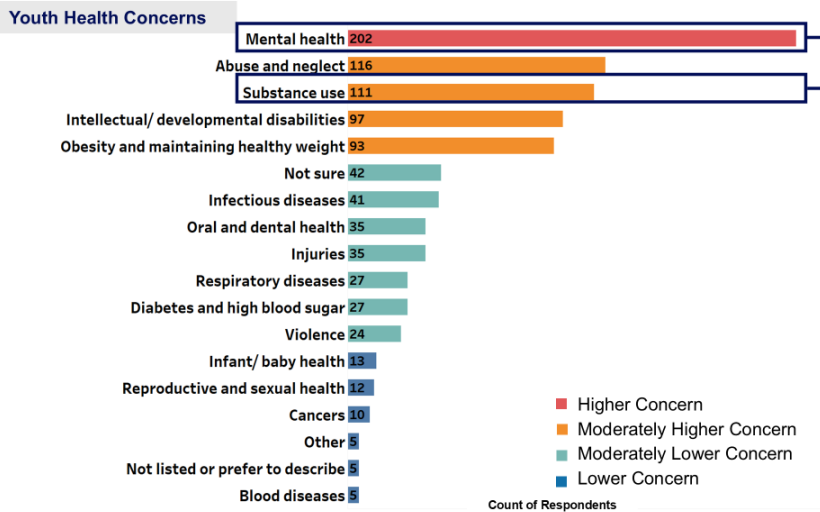


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## Thinking about your or other children in the community where you live, what are the top health problems? (Respondents selected up to 3 items.)

393  
Total Respondents in St. Francois County

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



Notes

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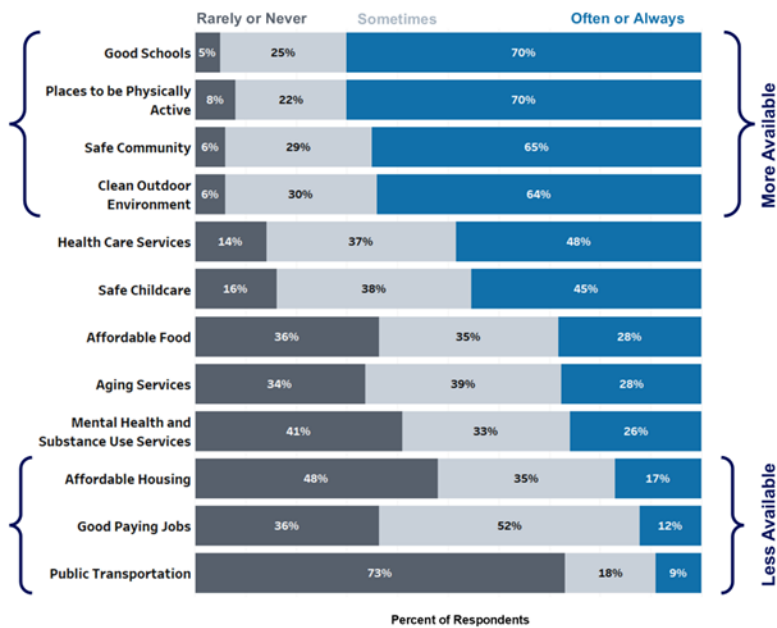


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## Thinking about the community where you live, how available are the following resources?



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

Good schools, places to be physically active, safe community and clean outdoor environment were rated as being more available, with over 60% of respondents indicating that the resources were often or always available in their community.

Public transportation, good paying jobs, and affordable housing were reported to be less available, with less than 20% indicating that the resources were often or always available in their community.

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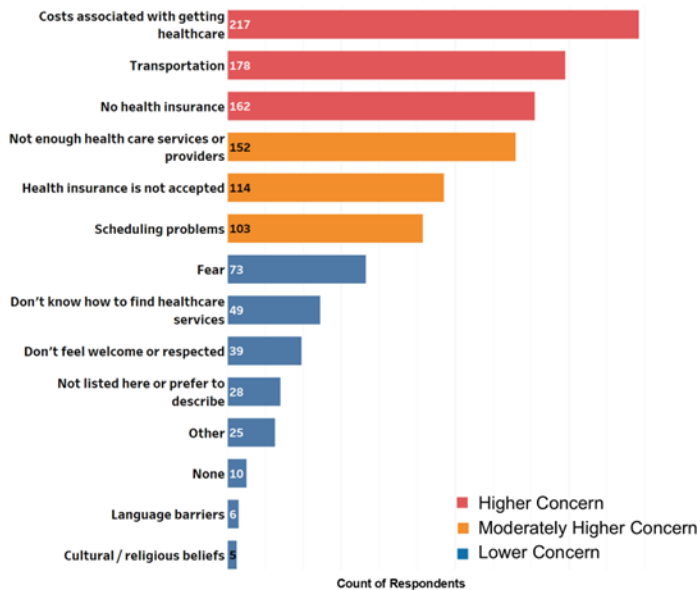
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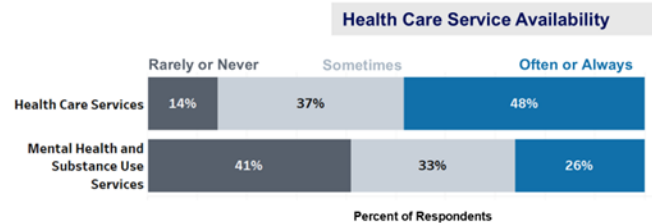
## Thinking about the community where you live, which barriers prevent access to health care?

### Barriers to Health Care Access



Forty-eight percent (48%) of community members who responded to the survey indicated that health care services were often or always available in St. Francois County. Only 26% indicated that mental health and substance use services had good availability.

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



Notes

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## Appendix G: Community Leader Conversation Participants

Parkland Health Center: Community Leader Conversation Participants			
Organization	First Name	Last Name	Title
Alzheimer's Association	Maddie	Erwin	Manager
CASA of the Parkland	JoAnna	Watts	Executive Director
Desloge Chamber of Commerce	Cheri	Henderson	Director
East Missouri Action Agency	Nicolle	Hahn	Community Services Director
Farmington Regional Chamber of Commerce	Candy	Hente	Director
Great Mines Health Center	T.R.	Dudley	Community Resource and Development Specialist
Help the Hungry Bake Sale	Becky	Panchot	Treasurer
LIFE, Inc. Center for Independent Living	Randy	Windsor	Marketing Director
Mineral Area CPRC	Jessica	Herwig	Quality Management Director
N/A	Kevin	Cook	Retired
St. Francois County Health Center	Cate	Dallas	WIC Dietitian
St. Francois County Health Center	Ernest	Gibson	Office Manager

## Appendix H: Community Conversations Summary

BJC held community conversations with community leaders and members to gather insights on each local community. Community leaders and members shared their perspective on the most pressing health needs, and the strengths, challenges, and resources available in their community. The following pages provide an overview of key topics and insights that were shared related to health needs and health resources.

The following community conversations are summarized below:

- **Community Leaders** | Farmington Public Library – October 22, 2024 – 12 participants
- **Community Members** | Farmington Public Library – December 19, 2024 – 8 participants

### Community Leader Conversation on Health Needs

#### Mental Health

- Mental health

#### Substance Use

- Substance use
- Substance use specifically fentanyl, cannabis, and heroin

#### Chronic Pain and Pain Management

- Expected pain management to be higher

#### Oral and Dental Health

- Oral and dental health is an issue

### Community Leader Conversation on Health Resources

#### Public Transportation

- Public transportation is a need
- Transportation is a barrier

#### Affordable Housing

- Homelessness is increasing by the week
- Need a homeless shelter – is it possible
- No resources for homelessness and unhoused

#### Mental Health and Substance Use Services

- There are no mental health resources in St. Fancies County Health Center
- No service for youth
- Postpartum screening is a need
- Narcan vending machine could help

- No inpatient psychiatric beds
- No diversion beds

### **Affordable, Healthy Food**

- Food drives tend to run out of food frequently

### **Health Care Services**

- Need affordable healthcare/insurance
- Medication shortages exist
- Long wait times in the ER

### **Good Schools**

- Good schools for good students/kids
- Challenges and obstacles exist for students with mental health/spectrum
- Families/students who need help may see public schools as not being good
- Bullying is an issue in the schools

## **Community Member Conversation on Health Needs**

### **Mental Health**

- Mental Health/Mental Health in schools
- ADHD
- Bipolar
- Seeing an increase in suicide rates
- Cutting among students
- Mental Health is a top priority

### **Substance Use**

- Substance use rates are increasing
- Substance use is a top priority

### **Obesity and Maintaining Healthy Weight**

- Low quality food could lead to obesity

### **Violence**

- School bullying is bad
- Bullying/violence is not being addressed
- The community is not as safe as it was five years ago.
- Community is seen as safe to walk around. Violence is in the home and at school

# Community Member Conversation on Health Resources

## Public Transportation

- Transportation is a barrier
- Public transportation has stopped serving the north part as funding was lost
- Transportation is hard to get/lack of vehicles
- Existing resource: SNTS (rural Transportation)

## Good Paying Jobs

- Not accessing healthcare due to not being able to miss work

## Affordable Housing

- Need more resources for those trying to pick themselves up (e.g., homeless)

## Mental Health and Substance Use Services

- There are no mental health resources for youth
- Crisis Centers don't offer youth services
- School counselors are stretched thin and need additional tools/skills
- Want more information on mental health and substance use
- Need to make Narcan accessible
- Stigma around mental health is preventing people from coming to the table to address mental health
- Existing resources include 988 suicide and crisis line
- Existing programs include Too Good for Drugs, Teens Teach Vaping Prevention, Drug Free Communities Coalition

## Affordable, Healthy Food

- Low quality food
- Cheaper to buy processed and frozen foods than healthier options
- High exposure to unhealthy foods
- Want more information related to obesity (e.g., budgeting, meal prep, healthy food choices)

## Health Care Services

- Need access to health insurance coverage
- In network providers are limited
- Need to expand Medicaid beyond children
- It is difficult to keep providers in the area
- The distance and general access are major challenges
- Long wait list
- Long wait times once at the doctors office to receive care
- High co-pays
- Cost of insurance is high for an employer to provide to employees

**Places to be Physically Active**

- Need safe and exercise friendly spaces – many can't afford to have a gym membership

**Good Schools**

- Bullying/violence is not being addressed – affecting all ages not just young children/elementary school aged

# Appendix I: Hospital Team Survey

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

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

## Tell Us About Your Community

### 1. Which hospital do you represent?

Enter the name of the hospital where you primarily work: \_\_\_\_\_

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

### 2. Thinking about the community that your hospital serves, how available are the following resources?

For each resource below, choose a number from 1 to 5, where 1 means *Never available*, and 5 means *Always available*. If you do not know, choose *Not sure*.

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

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

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

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

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

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

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

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

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

Please share any questions or thoughts.

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

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

## Appendix J: Hospital Community Health Needs Selection Team

Parkland Health Center 2025 Community Health Needs Selection Team Attendees 04/21/2025			
Last Name	First Name	Title	Department
Davis	Ashley	Strategist, Marketing - SR	Hospital Marketing
Gegg	Julie	Dietician / Health Educator	St. Francois County Health Center
Goldsmith	Cheri	Manager, Finance	Finance Operations
James	Kelsey	Consultant, Quality Patient Care	Quality Assurance
Ledbetter	Holli	Manager, Program-Service Line / Community Health Improvement Lead	Marketing
Marberry	Missy	Clinical Excellence Director	Risk Management
Mohl	Amanda	Program Manager, Belonging & Inclusion	Office of DE&I
Robinson	Kimberly	Administrator	Medical Services
Schnabel	Annettee	President	Executive Administration
Weber	Mindy	Manager, Case Coordination	Care Management
Winschel	Chris	Vice President, Operations	Executive Administration

# Appendix K: Elevated Health Needs Ranking Process

## Our Goal

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

## Data Sources Used

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

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

## How we Sorted Each Need

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

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

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

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

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

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

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

