2025-2028 Community Health Needs Assessment and Improvement Plan

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BJC HealthCare
Progress West Hospital

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

A Message from Bob Cannon, President, BJC HealthCare, and Greg Patterson, President, Barnes-Jewish St. Peters Hospital and Progress West 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 Progress West 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 Progress West Hospital, we are committing to focused efforts around diabetes and high blood sugar, and mental 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

Greg Patterson
President, Barnes-Jewish St. Peters Hospital
and Progress West Hospital

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About BJC HealthCare

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

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

BJC HealthCare

Purpose

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

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

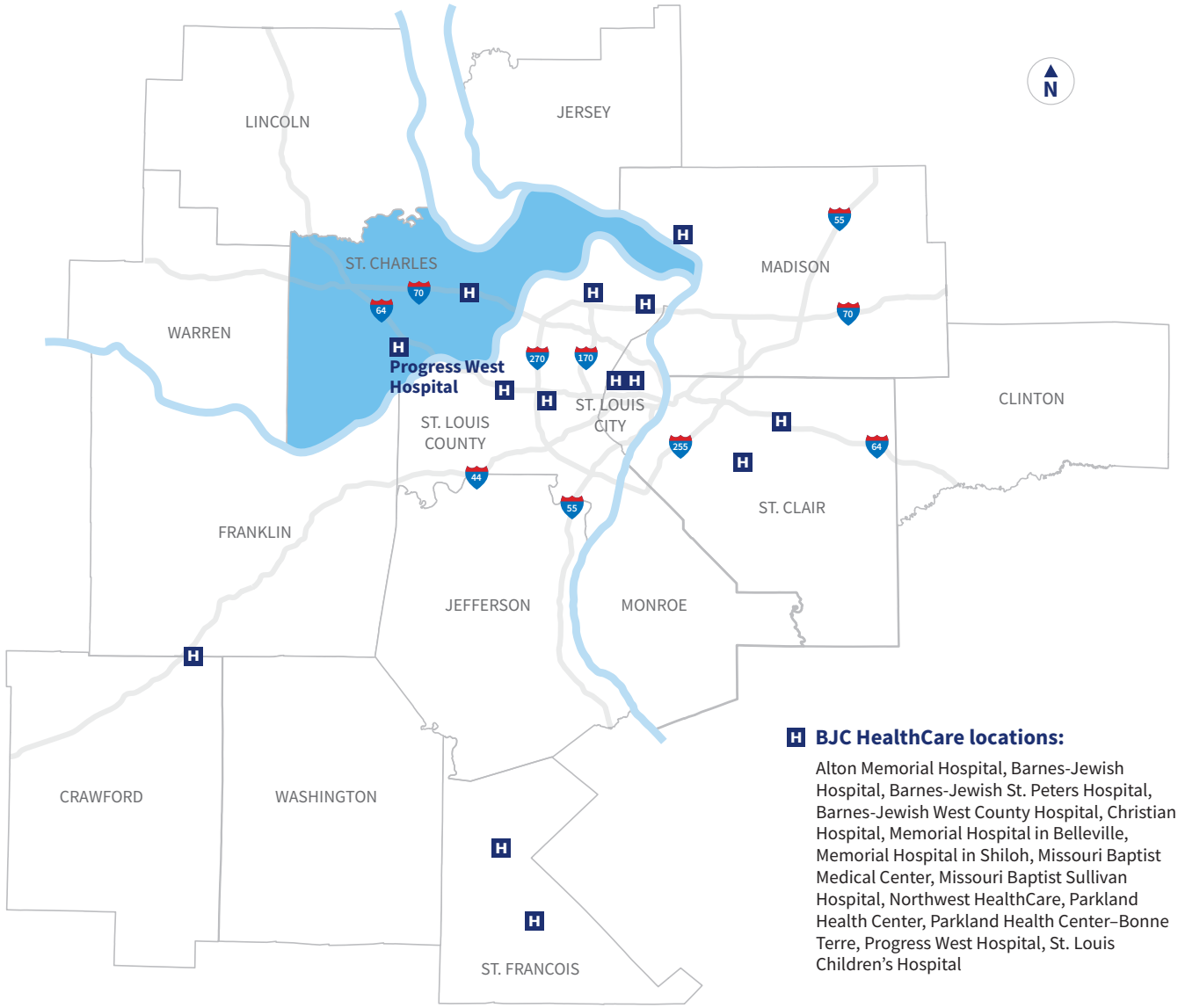
All nonprofit hospitals, including all BJC HealthCare hospitals, are required to complete a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. Each hospital determines their community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

Progress West Hospital and the Community We Serve

The Progress West Hospital Community Health Needs Assessment is focused on **St. Charles County, Missouri**. Progress West Hospital provides surgical services, endoscopy services, a cardiac catheterization lab, medical and surgical inpatient services, diagnostic imaging, and outpatient lab services. Progress West Hospital's Childbirth Center offers a Level II Newborn Intensive Care Unit that can provide care for premature babies born as early as 31 weeks while keeping mothers and babies together.

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



BJC HealthCare locations:

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

The hospital also offers an adult Emergency Department and a **specialized pediatric emergency unit** in partnership with WashU Medicine physicians from St. Louis Children's Hospital.

Progress West Hospital is recognized as a Certified Level II Stroke Center with telestroke capabilities. The hospital's medical office building houses specialists in primary care, cardiology, obstetrics, pediatrics, and orthopedics.

Progress West Hospital Community Health Needs Assessment service area close-up

Over the years, Progress West Hospital has given back to the community in many ways. In 2023, the Hospital provided **$8.3 million** in community benefit. This total includes:

- $3.9 million in **financial assistance** based on individual need, including free care, reduced charges, and payment plans with no interest
- $2.1 million in **services that fill gaps** in health care access for the community
- $2.1 million in **unreimbursed care** for people with Medicaid and Medicare
- $0.1 million in **education and professional support** for current and future health professionals
- $0.1 million in **programs that bring health resources and education** to the community

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

Progress West Hospital has dedicated staff who provide care for many community members. The team includes 536 employees and 692 physicians who practice at our hospital. In 2024, we cared for 4,578 inpatient admissions, 2,641 outpatient surgeries, and 25,827 Emergency Department visits. See more details in the graphic below.

Progress West Hospital by the Numbers

536
Total Employees

692
Physicians

$123.1
Million Net Revenue (2023)

77
Staffed Beds

4,578
Inpatient Admissions

2,641
Outpatient Surgeries

25,827
Emergency Department Visits

765
Deliveries

About **410,000 people** call St. Charles County home.[1] The county is an urban area.[1] Most of the people who live in St. Charles County are white, and about one in six residents are older than 65 years.[1] The life expectancy for St. Charles County residents is about 79 years, which is about four years more than the life expectancy for all Missouri residents.[2]

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

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

More than a third of St. Charles 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. Charles County, **most residents have a high school degree**.[1] High school degrees and other types of education are directly linked to employment opportunities. The median, or middle, household income in St. Charles County is about $103,000 per year.[1] The median state household income is about $69,000 per year.[1]

About 1 in 20 children in St. Charles County live in poverty.[1] This is less than in Missouri, where one in six children live in poverty.[1]

Community Feature: Katy Trail

Katy Trail State Park is a 240-mile recreational trail running along the former Missouri-Kansas-Texas Railroad.[3] The east end of the trail is located in Historic St. Charles and is an official part of the Lewis and Clark National Historic Trail.[3,4] Katy Trail is the longest developed rail-trail in the country. The trail is also part of the American Discovery Trail, which spans the U.S. from Delaware to northern California.[4,5] Visitors can explore Katy Trail on foot or bicycle, and sections of the trail are open for horseback riding.[3] Along the trail, visitors can learn more about the history of small towns that were once important stops along the railroad.[4]

Katy Trail State Park, Missouri

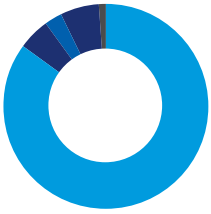
Progress West Hospital Community Characteristics

St. Charles County

Population
409,830

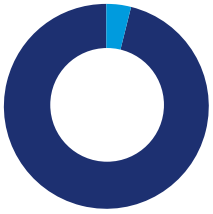
Land Area
561 sq. mi.

Race



- **85%** White
- **5%** Black
- **3%** Asian
- **6%** 2 or more races
- **1%** Other*

Ethnicity



- **4%** Hispanic/ Latino
- **96%** Not Hispanic/ Latino

Most people have at least a high school education

St. Charles Co.	Missouri
96%	92%

Life Expectancy

St. Charles Co.	Missouri
79	75

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

St. Charles Co.	Missouri
$102,912	$68,920

More than a third of people spend more than 30% of their income on housing

St. Charles Co.	Missouri
38%	42%

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

St. Charles Co.	Missouri
5%	16%

People over 65

St. Charles Co.	Missouri
16%	18%

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

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

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

Where We've Been…

In 2022, every BJC HealthCare East Region hospital completed a Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). Each hospital looked at its local community's **strengths, challenges, and opportunities**. Our region includes a wide geographic area, and 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.

Progress West Hospital Community Health Needs and Goals from 2022–2025

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

Mental Health

Goal: To improve health and quality of life of St. Charles County residents affected by mental health.

Heart Health

Goal: To improve cardiovascular health and quality of life through prevention, detection, and access to treatment of risk factors for heart attack.

Heart Health

Goal: To increase early identification and treatment of heart attacks and strokes and prevent repeated cardiovascular events.

Mental Health

Our Strategy ▸

We wanted to improve the mental health of residents in St. Charles County. We also wanted to improve their quality of life. To do this, we focused on education. We wanted to **improve knowledge of healthy behaviors** in St. Charles County residents who live with mental health concerns.

We worked with Barnes-Jewish St. Peters Hospital and St. Louis Oasis to provide education about healthy behaviors. We offered educational opportunities virtually and in person. We wanted to make sure all St. Charles County residents had access to our programs. We collaborated with other local organizations like PreventEd, Center Pointe, the Missouri Prevention Resource Center Network, the St. Charles County Ambulance District, St. Charles County Public Health, and Compass Health to expand the reach of our programs.

We wanted to make sure our programs were helping our patients. We gave participants a test before the programs started. This test measured their understanding of healthy behaviors. We gave them the same test after the programs were completed. We looked at their scores to see how their knowledge of healthy behaviors changed. We wanted to improve knowledge of healthy behaviors by 10% each year.

A nurse worked to coordinate collaboration between all the resources and organizations. The nurse participated in the St. Charles County CRUSH coalition. This coalition is a community group that works to prevent and reduce substance use. The nurse also supported BJC staff members.

Our Progress on Our Strategy ▸

In 2023, St. Louis Oasis taught 7 classes with 72 participants. In 2024, St. Louis Oasis taught 5 classes with 84 participants. St. Louis Oasis met with more people in 2024. After the classes, we looked at participants' knowledge of healthy behaviors. From 2023 to 2024, there was a 14% increase in knowledge.

In 2023, we purchased a therapy dog for the St. Charles County Police Department. The therapy dog visited schools, the hospital, and community locations after difficult events.

Massage, horticulture, pet, and yoga therapies allowed us to connect with patients and their families. We connected with 23,500 people through these events.

Also in 2023, a Patient Companion Cart was started. This cart offered stress reduction items. In the last four months of 2023, the cart served 444 people. In 2024, the cart served 2,910 people.

In 2024, our Community Health department provided mental health resources to 2,094 people. We also wanted to support the mental health of our employees. To reduce stress, we offered massages, therapeutic rock drawings, and adult coloring books.

Heart Health

Our Strategy ▸

We wanted to improve heart health for community members. We also wanted to improve their quality of life. We set out to do a broad range of activities.

We wanted to **prevent heart disease and stroke**. We created educational materials about preventing these conditions. The materials also covered ways to reduce risk factors for heart disease and stroke. Our Community Health department, stroke and heart team, passed out these materials to community members.

We also wanted to **screen community members for heart disease and stroke risk**. When we screen patients, we look at test results to see if they are more likely to have a disease or condition. Our community education nurses, dietitians, and other health professionals give these screenings to patients. They tested for high blood pressure, cholesterol, and blood glucose levels. While testing for heart disease, they also did stroke risk assessments.

As part of the screening, patients received:

- Counseling about any of their personal risk factors, the results of the screening, and education about healthy lifestyles
- Education about the signs and symptoms of stroke and when to call 911
- Referrals to smoking cessation programs and blood pressure self-management programs
- Education about the long-term risks of high blood pressure and how to track blood pressure

We wanted to screen 200 adults in 2023 and increase that number by 10% each year after.

We wanted to **make sure that patients who screened positively for heart disease were able to access needed care**. We gave patients an opportunity to start follow-up care. Our follow-up care included education. The education covered topics like nutrition, exercise, smoking cessation, and early warning signs of heart attack or stroke. We wanted to provide 12 months of follow-up care to 40% of our patients who screened positively for heart disease.

When patients agreed to start follow-up care, we gave them a test about healthy lifestyle changes. After the educational program, we gave them the same test. We looked at the difference between the two tests. We wanted patients to improve their knowledge of healthy lifestyle changes by 10%.

Staff offered to screen patients again to track changes in lifestyle choices. These screenings were offered at six months and one year after the first screening. We worked with the emergency medical services team to share materials about prevention and risk factors.

In addition to improving heart health, we wanted to **teach patients early warning signs and to seek emergency medical treatment for heart attacks and strokes**.

We worked with St. Louis Oasis to promote and host their chronic disease self-management program. This program helped adults learn ways to manage chronic conditions, like heart disease.

Our Progress on Our Strategy ▶

In 2024, we developed educational resources about stroke. These resources included a stroke risk assessment flyer and a smoking cessation resource list. We offered these resources at community events and screenings.

We tested community members for high blood pressure, cholesterol, and blood glucose levels. Community members who screened positive received education and nutrition counseling.

Due to staffing challenges, we did not meet screening goals in 2023. In 2023, we screened 184 adults. Of these patients, 13% had high-risk blood pressure. There was a 7% increase in participants performing 30 minutes of activity three times per week. This fell short of our goal of 10%. We were not able to begin follow-up activities.

In 2024, we screened 256 adults, passing our goal. Of these patients, 17% had high-risk blood pressure. We were able to follow up with patients from time to time. We developed a process to re-screen participants as well.

Since 2022, we have led a monthly stroke support group. On average, 8 to 10 people attend each session.

We noticed that some of our community members did not have primary care physicians (PCPs). In 2023, 10% of our screened community members did not have a PCP. In 2024, 12% did not have a PCP. Community members without a PCP were referred to our call center for more assistance.

We also saw an increase in high blood pressure. In 2023, 13% of screened community members had high blood pressure. In 2024, 17% had high blood pressure.

Where We Are Today…

2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of the St. Charles 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. Charles 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. Charles 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. Charles County. 788 community members completed the survey. See Appendix B and Appendix C for more details.

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

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

COMMUNITY SURVEY

Top 5 Health Problems

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

Top 5 Mental Health Concerns

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

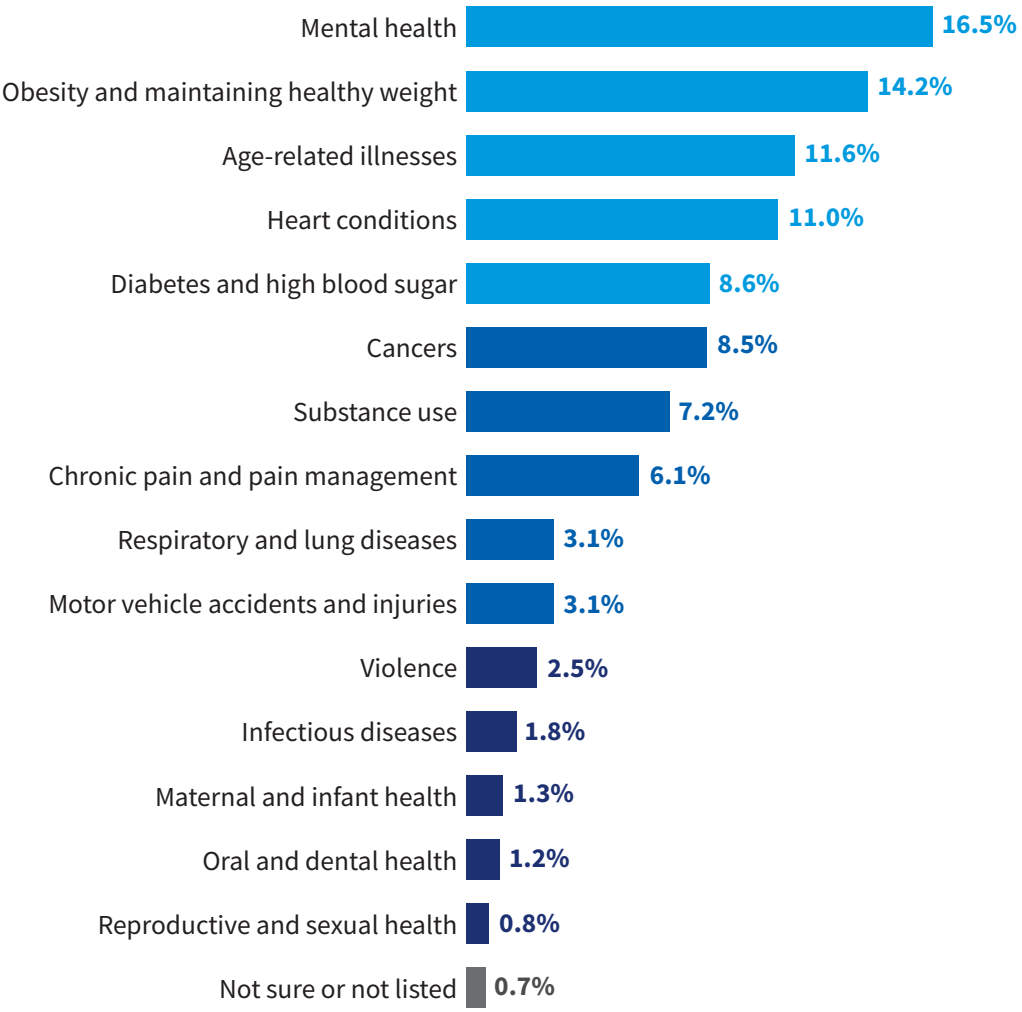
Top 5 Barriers to Care

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

Top 5 Community Resource Needs

1. Public transportation
2. Affordable housing
3. Mental health and substance use services
4. Aging 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. Charles County from Conduent's Healthy Communities Institute (HCI) online tool. We use the HCI tool to explore **large amounts of information on community health**.

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

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

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

We used HCI's Data Scoring Tool to compare St. Charles 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, prevention and safety, and cancer. The top social determinants of health needs were community (like the use of public transportation and access to the internet), economy (like poverty and employment rates), and environmental health. See more details in the list on the right.

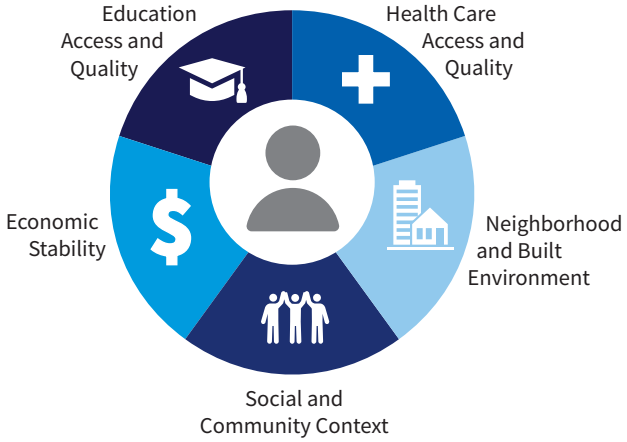
COMMUNITY INFORMATION

Top 5 Health Problems

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

Top 3 Most Needed Social Determinants of Health

1. Community
2. Economy
3. Environmental health



Community Conversations

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

Community Leaders

We invited many community leaders to meetings at St. Charles County 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, obesity and maintaining healthy weight, diabetes and high blood sugar, violence, 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; and affordable, healthy food. See more details in the list on the right.

Community Leader Conversation at St. Charles County Library

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
- Diabetes and blood sugar
- Violence
- Oral and dental health

Discussed Community Health Resources

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

Community Members

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

We spoke with community members at Boys and Girls Club. We asked community members which health needs were the most important to them. Community members discussed mental health.

We then asked community members which community resources were most needed. They discussed safe communities, places to be physically active, and health care services. See more details in the list on the right.

Boys and Girls Club of St. Charles County, St. Charles, Missouri, where conversations with community members took place

COMMUNITY MEMBER CONVERSATIONS

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

Discussed Community Health Needs

- Mental health

Discussed Community Health Resources

- Safe communities
- Places to be physically active
- Health care services

Hospital Service Information

When patients receive care at a hospital, their care is billed to their insurance. This is known as a claim. We looked at the hospital claims data for Progress West Hospital. We looked at all types of care, including same-day appointments, inpatient care, and Emergency Department visits.

We looked at this information at a group level. We wanted to see the most common reasons patients come to our hospital for care. For Progress West Hospital, the most common reasons patients visit the hospital are for hypertension, cancer, and diabetes. See more details in the list below.

HOSPITAL SERVICE INFORMATION

Top 5 Health Conditions

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

Hospital Team Survey

Progress West Hospital has a Community Health Needs Assessment (CHNA) team made up of **people from many different roles in the hospital**. We wanted our team to include people with different perspectives, knowledge, and skills. Team members work in areas like:

- Medical care (like doctors and nurses)
- Social work
- Community health support
- Marketing and communications
- Patient experience
- Finance

The Progress West Hospital CHNA team took a survey about local health needs. Team members were most concerned about mental health, age-related illnesses, and heart conditions. See more details in the list below.

HOSPITAL TEAM SURVEY

Top 5 Community Health Needs

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

Top 5 Most Needed Community Health Resources

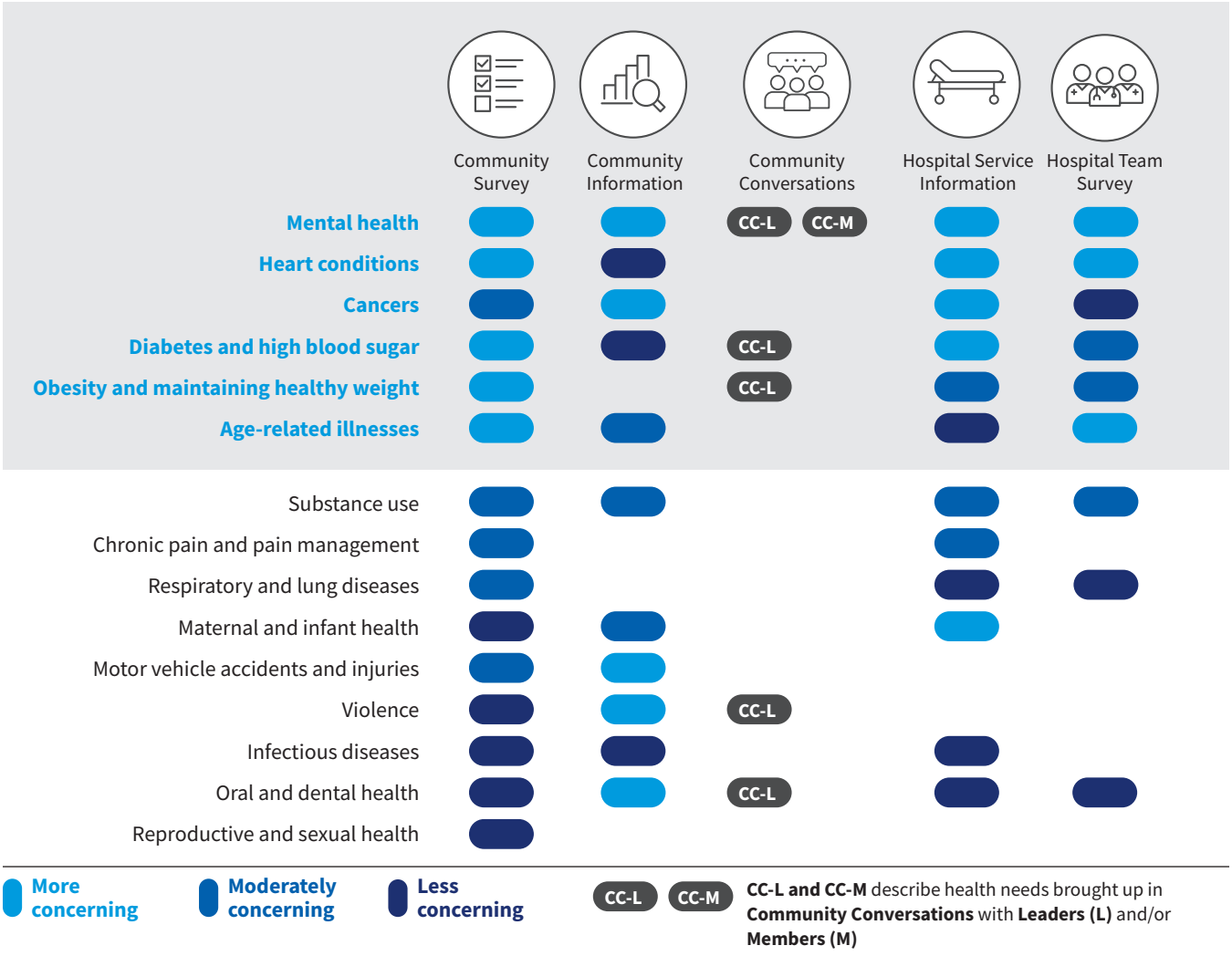
1. Public transportation
2. Mental health and substance use services
3. Affordable housing
4. Affordable, healthy food
5. Aging services

What We Learned: Our Selected Health Needs

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

We considered how important the health needs are to the audiences we spoke to. These include community members, community leaders, and BJC employees. We wanted to elevate the community's voice, so we made their answers count more than other information sources. We ranked six health needs as most important for Progress West Hospital. These needs are **mental health**, **heart conditions**, **cancers**, **diabetes and high blood sugar**, **obesity and maintaining healthy weight**, and **age-related illnesses**. 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 six health needs to consider working on in the Progress West Hospital community**.



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

How the Needs Were Selected

After we ranked the health needs, we met as a team to discuss the rankings and decide what to include in our Community Health Improvement Plan (CHIP). See a list of team members in Appendix J. 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, heart conditions, cancers, diabetes and high blood sugar, obesity and maintaining healthy weight, and age-related illnesses**.**

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 know heart conditions are important to our community members because of our Community Health Needs Assessment (CHNA). We also believe that heart conditions are important to focus on for our patients, and we do this with our existing heart care resources. We decided to prioritize other health needs where we think we can make a greater impact.

We also know that cancers are an important health need for our community. We have many resources dedicated to treating cancer at Progress West Hospital and we are already making good progress in this area. At this time, we want to focus our 2026–2028 CHIP on health needs that may have gaps in care. We chose to prioritize other health needs for this CHIP.

While obesity and maintaining weight are important to our community, we did not prioritize it for our 2026–2028 CHIP. We think that some of our work for diabetes and high blood sugar—which were chosen—may lead to improvements in obesity and maintaining healthy weight.

We chose to address substance use for our 2026–2028 CHIP under the focus of mental health, but not as a standalone. Substance use and mental health go hand in hand. Many of our community collaborators provide care for substance use disorder, and we are able to refer our patients to them for support.

We know age-related illnesses are important to our community. Many of our community members have advanced age. We provide care for many patients who have cancer or dementia, or who have fallen. After discussing with our team, we decided to focus on other health needs that may need more of our resources.

Health Needs We Will Prioritize in This CHIP

We decided to prioritize **diabetes and high blood sugar**. This was an important community need, and we want to do more to support patients with diabetes or who are at risk of diabetes. We feel that we have the resources needed to help improve diabetes and high blood sugar for our community members.

We also decided to prioritize **mental health** and include substance use efforts under this umbrella. We prioritized this health need for three reasons. First, we know this health need is important to our community because of our CHNA. Second, we think that many of our community members are affected by mental health concerns. Many of our patients take medication for mental health. Third, mental health affects some of the other health needs that our community is concerned about. By working to improve mental health, we may improve other health needs, too. We are connected to regional mental health resources like BJC Behavioral Health that can help us address this need.

A Closer Look at Our Prioritized Needs

We decided to prioritize diabetes and high blood sugar and mental health. This is how we define these concerns.

Diabetes and High Blood Sugar

Diabetes is a metabolic condition that affects how the body uses food for energy.[6] There are three types of diabetes:

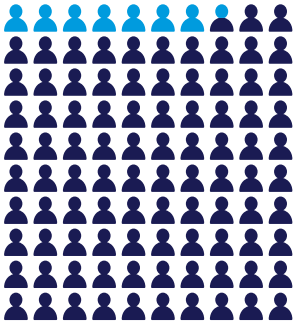
- **Type 1 diabetes** is an autoimmune disorder. An autoimmune disorder happens when the body's immune system attacks healthy cells. When people have Type 1 diabetes, their bodies attack the cells that make insulin. Insulin is a hormone that helps the body use or store energy from food. Without treatment, 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.[6] 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.[6] These changes include exercising more and eating healthy foods.[6]

In St. Charles County, about 1 in 10 adults over 20 years old have diabetes.[7]

In St. Charles County, about

7.6% of adults over 20 have diabetes



SOURCE: Centers for Disease Control and Prevention

Mental Health

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

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

People with serious mental health conditions are **more likely to die from violence** like homicide, suicide, and accidents.[8] They are also more likely to die from **chronic conditions**, like cardiovascular disease and respiratory diseases.[8] By prioritizing mental health, we can impact substance use and other health conditions, too.

About one in four adults in St. Charles County have had depression.[7] In the United States, about one in five adults have had depression.[7]

One part of mental health is suicide. About 1 in 10,000 people die from suicide in St. Charles County.[7] In Missouri, about 2 in 10,000 people die from suicide.[7] These numbers on deaths take into account the impact of age on illness.

In St. Charles County, about

1 in 4 adults have been diagnosed with depression

which is more than in the nation

St. Charles Co.	U.S.
23%	21%

SOURCE: Conduent Healthy Communities Institute

Older people are more likely to die from suicide.[9] For this reason, when talking about death from suicide, we have to consider the impact of age on deaths. When data sources have been **adjusted for age**, this means they have used math to take into account deaths across other age groups. When we adjust for age, we can compare death rates across younger and older communities.

Where We're Going

2026–2028 Community Health Improvement Plan (CHIP)

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

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

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

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

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

CHNA Health Need:
Diabetes and High Blood Sugar

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

Category: *Screenings*

INITIATIVE: Offer community events and screenings that include A1C's and wellness initiatives to increase awareness of diabetes and prevention.

MEASURES:
- #/type of events
- #/type of screenings delivered
- % of screened participants who receive education
- % of screened participants without primary care physician who receive referral

Category: *Health education*

INITIATIVE: Offer 1:1 and group diabetes nutrition education classes to those with prediabetes and diabetes.

MEASURES:
- Development of pre/post survey
- #/type of classes held
- # of participants
- % of participants who achieve yearly benchmark increase in knowledge, confidence, and behavior related to diabetes management

INITIATIVE: In collaboration with outside agencies, explore the feasibility of a new pilot initiative to provide healthy eating cooking classes and/or physical activity opportunities.

MEASURES:
- Establishment of resources and collaborations
- #/type of pilot events held
- # of participants
- % of participants who report improvement in pilot-related outcomes

CHNA Health Need:
Mental Health

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

Category: *Connection to care*

INITIATIVE: Collaborate with the local police department, who have received Crisis Intervention Training, to offer pet therapy for local schools, St. Charles County hospitals, and community, to demonstrate an increase in positive emotions.

MEASURES:
- # of student, hospital, and community encounters
- # of student encounters with pre/post survey responses
- % of student encounters who report a shift from negative/neutral emotions to positive emotions after a therapy dog visit

Category: *Connection to resources*

INITIATIVE: Support other organizations in St. Charles by participating in and increasing community engagement with mental health and substance abuse efforts to impact the well-being of the community.

MEASURES:
- #/type of events supported
- % of committee meetings attended
- # of people who attend events
- #/type of resources distributed (e.g., naloxone)
- % increase in resource distribution (year over year)

What Comes Next

Looking Forward

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

Health needs like diabetes and high blood sugar and mental 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. Charles 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. www.countyhealthrankings.org.
3. Katy Trail. St. Charles, Missouri. Accessed October 24, 2025. https://www.discoverstcharles.com/things-to-do/outdoors-recreation/katy-trail/.
4. Katy Trail State Park. Missouri State Parks. Accessed October 24, 2025. https://mostateparks.com/park/katy-trail-state-park.
5. Information about the American Discovery Trail. American Discovery Trail®. Accessed October 24, 2025. https://discoverytrail.org/about/.
6. Diabetes basics. Centers for Disease Control and Prevention. July 19, 2024. Accessed July 25, 2025. https://www.cdc.gov/diabetes/about/index.html.
7. Conduent Healthy Communities Institute (2025). Data Scoring Tool. Progress West Hospital. Published online March 10, 2025. https://admin-memhosp.thehcn.net/login.
8. Liu N, Daumit G, Dua T, et al. Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry*. 2017;16(1):30-40. doi: 10.1002/wps.20384.
9. Garnett M, Spencer M, Weeks J. *Suicide Among Adults Age 55 and Older*. Hyattsville, MD: National Center for Health Statistics; 2023. NCHS Data Brief 483. Accessed October 24, 2025. https://www.cdc.gov/nchs/data/databriefs/db483.pdf.

Photo Credits

A. Foundry Art Centre. Discover St. Charles. Retrieved from https://www.discoverstcharles.com/listing/foundry-art-centre/381/.

B. Lewis & Clark Boathouse and Museum. National Park Service. Retrieved from https://www.nps.gov/places/lewis-clark-boat-house-and-museum.htm.

C. Boys & Girls Club of St. Charles County. Boys & Girls Club of St. Louis. Retrieved from https://bgcstc.org/payments.

Appendices

Appendix A: Community Demographics

Demographics of St. Charles and Missouri		
	St. Charles	Missouri
POPULATION		
Population 2020	398,472	6,124,160
Population 2023 (estimate)	416,659	6,196,156
Population 2024 (estimate)	423,726	6,245,466
Population, Percent change - 2023 (estimate) to 2024 (estimate)	1.7	0.8
AGE		
Persons Under 5 Years, Percent, 2024	5.2	5.5
Persons Under 18 Years, Percent, 2024	21.9	21.9
Persons 65 Years and over, Percent, 2024	18.2	18.7
GENDER		
Female Persons, Percent, 2024	50.5	50.7
Male Persons, Percent, 2024	49.5	49.3
RACE/ETHNICITY		
White alone, Percent, 2024	83.1	77.6
White alone, not Hispanic or Latino, Percent, 2024	81.5	76.2
African American alone, Percent, 2024	5.3	10.5
Hispanic or Latino, Percent, 2024	4.5	5.6
Two or More Races, Percent, 2024	6.6	7.3
American Indian and Alaska Native alone, Percent, 2024	0.1	0.3
Asian alone, Percent, 2024	3.4	2.3
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.1	0.1
LANGUAGE		
Foreign Born Persons, Percent, 2024	5.3	4.9
HOUSING		
Housing Units, 2024	172,400	2,858,527
Homeownership Rate, Percent, 2024	79.3	68.6
Median House Value, Dollars, 2024	344,300	254,400
FAMILIES & LIVING ARRANGEMENTS		
Households, 2024	165,353	2,563,244
Persons per Household, 2024	2.5	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	6.8	7.4
EDUCATION		
High School Graduate or Higher, Percent of Persons Age 25+, 2024	95.5	92.0
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	43.4	33.5
INCOME		
Median Household Income, Dollars, 2024	103,686	71,589
Per Capita Income in past 12 months (in dollars), 2024	50,323	40,284
People Living Below Poverty Level, Percent, 2024	6.8	12.3

Appendix B: Community Survey Tool

St. Louis Community Health Needs Assessment

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

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

Tell Us About Your Community

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tell Us About You

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

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

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

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

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

11. Which of the following best describes you?

Choose one answer.

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

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

Choose one answer.

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

13. Which languages do you speak at home?

Choose all that apply.

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

14. What best describes your employment status?

Choose one answer.

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

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

Choose one answer.

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

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

Thank you for your time and input!

Appendix C: Community Survey Respondents Demographics

In St. Charles County, Missouri, 788 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 1 to 147. On average, just over 20% of participants did not answer the optional demographic questions. Among those who did respond, most were between 45 and 54 years old (19%), women (63%), White (66%), non-Hispanic (62%), and primarily English-speaking at home (76%). Many held a four-year college or bachelor's degree (22%), were employed full time (53%), and reported a household income between $100,000 and $149,999 (16%).

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. Charles County

Key Survey Findings

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

2024 Community Health Needs Assessment Survey

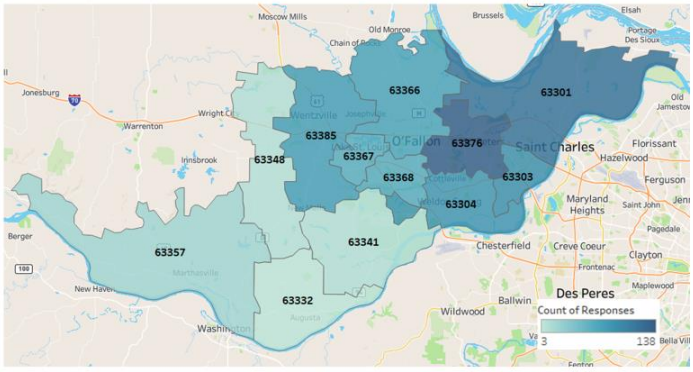
Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

752
Total Respondents in St. Charles County

In St. Charles County, 752 community members responded to the community health needs survey. The number of survey respondents in St. Charles County ZIP codes ranged between 3 and 138.

Survey Respondents by ZIP code



Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

752
Total Respondents in St. Charles County

About 20% of respondents in St. Charles County did not complete the optional demographic survey questions (non-respondents range from n=150 to 225, depending on the question).

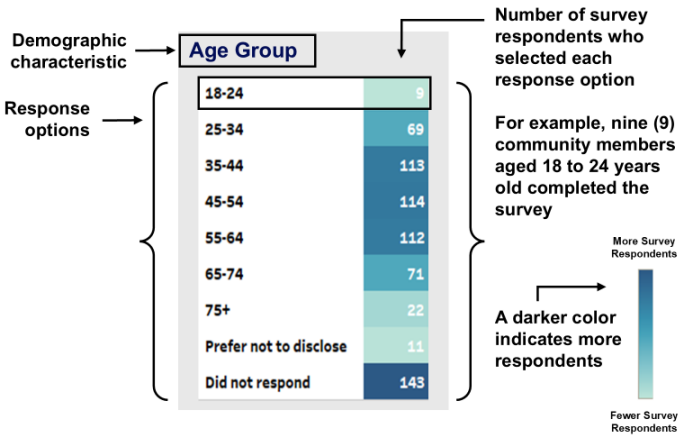
A summary of the most common characteristics among those who did respond to demographic questions is provided below. Percentages are calculated out of the total number of respondents (n=752).

Most respondents:

- Are between the age of 45 and 54 years old (20%)
- Are women (66%)
- Are White (69%)
- Are non-Hispanic (65%)
- Speak English at home (78%)
- Have a 4-year college/Bachelor's degree (23%)
- Are employed full time (55%)
- Have a household income between $100,000 to $149,999 (16%)

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

Example: Survey Respondents by Age Group



Notes

Preliminary survey data through June 2024 presented to community leaders

1 Who responded to the survey?

752
Total Respondents in St. Charles County

Age Group

Under 18	23
18-24	24
25-34	69
35-44	109
45-54	149
55-64	110
65-74	76
75+	32
Prefer not to disclose	8
Did not respond	152

Educational Attainment

Less than high school	25
High school diploma/GED	40
Some college credit, no degree	71
2-year college/Vocational training	93
4-year college/Bachelor's degree	175
Master's, Professional, or Doctorate degree	171
Other or prefer to self-describe	7
Prefer not to disclose	15
Did not respond	155

Employment

Full-time	410
Part-time	51
Disabled	7
Retired	70
Self Employed	5
Student Full-time	10
Student Part-time	11
Not Employed	15
Other or prefer to self-describe	7
Prefer not to disclose	12
Did not respond	154

Income

Less than $10,000	5
$10,000 to $24,999	13
$25,000 to $49,999	50
$50,000 to $74,999	61
$75,000 to $99,999	73
$100,000 to $149,999	123
$150,000 to $199,999	80
$200,000 or more	81
Prefer not to disclose	105
Did not respond	161

More Survey Respondents

Fewer Survey Respondents

Gender

Woman	493
Man	85
Genderqueer	1
Transgender/Trans wo..	1
Non-binary	3
Other or prefer to self-d..	2
Prefer not to disclose	15
Did not respond	152

Race

White	520
Black or African American	27
Asian	8
Other or prefer to self-describe	9
American Indian or Alaska Native	7
Prefer not to disclose	23
Did not respond	157
Native Hawaiian or Other Pacific I..	1

Ethnicity

Hispanic	9
Non-Hispanic	488
Prefer not to disclose	30
Did not respond	225

Language at Home

English	589
Spanish	1
Other or prefer to self-d..	1
Prefer not to disclose	11
Did not respond	150

2024 Community Health Needs Assessment Survey

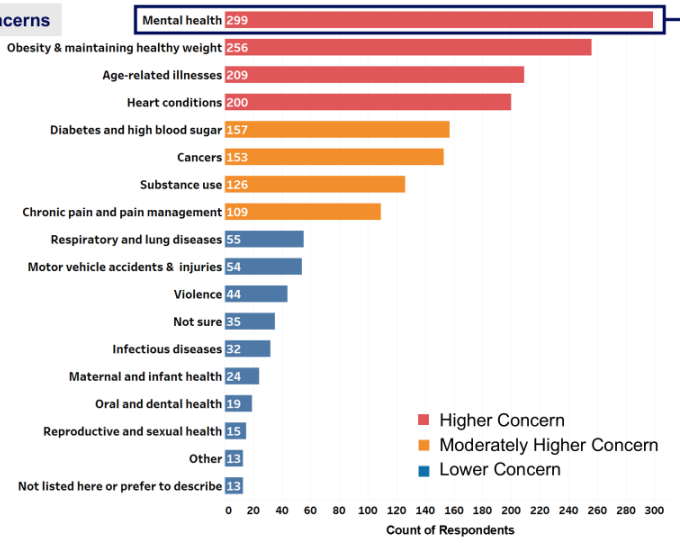
Preliminary survey data through June 2024 presented to community leaders

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.)

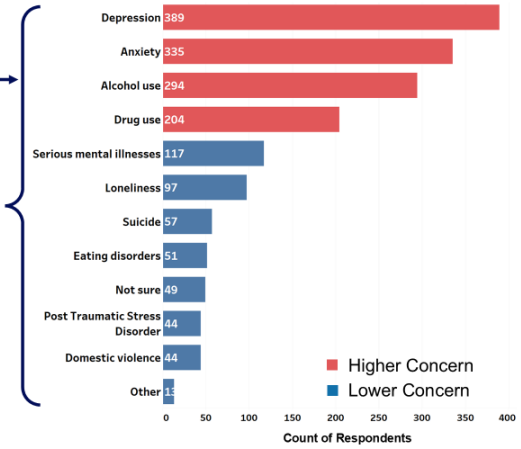
752 Total Respondents in St. Charles County

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

Health Concerns



Mental Health & Substance Use Concerns



Notes

Preliminary survey data through June 2024 presented to community leaders

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

752 Total Respondents in St. Charles County

The table below details the top health concerns among respondents by race. Most of the top health concerns remained consistent across groups with some differences in the order of concerns. Notably, violence was identified as a top concern among Black or African American respondents. Additionally, motor vehicle accidents & injuries was identified as a top concern for respondents of another race.

Health Concerns by Race

Higher Concern
Moderately Higher Concern

Top Concerns	All Respondents n=752	White n=520	Black or African American n=27	Another Race* n=25	Did not respond or prefer not to disclose n=180
1	Mental health	Mental health	Mental health	Obesity	Age-related illnesses
2	Obesity	Obesity	Obesity	Mental health	Obesity
3	Age-related illnesses	Heart conditions	Substance use	Age-related illnesses	Mental health
4	Heart conditions	Age-related illnesses	Cancers	Heart conditions	Substance use
5	Diabetes	Diabetes	Age-related illnesses	Diabetes	Cancers
6	Cancers	Cancers	Heart conditions	Cancers	Heart conditions
7	Substance use	Substance use	**Violence**	Substance use	Diabetes
8	Chronic pain and pain management	Chronic pain and pain management	Diabetes	**Motor vehicle accidents & injuries**	Chronic pain and pain management

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

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

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

752 Total Respondents in St. Charles County

The table below details the top mental health and substance use concerns among respondents by race. Most of the top concerns remained consistent across groups with some differences in the order of concerns. Notably, Post Traumatic Stress Disorder was identified as a top concern among Black or African American respondents and respondents of another race.

Mental Health & Substance Use Concerns by Race

Higher Concern
Lower Concern

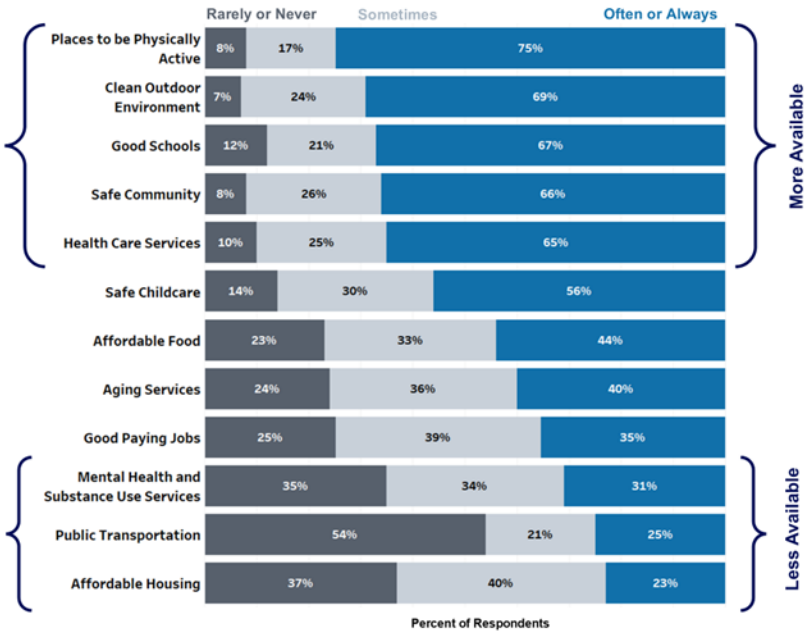
Top Concerns	All Respondents n=752	White n=520	Black or African American n=27	Another Race* n=25	Did not respond or prefer not to disclose n=180
1	Depression	Depression	Depression	Depression	Depression
2	Anxiety	Anxiety	Anxiety	Drug use	Anxiety
3	Alcohol use	Alcohol use	Alcohol use	Alcohol use	Drug use
4	Drug use	Drug use	Drug use	Serious mental illnesses	Alcohol use
5	Serious mental illnesses	Serious mental illnesses	Serious mental illnesses	Anxiety	Serious mental illnesses
6	Loneliness	Loneliness	**Post Traumatic Stress Disorder**	Loneliness	Loneliness
7	Suicide	Suicide	Loneliness	Suicide	Suicide
8	Eating disorders	**Not sure**	Eating disorders	**Post Traumatic Stress Disorder**	**Not sure**

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

Preliminary survey data through June 2024 presented to community leaders

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

752 Total Respondents in St. Charles County



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

Places to be Physically Active, Clean Outdoor Environment, Good Schools, Safe Community, and Health Care Services were rated as being more available, with over 65% of respondents indicating that the resources were often or always available in their community.

Mental Health and Substance Use Services, Public Transportation, and Affordable Housing were reported to be less available, with less than 35% of respondents indicating that the resources were often or always available in their community.

Notes

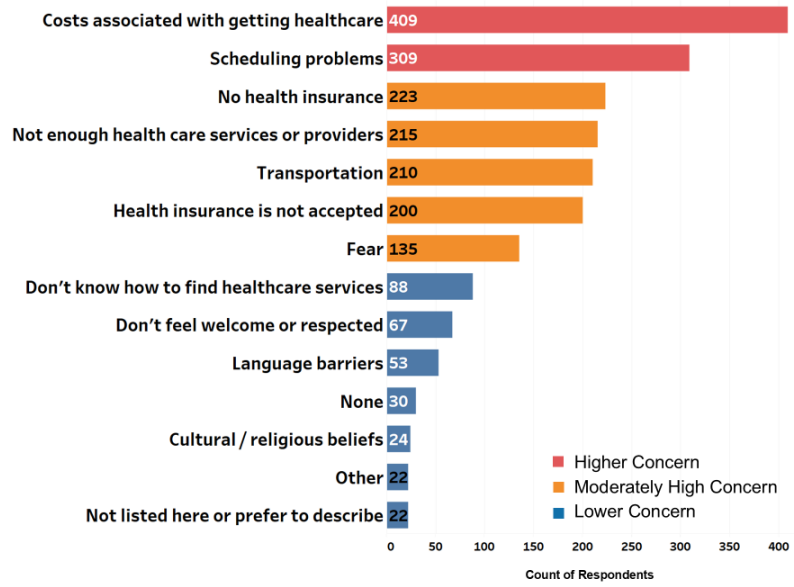
Preliminary survey data through June 2024 presented to community leaders

4

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

752
Total Respondents in St. Charles County

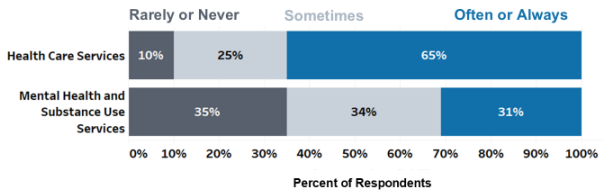
Barriers to Health Care Access



Sixty-five percent (65%) of community members who responded to the survey indicated that health care services were often or always available in St. Charles County. Only 31% indicated that mental health and substance use services had good availability.

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

Health Care Service Availability



Notes

2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders

Appendix G: Community Leader Conversation Participants

Barnes-Jewish St. Peters Hospital and Progress West Hospital: Community Leader Conversation Participants			
Organization	**First Name**	**Last Name**	**Title**
Behavioral Health Network	Jennifer	Miller	Director of Community Programs
Boys & Girls Clubs of St. Charles County	Karen	Englert	Chief Executive Officer
Catholic Charities of St. Louis	James	Whitaker	Navigator
Community Council of St. Charles County	Todd	Barnes	Executive Director
Compass Health Network	Vicky	Walker	Provider
Crossroads Clinic	Susan	Baker	Office Coordinator
Gateway Region YMCA- O'Fallon Missouri	Matt	Jones	Executive Director
Gateway Region YMCA- St. Charles	Renee	Tillman	Executive Director
Missouri SHIP	Peg	Illert	
Operation Food Search Inc	Melanie	Aubrey	Agency Partnerships Manager
PreventED	Kristin	Bengtson	Director of Community Services
SSM Health	Mitch	Miller	Director - Strategy and Business Development
SSM Health	Lauren	Fagan	Administrative Director of Nursing Operations
St. Charles City-County Library	Jason	Kuhl	Chief Executive Officer
St. Charles County Ambulance District	Kelly	Cope	Chief Executive Officer
St. Charles County Ambulance District	Kyle	Gaines	Division Chief – Public Information Officer
St. Charles County Department of Health	Brennan	Burk	Epidemiologist
St. Charles County Department of Health	Samantha	VanNatta	Acting Assistant Department Director
St. Charles County Department of Health	Jessica	McHugh	Epidemiologist
St. Louis Oasis	Marissa	Sandbothe	Education Manager
Youth In Need	Carrie	Williams	Health and Nutrition Manager

Appendix H: Community Conversations Summary

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

The following community conversations are summarized below:

- **Community Leaders** | St. Charles City-County Library – July 25, 2025 – 21 participants
- **Community Members** | Boys & Girls Club of St. Charles County – December 11, 2024 – 10 participants

Community Leader Conversation on Health Needs

Mental Health

- Mental health issues are a top health need
- Stigma, long wait times, and a lack of providers are barriers to accessing care
- Need to focus on mental wellness rather than mental illness
- Holistic, family-based mental health care is needed to support the overall health and well-being of households, not just individual children

Obesity and Maintaining Healthy Weight

- Lack of access to fresh, nutritious food contributes to poor health outcomes, including obesity

Diabetes and High Blood Sugar

- Lack of access to fresh, nutritious food contributes to poor health outcomes, including diabetes

Violence

- Community and domestic violence are critical issues
- Violence contributes to trauma, especially for children
- Violence exacerbates mental health challenges
- Violence is connected to systemic issues, like housing instability, which contributes to stress and poor mental health outcomes
- Trauma-informed care and early intervention are needed to mitigate the impact of violence on health outcomes

Oral and Dental Health

- Access to dental care is a significant barrier for many families
- Free or sliding-scale dental services are needed
- Poor oral health often worsens other health conditions

Community Leader Conversation on Health Resources

Public Transportation

- Access to reliable transportation, especially for older adults and low-income individuals, is an important social determinant of health and a challenge
- Lack of transportation options are a barrier to accessing health care services
- Health care systems need to expand transportation services, including increasing use of mobile health services, to overcome transportation barriers

Affordable Housing

- Shelters for those experiencing domestic violence are limited
- Housing instability, including homelessness and lack of affordable housing, contributes to stress and poor health outcomes
- Housing instability has worsened in recent years
- Health care systems need to invest in affordable housing options

Mental Health and Substance Use Services

- There is a growing demand for mental health services, especially in underserved communities
- Several barriers to accessing mental health services exist, including: Long wait times (up to 9 months for a psychiatrist), a shortage of Medicaid-accepting providers, and stigma
- Mental health services for those experiencing domestic violence are limited
- Health care systems need to expand the availability of culturally competent mental health providers and pursue community-centered strategies (e.g., embedding counselors in schools and community centers, providing mobile mental health services)

Health Care Services

- Access to primary care is a significant barrier for many families
- Some health care resources exist, but many people are either unaware of them or struggle to navigate them due to transportation or language barriers
- Fragmentation of health care services also make them difficult to navigate
- There is a need for better coordination among healthcare providers, social services, and community organizations to ensure seamless care
- Mistrust of health care institutes is a challenge and barrier, especially for communities of color and immigrant populations, who have experienced systemic racism, negative encounters, and fear of judgement or discrimination
- Healthcare providers need to built trust by engaging with the community, being transparent, and offering culturally competent care
- Health care systems need to invest in trauma-informed and culturally competent care models

Affordable, Healthy Food

- Food insecurity is an important social determinant of health and a significant barrier to health and well-being
- Lack of access to fresh, nutritious food contributes to poor health outcomes, including obesity, diabetes, and other chronic conditions
- Demand for food assistance is surging, especially in more rural areas of St. Charles County

Community Member Conversation on Health Needs

Mental Health

- Mental health care for families is the top need
- Stigma and limited mental health services exacerbate the challenges that individuals and families face in accessing mental health care

Community Member Conversation on Health Resources

Safe Community

- A healthy community is one where neighbors know each other and communicate

Places to be Physically Active

- Parks, walking tracks, and other shared spaces are critical for promoting health and fostering community relationships
- Health care systems need to enhance the availability and accessibility of parks, community centers, and other shared spaces to promote health and well-being

Health Care Services

- High cost of health care is a barrier to accessing services
- Complex health care systems and referral processes are a barrier to accessing services
- Poor communication and a lack of empathy from healthcare providers act as a barrier to seeking care
- Health care systems need to explore patient advocates who can guide families through complex systems to help alleviate confusion and stress
- Mobile health care services are needed to alleviate access issues

Health care systems need to advocate for transparent billing practices and explore strategies to lower out-of-pocket health care costs

Appendix I: Hospital Team Survey

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

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

Tell Us About Your Community

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

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

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

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

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

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

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

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

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

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

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

Thank you for your time and input!

Appendix J: Hospital Community Health Needs Selection Team

Barnes-Jewish St. Peters Hospital and Progress West Hospital 2025 Community Health Needs Selection Team Attendees 05/05/2025			
Last Name	**First Name**	**Title**	**Department**
Bailey	Sarah	Social Worker, Clinical	Patient Care Evaluation
Beldner	Bradly	Director, Finance & Support Services	Financial Operations
Biermann	Kathryn	Social Worker, Clinical	Patient Care Evaluation
Earlewine	Cynthia	Manager, Assistant Nurse (Clinical)	Women's Services
Garba	Nila	Analyst, Clinical Analyst - SR	Clinical Info & Analytics
Harlow	Kimberly	Manager, Program - CSL	Surgery
Hill	Rebecca	Manager, Clinical Dietitian	Food Services
Kelly	Stephanie	Spec, Patient Flow-Bed Mgt	Patient Placement Center
Meadows	Lisa	Manager, Community Health / Community Health Improvement Lead	Family Health Resource Center
Mohan	Karen	Supervisor, Physician Services	Physician Services
O'Neal	Lindsey	Assistant Nurse Manager	Recovery Room
Roth	Jill	Manager, Radiation Oncology	Radiation Oncology
Schob	Tina	Capacity Planning Program Manager	Nursing Resources
Sparks	Rachel	Director, Quality	QSIP (Qual, Safety & IP)
Turnipseed	Mark	Foundation Director / Community Health Improvement Lead	General Administration - Fundraising

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			