2025-2028 Community Health Needs Assessment and Improvement Plan

BJC HealthCare | Encompass Health

The Rehabilitation Institute of St. Louis

Central West End • St. Peters • West County

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

A Message from Bob Cannon, President, BJC HealthCare, and Jeff Reese, Area Chief Executive Officer, Encompass Health

The Rehabilitation Institute of St. Louis, a joint venture between BJC HealthCare and Encompass Health, aims to live out its mission to expand possibilities and enhance the lives of those we serve. In order to do this, we must help our community members live their healthiest lives by addressing their heath needs, both inside and outside our walls.

This report includes our 2025 Community Health Needs Assessment (CHNA) and the resulting 2026–2028 Community Health Improvement Plan (CHIP) for The Rehabilitation Institute of St. Louis, 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 The Rehabilitation Institute of St. Louis, we are committing to focused efforts around heart conditions, and more specifically, stroke. This priority was 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 The Rehabilitation Institute of St. Louis, 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

Jeff Reese
Area Chief Executive Officer for St. Louis and Southern Illinois
The Rehabilitation Institute of St. Louis, an affiliate of
BJC HealthCare and Encompass Health

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About BJC HealthCare and Encompass Health

The Rehabilitation Institute of St. Louis is a joint venture between BJC HealthCare and Encompass Health and affiliated with WashU Medicine in St. Louis.

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.

Encompass Health is a national network of inpatient rehabilitation hospitals. In their partnership with BJC Health System, The Rehabilitation Institute of St. Louis has four locations in the St. Louis metro area covering communities in both Missouri and Illinois.

BJC HealthCare | Encompass Health

The Rehabilitation Institute of St. Louis

Central West End • St. Peters • West County

Mission

Expanding possibilities and enhancing the lives of those we serve.

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

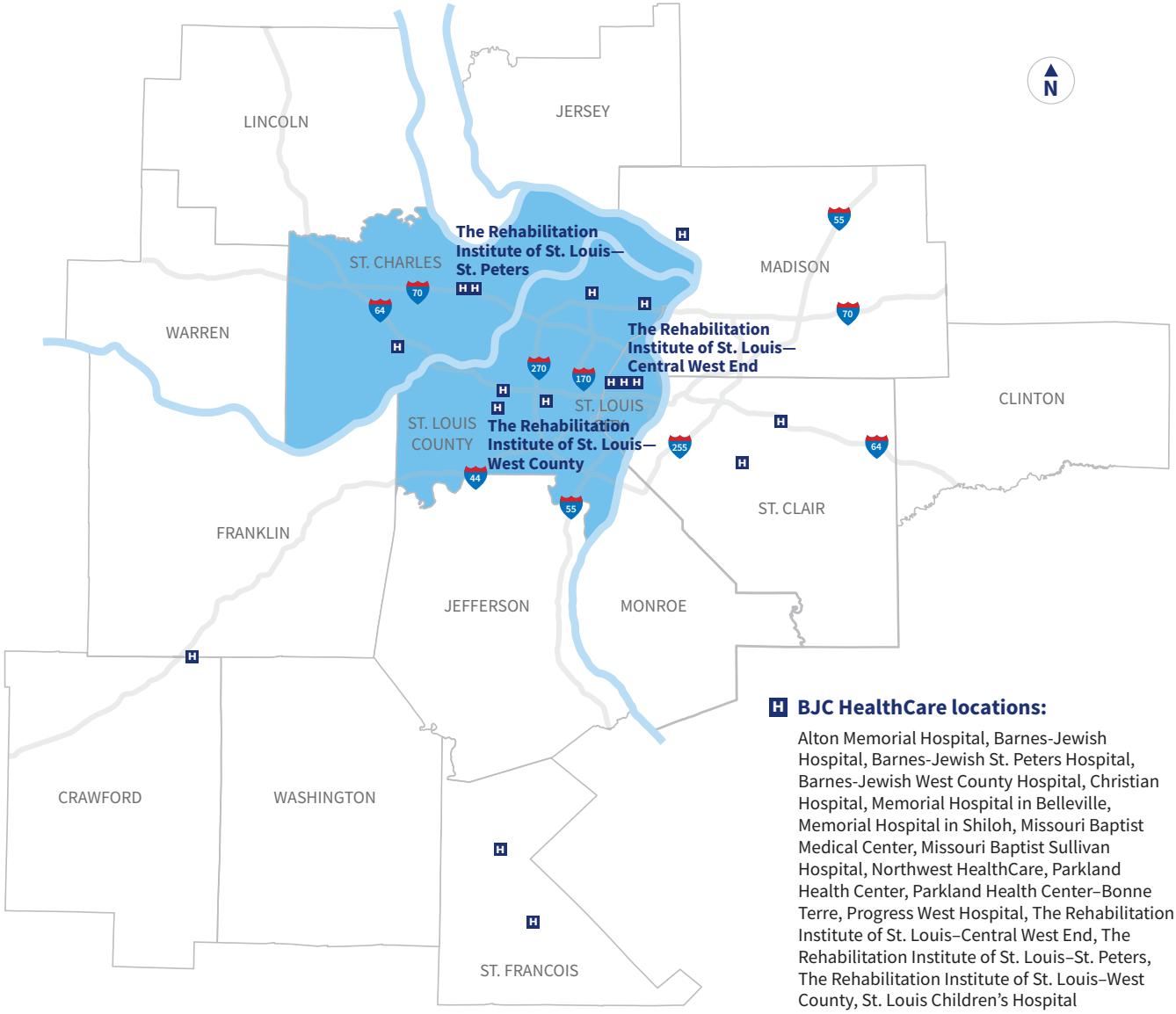
All nonprofit hospitals, including all BJC HealthCare hospitals, are required to do a Community Health Needs Assessment (CHNA) every three years. CHNAs are an important opportunity for hospitals to learn about what their community needs to be healthier. The Rehabilitation Institute of St. Louis is required to conduct a CHNA because half of the entity is nonprofit (BJC HealthCare).

When their CHNAs are complete, hospitals create Community Health Improvement Plans. These plans set specific goals and actions to improve health needs in the community. In this report, we will share how we found out about health needs in the Rehabilitation Institute of St. Louis community and chose which health needs to work on. Then, we will talk about our goals and plans for building a healthier community.

The Rehabilitation Institute of St. Louis and the Community We Serve

The Rehabilitation Institute of St. Louis—Central West End, The Rehabilitation Institute of St. Louis—West County, and The Rehabilitation Institute of St. Louis—St. Peters work together on one combined Community Health Needs Assessment (CHNA) and Community Health Improvement Plan. Because of this, our CHNA is focused on **St. Louis City, Missouri; St. Louis County, Missouri; and St. Charles County, Missouri**.

The Rehabilitation Institute of St. Louis is part of the larger BJC service area, which includes health care locations across the St. Louis region.



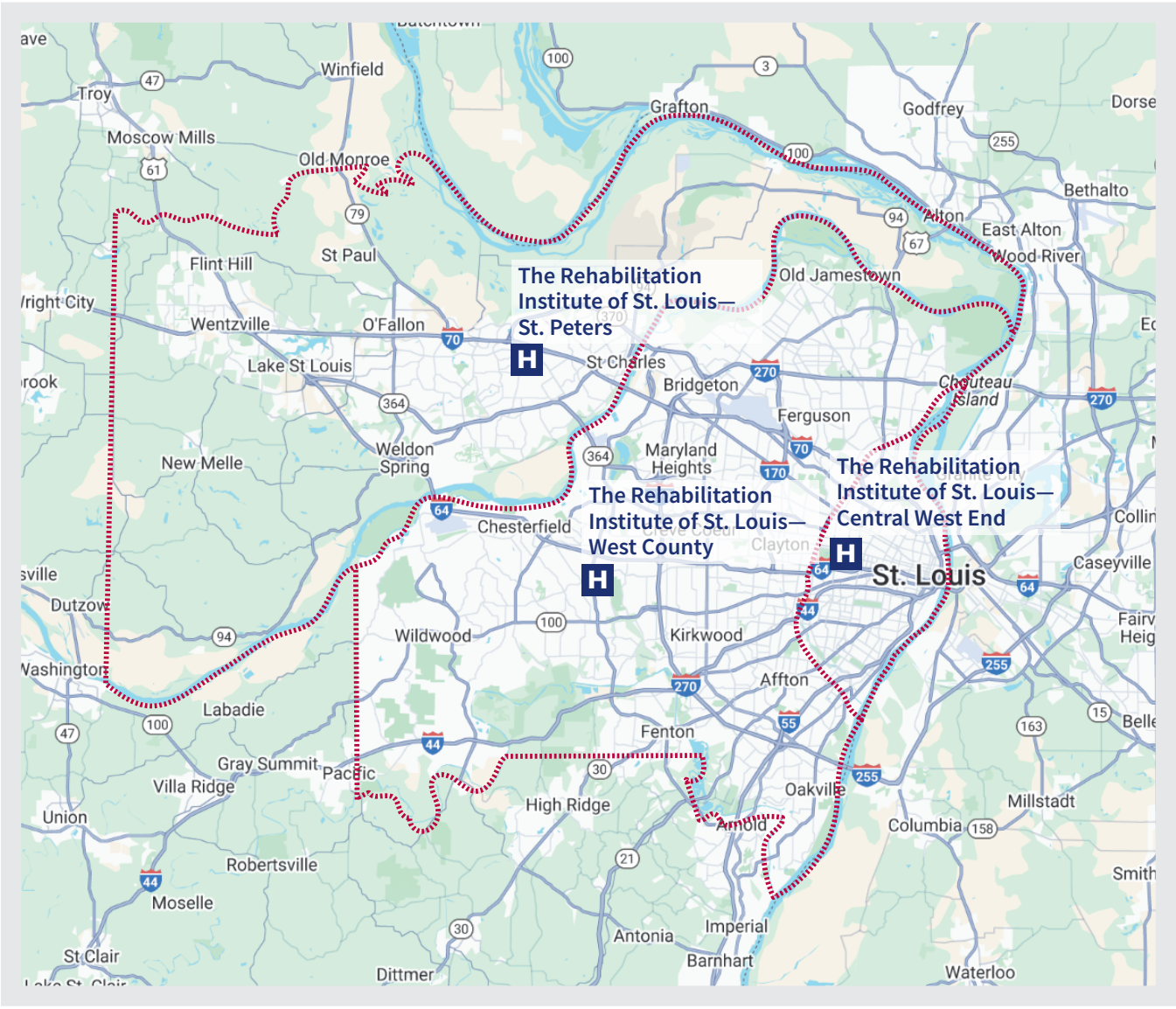
BJC HealthCare locations:

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, The Rehabilitation Institute of St. Louis–Central West End, The Rehabilitation Institute of St. Louis–St. Peters, The Rehabilitation Institute of St. Louis–West County, St. Louis Children's Hospital

The Institute offers a full range of inpatient rehabilitation services for patients recovering from stroke, brain, and spinal cord injuries; cancer; and neurologic and orthopedic conditions. The team is certified in many specialties, including rehab registered nursing, brain injury, wound care, neurology, and lymphedema therapy.

The Institute's staff collaborate with WashU Medicine on rehab research and education programs. We are dedicated to helping patients return home.

The Rehabilitation Institute of St. Louis Community Health Needs Assessment service area close-up



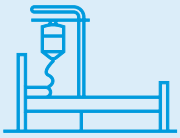
Patients admitted for rehab services receive at least three hours of therapy five days a week. This can include a combination of physical therapy, occupational therapy, and/or speech-language therapy, depending on each patient's needs. Each type of therapy helps patients build the skills they need to achieve their goals.

The Institute is certified by The Joint Commission in stroke, brain injury, amputation, wound care, and spinal cord injury rehab. We are also accredited through the Commission on the Accreditation of Rehabilitation Facilities for their **comprehensive inpatient rehab program**.

The Institute has dedicated staff who provide care for many community members. In 2024, we had 176 staffed hospital beds across our three counties.

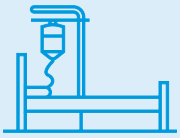
The Rehabilitation Institute of St. Louis by the Numbers

Central West End



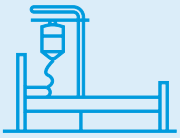
96
Beds
(free-standing)

St. Peters



40
Beds
(3rd floor of Barnes-Jewish St. Peters Hospital)

West County



40
Beds
(free-standing)

St. Louis City, Missouri

About **300,000 people** call St. Louis City home.[1] St. Louis City is an urban area.[1] About half of the people who live in St. Louis City are white, and about one in seven residents are older than 65 years.[1] The life expectancy for St. Louis City residents is about 72 years.[2] This is about three years less than the life expectancy for 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

Almost half of all St. Louis City 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. The median home value in St. Louis City is about $185,000.[1] In neighboring St. Louis County, the median home value is about $260,000.[1] When homes are worth less in your neighborhood, you have less to gain from selling your house. Houses that are worth less are taxed less, so less money goes to fund local schools, roads, and other infrastructure.

In St. Louis City, **nearly all residents have at least 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. Louis City is about $55,000 per year.[1] The median state household income is about $69,000 per year.[1]

About one in four children in St. Louis City live in poverty.[1] This is higher than across the state of Missouri, where one in six children live in poverty.[1]

St. Louis County, Missouri

About **one million people** call St. Louis County home.[1] Much of St. Louis County is the suburbs of the St. Louis metro area.[1] More than half of the people who live in St. Louis County are white, and about one in five residents are older than 65 years.[1] The life expectancy for St. Louis County residents is about 76 years, which is about a year more than the life expectancy for 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

Almost half of all St. Louis 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. Louis County, **nearly all residents have at least 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. Louis County is about $81,000 per year.[1] This is higher than the median state household income.[1]

About one in eight children in St. Louis County live in poverty.[1] This is lower than the state of Missouri, where one in six children live in poverty.[1]

St. Charles County, Missouri

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 five 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

About 4 in 10 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, **nearly all residents have at least 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] This is higher than the median state household income.[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]

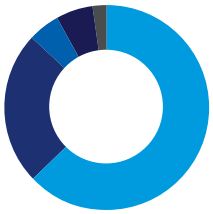
The Rehabilitation Institute of St. Louis— Central West End Community Characteristics

St. Louis City

Population
293,109

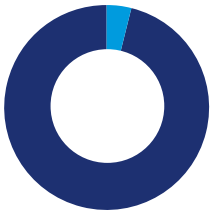
Land Area
62 sq. mi.

Race



- **46%** White
- **43%** Black
- **3%** Asian
- **6%** 2 or more races
- **2%** Other*

Ethnicity



- **5%** Hispanic/ Latino
- **95%** Not Hispanic/ Latino

Most people have at least a high school education

St. Louis City	Missouri
91%	92%

Life Expectancy

St. Louis City	Missouri
72	75

The median household income in St. Louis City is lower than for the state of Missouri

St. Louis City	Missouri
$55,279	$68,920

The median home value in St. Louis City is much lower than in St. Louis County

St. Louis City	St. Louis County
$185,100	$260,700

Poverty rates among children in St. Louis City are much higher than in the state of Missouri

St. Louis City	Missouri
27%	16%

People over 65

St. Louis City	Missouri
15%	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.*

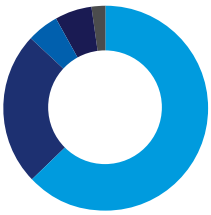
The Rehabilitation Institute of St. Louis—West County Community Characteristics

St. Louis County

Population
996,618

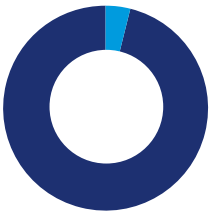
Land Area
508 sq. mi.

Race



63% White
24% Black
5% Asian
6% 2 or more races
2% Other*

Ethnicity



4% Hispanic/Latino
96% Not Hispanic/Latino

Most people have at least a high school education

St. Louis Co.	Missouri
94%	92%

Life Expectancy

St. Louis Co.	Missouri
76	75

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

St. Louis Co.	Missouri
$81,340	$68,920

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

St. Louis Co.	Missouri
45%	42%

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

St. Louis Co.	Missouri
13%	16%

People over 65

St. Louis Co.	Missouri
19%	18%

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

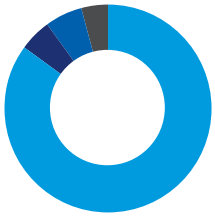
**Note: Other includes American Indian and Alaska Native people, Native Hawaiian and Pacific Islander people, and people of other races not included in the categories above.*

The Rehabilitation Institute of St. Louis—St. Peters
Community Characteristics

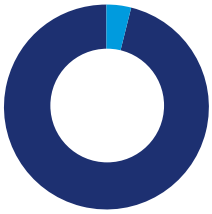
St. Charles County

Population
409,830

Land Area
561 sq. mi.



85% White
5% Black
6% 2 or more races
4% Other*

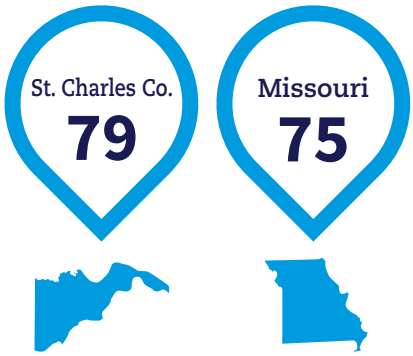


4% Hispanic/ Latino
96% Not Hispanic/ Latino

Most people have at least a high school education

St. Charles Co. **96%**
Missouri **92%**

Life Expectancy



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

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

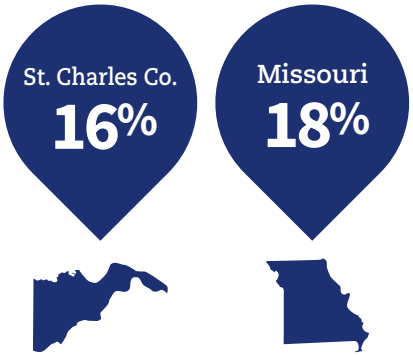
More than a third of people spend more than 30% of their income on housing

St. Charles Co. **38%**
Missouri **42%**

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

St. Charles Co. **5%**
Missouri **16%**

People over 65



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

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

Where We've Been…

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

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

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

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

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

The Rehabilitation Institute of St. Louis Community Health Need and Goal from 2022–2025

In our last Community Health Needs Assessment at The Rehabilitation Institute of St. Louis, we learned that heart conditions, including stroke, was one of the top health concerns in our communities. For this health need, we set a goal and made a plan to reach the goal.

Heart Conditions—Stroke

Goal: Promote stroke education and prevention

Heart Conditions—Stroke

Our Strategy ▸

We wanted to promote stroke education and prevention to people in St. Louis City, St. Louis County, and St. Charles County. The goal of this program was to **increase participants' knowledge about stroke risk factors, warning signs, and prevention strategies**.

To support this goal, we wanted to continue to offer blood pressure checks and distribute stroke education materials to community members, visitors, and staff during Stroke Awareness Month each May. We wanted residents to answer questions before and after the session to measure improvement in knowledge. We wanted to increase their knowledge by at least 10%.

The program also wanted to continue supporting the ABC Brigade and its related activities, like Strokes for Stroke and Stampede for Stroke, to provide ongoing education and support for stroke survivors and the broader community.

Our Progress ▸

During Stroke Awareness Month, we successfully provided blood pressure screenings and education on stroke prevention, as well as the signs and symptoms of stroke. To strengthen our action plan, we also included elementary school education based on input from physicians that stroke prevention education is helpful starting at a young age. Students who participated in the stroke education program showed a 19% increase in understanding how to prevent a stroke and a 23% increase in the importance of calling 911 when recognizing stroke symptoms. We also continued to partner with the ABC Brigade to support stroke survivors and promote stroke education and prevention. Unfortunately, due to unexpected challenges, the ABC Brigade has not been active for the past two years.

Where We Are Today…

2025 Community Health Needs Assessment (CHNA)

We wanted to understand the 2025 health needs of our community by doing a new Community Health Needs Assessment (CHNA). With the CHNA, we can make a plan with updated goals for improving community health. To understand St. Louis City's, St. Louis County's, and St. Charles County's current needs, we used many sources of information. We gathered some of this information for each county individually. For other sources, we worked with the Rehabilitation Institute of Southern Illinois to gather information about our larger service area. Our **information sources** included:

For the community survey and community information, we gathered the information separately for each county.

For the community conversations, we aligned with the Rehabilitation Institute of Southern Illinois. For the hospital service information and hospital team survey, we included information about all three Rehabilitation Institutes of St. Louis locations and the Rehabilitation Institute of Southern Illinois.

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: St. Louis City

We invited **community members in St. Louis City** 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 city 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 this survey. By working together, we asked community members these questions once instead of multiple times.

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

This included people from:

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

We also shared it at BJC hospitals, clinics, and community sites in St. Louis City. 1,158 community members completed the survey. See more details in Appendix B and Appendix C.

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

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

COMMUNITY SURVEY

Top 5 Health Problems

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

Top 5 Mental Health Concerns

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

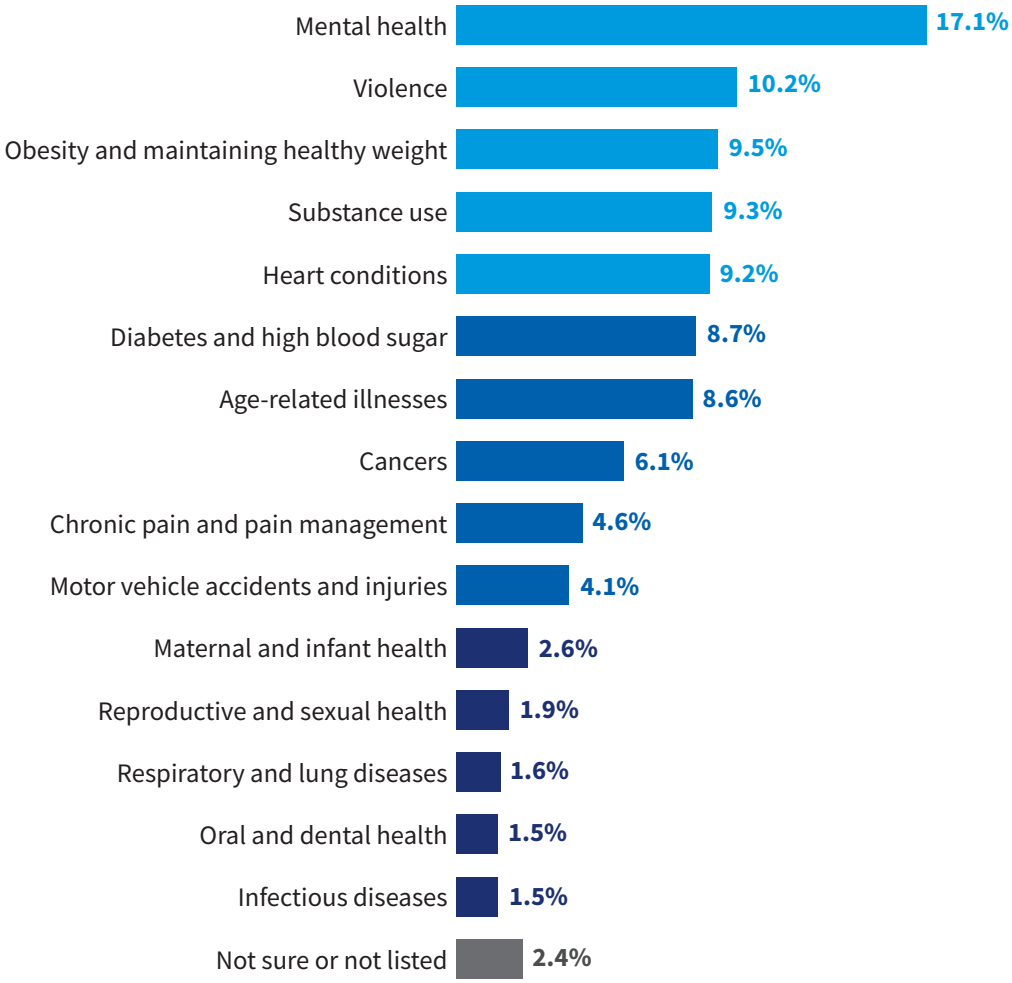
Top 5 Barriers to Care

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

Top 5 Community Resource Needs

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

Community members in St. Louis City 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**.



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

We learned that costs, scheduling problems, and transportation were serious challenges to getting care. The community needs more affordable housing, public transportation, 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. Age-related illnesses
3. Obesity and maintaining healthy weight
4. Heart conditions
5. Cancers

Top 5 Mental Health Concerns

1. Depression
2. Anxiety
3. Alcohol use
4. Drug use
5. Loneliness

Top 5 Barriers to Care

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

Top 5 Community Resource Needs

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

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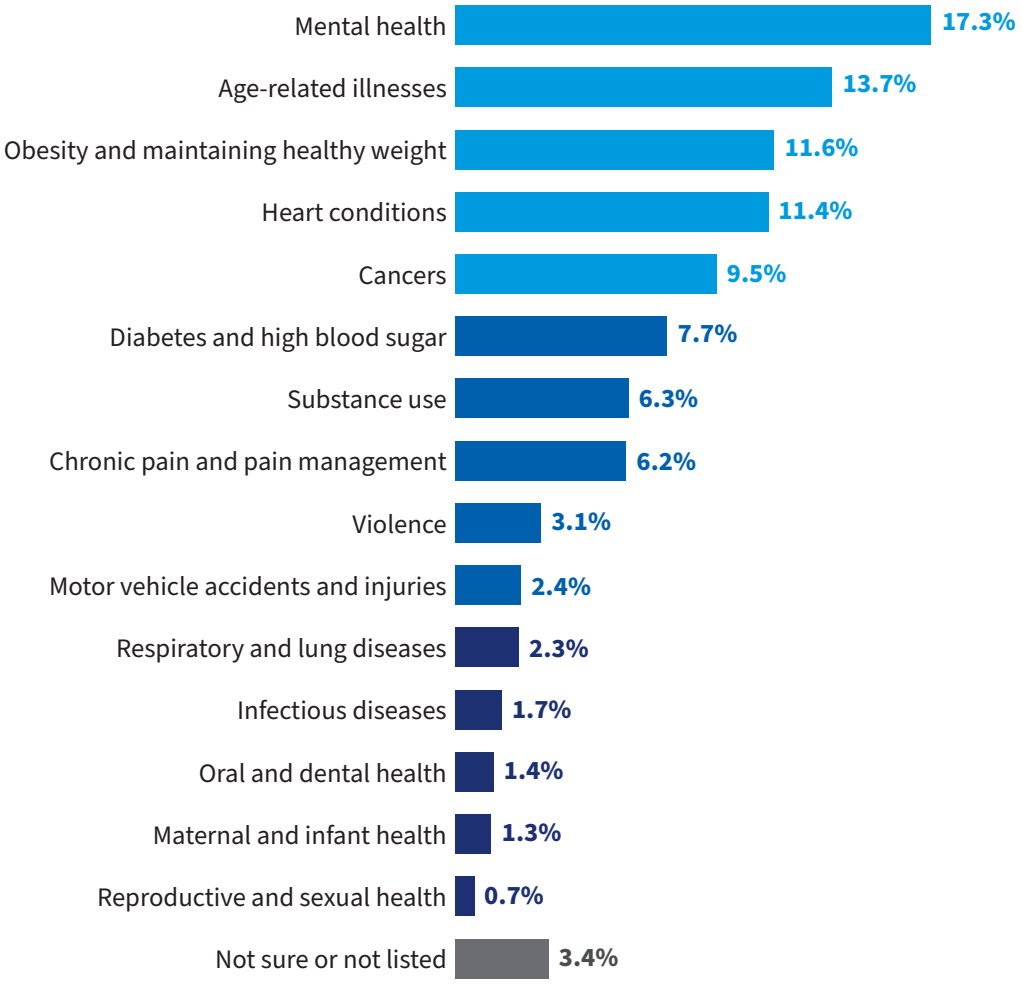

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- **Community resources** and strengths
- **Barriers** to health care

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 more details in Appendix B and Appendix C.

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

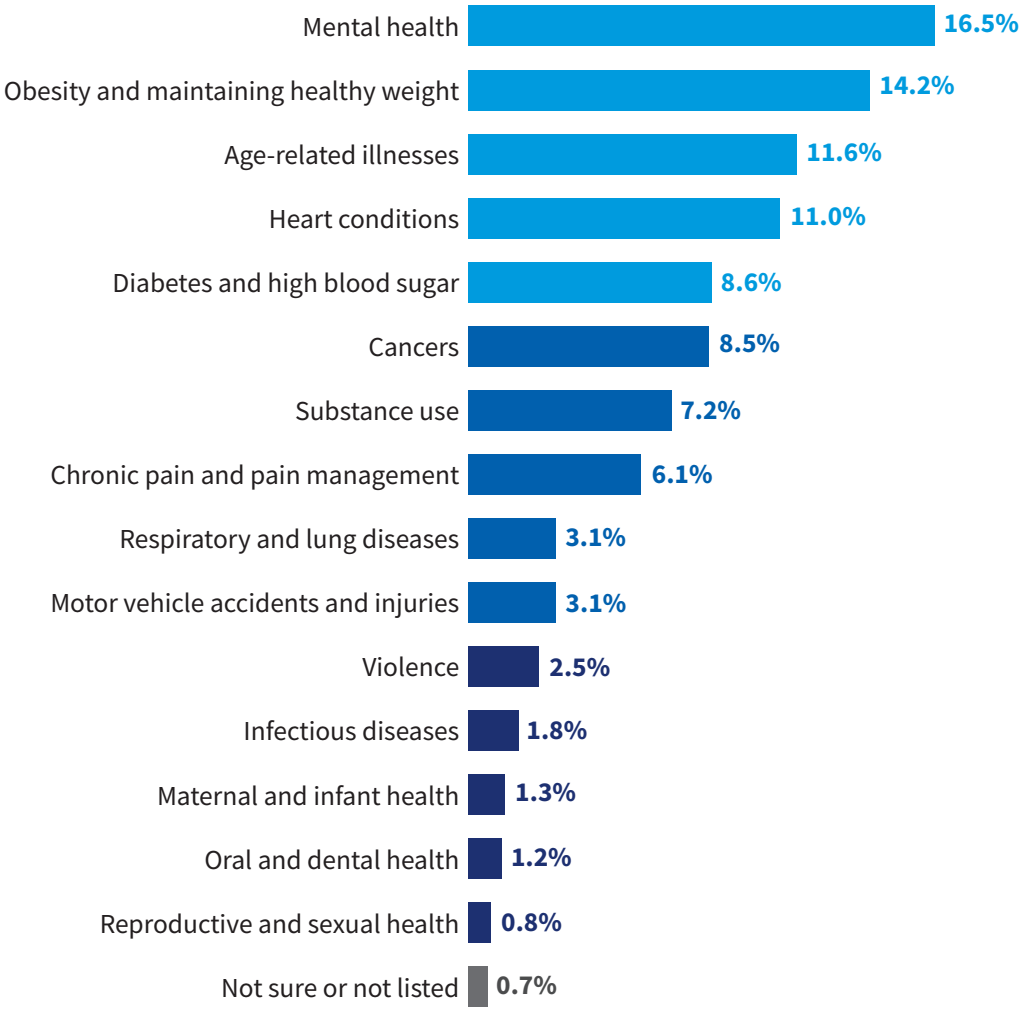
Top 5 Barriers to Care

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 in St. Charles County 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: St. Louis City

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

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

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

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

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

The top health needs from HCI were immunizations and infectious diseases; older adults; and maternal, fetal, and infant health. The top social determinants of health needs were economy (like poverty and employment rates), community (like the use of public transportation and access to the Internet), and environmental health. See more details in the list on the right.

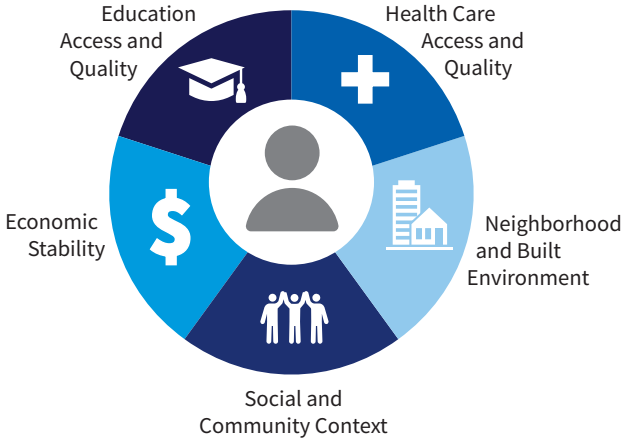
COMMUNITY INFORMATION

Top 5 Health Problems

1. Immunizations and infectious diseases
2. Older adults
3. Maternal, fetal, and infant health
4. Prevention and safety
5. Heart disease and stroke

Top 3 Most Needed Social Determinants of Health

1. Economy
2. Community
3. Environmental health



Community Information: St. Louis County

We looked at community information 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 Human Services. The information from HCI is usually two to six years old because different information is collected at different times. It also takes time to get the data ready to be shared.

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

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

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

The top health needs from HCI were prevention of and safety from violence and injury; cancer; and maternal, fetal, and infant health. The top social determinants of health needs were community (like the use of public transportation and access to the Internet), health care access and quality, and environmental health. See more details in the list on the right.

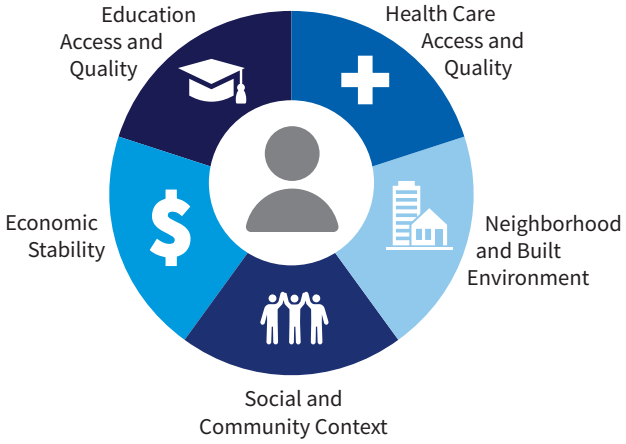
COMMUNITY INFORMATION

Top 5 Health Problems

1. Prevention and safety
2. Cancer
3. Maternal, fetal, and infant health
4. Alcohol and drug use
5. Older adults

Top 4 Most Needed Social Determinants of Health

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



Community Information: St. Charles County

We looked at community information 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. We held the community leader and member conversations jointly for all three Rehabilitation Institute of St. Louis locations.

Community Leaders

We invited many community leaders to a meeting at the Rehabilitation Institute of St. Louis—West County. These leaders included:

- Health care providers
- Public health officials
- 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 a healthy weight, diabetes and high blood sugar, and chronic pain and pain management. 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; aging services; and affordable, healthy food. See more details in the list on the right.

The Rehabilitation Institute of St. Louis—West County in Ballwin, Missouri, where conversations with community leaders took place

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 high blood sugar
- Chronic pain and pain management

Discussed Community Health Resources

- Public transportation
- Aging services
- Affordable, healthy food

Community Members

After speaking with community leaders, we wanted to speak with community members. We hosted community member conversations with the help of our community leaders.

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 were invited to participate in the conversations.

We met with community members at Paraquad. We asked community members which health needs were the most important to them. Community members discussed mental health and heart conditions.

We then asked community members which community resources were most needed. They discussed public transportation, aging services, good paying jobs, and others. See more details in the list on the right.

Paraquad in St. Louis City, 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
- Heart conditions

Discussed Community Health Resources

- Public transportation
- Aging services
- Good paying jobs
- Affordable, healthy food
- Safe community
- Health care services
- Places to be physically active

Hospital Service Information

When patients receive care at a hospital, their care is billed to their insurance. This is known as a claim. We looked at the hospital claims data across the Rehabilitation Institutes of St. Louis and Southern Illinois. We looked at all types of inpatient care.

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 the Rehabilitation Institutes of St. Louis and Southern Illinois, the most common reasons patients visit are for hypertension, behavioral health disorders, and diabetes. See more details in the list below.

HOSPITAL SERVICE INFORMATION

Top 5 Health Conditions

1. Hypertension
2. Behavioral health disorders
3. Diabetes
4. Chronic kidney disease
5. Ischemic heart disease

Hospital Team Survey

The Rehabilitation Institutes of St. Louis and Southern Illinois came together to form a Community Health Needs Assessment (CHNA) team. Our team was made up of **people from many different roles in the Rehabilitation Institutes**. We wanted our team to include people with different perspectives, knowledge, and skills. Team members work in areas like:

- Case management
- Community health support
- Care services and quality
- Finance

The Rehabilitation Institutes CHNA team took a survey about local health needs. Team members were most concerned about heart conditions, mental health, age-related illnesses, and diabetes and high blood sugar. See more details in the list below.

HOSPITAL TEAM SURVEY

Top 4 Community Health Needs

1. Heart conditions
2. Mental health (tie)
2. Age-related illnesses (tie)
2. Diabetes and high blood sugar (tie)

Top 4 Most Needed Community Health Resources

1. Affordable housing (tie)
1. Mental health and substance use services (tie)
2. Public transportation
3. Safe childcare

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 our communities. Then, we at the Rehabilitation Institutes of St. Louis and Southern Illinois met to plan how to improve these health needs within our counties.

We considered how important the health needs are to the audiences we spoke to. These include community members, community leaders, and employees of the Rehabilitation Institutes. We wanted to elevate the community's voice, so we made their answers count more than other information sources. We ranked five health needs as most important for each of our counties. 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 five health needs in each county to consider working on in The Rehabilitation Institute of St. Louis community**.

St. Louis City	St. Louis County	St. Charles County
Mental health	Mental health	Mental health
Heart conditions	Heart conditions	Heart conditions
Substance use	Age-related illnesses	Age-related illnesses
Obesity & maintaining healthy weight	Diabetes & high blood sugar	Diabetes & high blood sugar
Diabetes & high blood sugar	Obesity & maintaining healthy weight	Obesity & maintaining healthy weight
Violence	Chronic pain & pain management	Cancers
Age-related illnesses	Cancers	Substance use
Cancers	Substance use	Chronic pain & pain management
Chronic pain & pain management	Violence	Respiratory & lung diseases
Motor vehicle accidents & injuries	Motor vehicle accidents & injuries	Motor vehicle accidents & injuries
Respiratory & lung diseases	Respiratory & lung diseases	Violence
Maternal & infant health	Infectious diseases	Infectious diseases
Reproductive & sexual health	Oral & dental health	Maternal & infant health
Infectious diseases	Maternal & infant health	Oral & dental health
Oral & dental health	Reproductive & sexual health	Reproductive & sexual health

● More concerning ● Moderately concerning ● Less concerning

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

We met virtually as a joint Rehabilitation Institutes 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 heart conditions, diabetes, mental health, and obesity and maintaining healthy weight.

Health Needs We Will Not Prioritize in This CHIP

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

We decided not to prioritize mental health, diabetes, and obesity and maintaining a healthy weight. The team determined that our stroke-related programming already addresses mental health needs and chronic conditions, including obesity and diabetes. We will continue to build on our efforts and implement stroke programming that takes into consideration these important, and related, needs.

Health Need We Will Prioritize in This CHIP

We decided to prioritize **heart conditions**, focusing mainly on **stroke**. Stroke education and prevention are in strongest alignment with our team's expertise and the resources and partnerships available to us. By working to improve heart conditions, mainly stroke, we may improve other health needs, too.

A Closer Look at Our Prioritized Need

We decided to prioritize heart conditions, focusing mainly on stroke. This is how we define this concern.

Heart Conditions—Stroke

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

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

One aspect of heart disease is **stroke**. There are two types of strokes. One type, ischemic stroke, happens because blood flow to the brain is blocked.[3] Ischemic stroke is the most common type of stroke.[3] The other type, hemorrhagic stroke, happens because of sudden bleeding in the brain.[3]

Both types of strokes can cause **long-term brain damage, disability, and death**.[3]

In St. Louis City, about 4 adults out of 100 have had a stroke, and about 5 out of 10,000 people die because of stroke.[4]

In St. Louis County, about 4 adults out of 100 have had a stroke, and about 4 out of 10,000 people die because of stroke.[4]

In St. Charles County, about 4 adults out of 100 have had a stroke, and about 3 people out of 10,000 die because of stroke.[4]

In the state of Missouri, about 4 out of 10,000 people die because of stroke.[4] These numbers take into account the impact of age on death.

In the St. Louis region and the state of Missouri, about

4% of people have had a stroke

St. Louis City	St. Louis County	St. Charles County
4%	4%	4%

SOURCE: Conduent Healthy Communities Institute

Older people are more likely to die from stroke.[5] For this reason, when talking about death from stroke, 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 at the Rehabilitation Institute of St. Louis learned about our community's needs. We did this in collaboration with our community leaders, community members, staff from the Rehabilitation Institutes of St. Louis and Southern Illinois, 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.

We brought together team members with different kinds of expertise about our selected health need. Our team drafted a plan to address this health need. When developing our CHIP, the workgroup thought about the resources available, 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:
Heart Conditions—Stroke

Goal: Increase access to stroke prevention, detection, education, and treatment to improve outcomes and quality of life for people who have experienced or are at risk of experiencing a stroke

Category: *Health education*

INITIATIVE: In collaboration with community organizations and local schools, deliver stroke education and prevention resources.

MEASURES:
- #/type of sessions delivered
- #/type of sites engaged
- #/type of participants reached
- % of participants who report increased knowledge related to stroke risk factors, signs, and symptoms

What Comes Next

Looking Forward

At the Rehabilitation Institute of St. Louis, 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 heart conditions and stroke are complex. With our plan, we will continue to uphold our **long-term commitment** to our community. We will continue to provide timely and high-quality care for our community's needs. Over the next three years, we will build collaborations and create initiatives for our community's health needs. We will also gather important information about the health needs. These steps are crucial to ensure continued progress toward our community's health needs beyond the next three years. We also look forward to sharing our progress along the way. We will collaborate with community organizations and community members to improve the lives of people in St. Louis City, St. Louis County, and 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.

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Appendices

Appendix A: Community Demographics

Demographics of St. Louis City, St. Louis County, St. Charles, and Missouri				
	St. Louis City	St. Louis County	St. Charles	Missouri
POPULATION				
Population 2020	304,709	996,179	398,472	6,124,160
Population 2023 (estimate)	281,754	987,059	416,659	6,196,156
Population 2024 (estimate)	279,695	992,929	423,726	6,245,466
Population, Percent change - 2023 (estimate) to 2024 (estimate)	-0.7	0.6	1.7	0.8
AGE				
Persons Under 5 Years, Percent, 2024	5.3	5.3	5.2	5.5
Persons Under 18 Years, Percent, 2024	17.8	21.6	21.9	21.9
Persons 65 Years and over, Percent, 2024	16.6	20.1	18.2	18.7
GENDER				
Female Persons, Percent, 2024	51.8	52.2	50.5	50.7
Male Persons, Percent, 2024	48.2	47.8	49.5	49.3
RACE/ETHNICITY				
White alone, Percent, 2024	46.2	62.9	83.1	77.6
White alone, not Hispanic or Latino, Percent, 2024	44.9	62.1	81.5	76.2
African American alone, Percent, 2024	40.5	23.3	5.3	10.5
Hispanic or Latino, Percent, 2024	5.7	4.1	4.5	5.6
Two or More Races, Percent, 2024	7.1	6.1	6.6	7.3
American Indian and Alaska Native alone, Percent, 2024	0.3	0.1	0.1	0.3
Asian alone, Percent, 2024	3.9	5.4	3.4	2.3
Native Hawaiian and Other Pacific Islander alone, Percent, 2024	0.0	0.2	0.1	0.1
LANGUAGE				
Foreign Born Persons, Percent, 2024	8.8	8.5	5.3	4.9
HOUSING				
Housing Units, 2024	174,694	447,542	172,400	2,858,527
Homeownership Rate, Percent, 2024	46.0	69.9	79.3	68.6
Median House Value, Dollars, 2024	214,500	300,800	344,300	254,400

Demographics of St. Louis City, St. Louis County, St. Charles, and Missouri				
	St. Louis City	St. Louis County	St. Charles	Missouri
FAMILIES & LIVING ARRANGEMENTS				
Households, 2024	148,637	412,517	165,353	2,563,244
Persons per Household, 2024	1.8	2.4	2.5	2.4
Language other than English spoken at home, Percent of persons age 5 years +, 2024	10.8	11.0	6.8	7.4
EDUCATION				
High School Graduate or Higher, Percent of Persons Age 25+, 2024	90.8	94.6	95.5	92.0
Bachelor's Degree or Higher, Percent of Persons Age 25+, 2024	45.0	48.4	43.4	33.5
INCOME				
Median Household Income, Dollars, 2024	53,374	83,669	103,686	71,589
Per Capita Income in past 12 months (in dollars), 2024	44,949	52,297	50,323	40,284
People Living Below Poverty Level, Percent, 2024	21.7	9.7	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. Louis City, Missouri, 1,158 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 1 to 134. On average, about 25% of participants chose not to answer the optional demographic. Among those who did respond, most were between 35 and 44 years old (17%), women (58%), White (49%), non-Hispanic (58%), and primarily English-speaking at home (72%). Many held advanced degrees such as a Master's, Professional, or Doctorate degree (31%), were employed full time (53%), and reported a household income between $100,000 and $149,999 (11%).

In South-Mid-West St. Louis County, Missouri, 1,701 people participated in the Community Health Needs Survey. The number of respondents from each ZIP code ranged from 6 to 144. On average, about 25% of participants chose not to answer the optional demographic. Among those who did respond, most were between 55 and 64 years old (16%), women (59%), White (64%), non-Hispanic (60%), and primarily English-speaking at home (73%). Many held advanced degrees such as a Master's, Professional, or Doctorate degree (32%), were employed full time (46%), and reported a household income between $100,000 and $149,999 (13%).

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

The Rehabilitation Institute of St. Louis

Key Survey Findings

BJC HealthCare

The Rehabilitation Institute OF ST. LOUIS
an affiliation of BJC HealthCare and Encompass Health

2024 Community Health Needs Assessment Survey

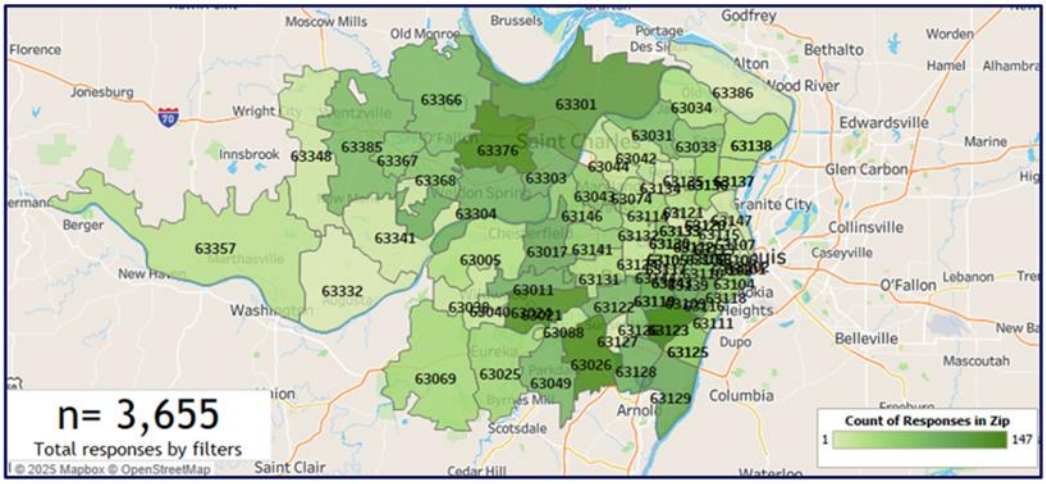
Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

3,655
Total Respondents in 3-County Area

In the three-county area that includes the City of St. Louis, St. Louis County, and St. Charles County, 3,655 community members responded to the community health needs survey. The number of survey respondents in these ZIP codes ranged between 1 and 147.

Survey Respondents by ZIP Code



2024 Community Health Needs Assessment Survey

Preliminary survey data through June 2024 presented to community leaders*

1 Who responded to the survey?

3,655
Total Respondents in 3-County Area

Over 20% of respondents in the three-county area did not complete the optional demographic survey questions (non-respondents range from n=881-1,293 depending on the survey 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=3,655).

Most respondents:

- Are between the age of 45 and 54 years old (16%)
- Are women (60%)
- Are White (58%)
- Are non-Hispanic (59%)
- Speak English at home (74%)
- Have a Master's, Professional, or Doctorate degree (28%)
- Are employed full time (51%)
- Have a household income between $100,000 and $149,999 (14%)

Additional details for each demographic characteristic are provided on the next handout.

An example of how to engage with the demographic visuals is provided to the right.

Example: Survey Respondents by Age Group

Demographic characteristic → **Age Group**

Response options →

Age Group	
Under 18	27
18-24	71
25-34	339
35-44	567
45-54	576
55-64	553
65-74	420
75+	169
Prefer not ot disclose	52
Null	881

Number of survey respondents in the specific geography who selected each response option

For example, 71 community members, between the age of 18 to 24 years old, completed the survey

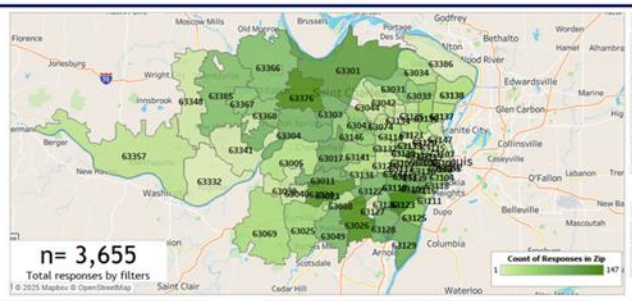
A darker color indicates more respondents

More Survey Respondents

Fewer Survey Respondents

1 Who responded to the survey?

3,655
Total Respondents in 3-County Area



Race	
White	2,102
Black or African American	368
American Indian or Alaska Native	30
Asian	64
Native Hawaiian or Othe Pacific Islander	2
Middle Eastern or North African	2
Other or prefer to self-describe	40
Prefer not to disclose	141
Null	906

Ethnicity	
Non-Hispanic	2,171
Hispanic	56
Prefer not to disclose	135
Null	1,293

Gender	
Woman	2,201
Man	464
Genderqueer	9
Non-binary	12
Transgender/Trans man	1
Other or prefer to self-describe	7
Prefer not to disclose	75
Null	886

Education	
Less than high school	38
High school diploma/GED	159
Some college credit, no degree	311
2-year college/Vocational training	318
4-year college/Bachelor's degree	809
Master's, Professional, or Doctorate degree	1,030
Other or prefer to self-describe	37
Prefer not to disclose	63
Null	890

Primary Language	
English	2,701
Spanish	5
Bosnian	1
Hindi	3
Mandarin	1
Other or prefer to self-describe	9
Prefer not to disclose	43
Null	892

Age Group	
Under 18	27
18-24	71
25-34	339
35-44	567
45-54	576
55-64	553
65-74	420
75+	169
Prefer not ot disclose	52
Null	881

Employment	
Full-time	1,849
Part-time	194
Self Employed	39
Retired	420
Disabled	71
Student Full-time	21
Student Part-time	16
Not Employed	45
Other or prefer to self-describe	40
Prefer not to disclose	52
Null	908

Income	
Less than $10,000	41
$10,000 to $24,999	112
$25,000 to $49,999	301
$50,000 to $74,999	347
$75,000 to $99,999	305
$100,000 to $149,999	494
$150,000 to $199,999	347
$200,000 or more	343
Prefer not to disclose	444
Null	921

More Survey Respondents

Fewer Survey Respondents

Notes

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.)

3,655 Total Respondents in 3-County Area

Community members identified mental health, obesity, age-related illnesses, and heart conditions as the top health concerns for adults in the three-county area. Most of the top health concerns remained consistent across counties with some differences in the order of concerns. Notably, violence and substance use were identified among the top concerns by respondents who live in the City of St. Louis.

More Survey Respondents

Fewer Survey Respondents

Adult Health Concerns

Percent of Respondents by County

	St. Charles County, MO	St. Louis City, MO	St. Louis County, MO	Grand Total
Mental health	16.49%	17.11%	16.93%	16.91%
Obesity and maintaining healthy weight	14.20%	9.53%	10.96%	11.24%
Age-related illnesses	11.63%	8.61%	12.17%	11.11%
Heart conditions	11.03%	9.18%	11.55%	10.84%
Cancers	8.47%	6.06%	9.00%	8.29%
Diabetes and high blood sugar	8.63%	8.65%	8.77%	8.57%
Substance use	7.15%	9.34%	6.61%	7.41%
Chronic pain and pain management	6.12%	4.61%	5.81%	5.56%
Violence	2.46%	10.21%	4.43%	5.51%
Motor vehicle accidents and injuries	3.06%	4.12%	2.60%	3.09%
Not sure	1.97%	2.40%	2.59%	2.30%
Respiratory and lung diseases	3.06%	1.60%	2.24%	2.41%
Maternal and infant health	1.31%	2.63%	1.63%	1.81%
Oral and dental health	1.15%	1.49%	1.55%	1.42%
Infectious diseases	1.75%	1.49%	1.57%	1.64%
Not listed here	0.71%	1.03%	0.76%	0.82%
Reproductive and sexual health	0.82%	1.94%	0.84%	1.08%
Null	0.00%	0.00%	0.00%	0.00%

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 mental health and substance use problems? (Respondents selected up to 3 items.)

3,655 Total Respondents in 3-County Area

Among mental health and substance use-related needs, depression, anxiety, alcohol use, and drug use are top of mind. Most of the top mental health and substance use concerns remained consistent across counties with some differences in the order of concerns. Notably, serious mental illness was identified as a concern by a greater share of respondents in the City of St. Louis, as compared with St. Louis and St. Charles Counties.

More Survey Respondents

Fewer Survey Respondents

Adult Mental Health & Substance Use Concerns

Percent of Respondents by County

	St. Charles County, MO	St. Louis City, MO	St. Louis County, MO	Grand Total
Depression	22.90%	19.82%	23.01%	22.14%
Anxiety	19.70%	16.18%	19.18%	18.47%
Drug use	12.12%	15.47%	11.99%	12.92%
Alcohol use	17.48%	14.67%	14.53%	15.18%
Serious mental illnesses	6.88%	9.95%	7.26%	7.87%
Loneliness	5.71%	7.44%	7.68%	7.13%
Domestic violence	2.56%	5.02%	3.55%	3.79%
Post Traumatic Stress Disorder	2.56%	4.01%	3.23%	3.32%
Not sure	2.91%	3.26%	4.02%	3.56%
Suicide	3.38%	1.51%	2.55%	2.48%
Eating disorders	3.03%	1.84%	2.42%	2.41%
Not listed here	0.76%	0.84%	0.58%	0.73%
Null	0.00%	0.00%	0.00%	0.00%

Notes

2024 Community Health Needs Assessment Survey

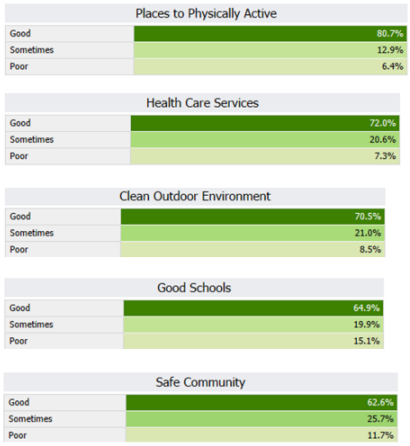
Preliminary survey data through June 2024 presented to community leaders

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

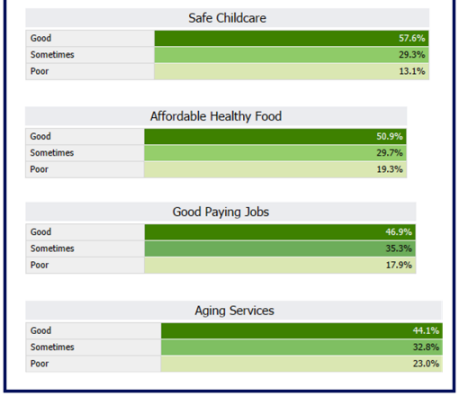
3,655 Total Respondents in 3-County Area

Community members rated the availability of several resources in the three-county area. Resources are grouped below based on the percent of respondents who indicated a resource had good availability (Often or Always Available).

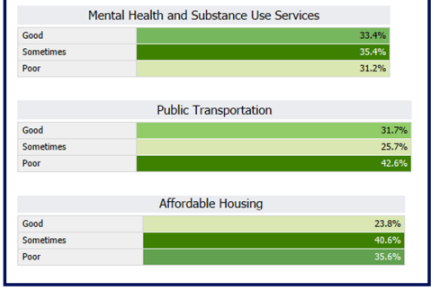
60%+ indicated GOOD availability:



40-59% indicated GOOD availability:



<40% indicated GOOD availability:



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?

3,655 Total Respondents in 3-County Area

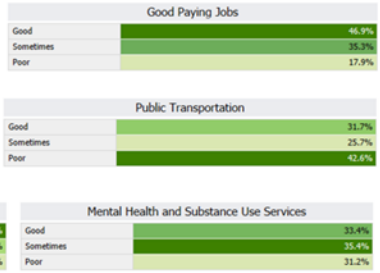
Barriers to Health Care Access

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

The availability of several community resources that may impact access to health care are noted on the right, including the availability of:

- **Good paying jobs**
- **Public transportation**
- **Health care services**
- **Mental health and substance use services**

Resource Availability



Notes

Preliminary survey data through June 2024 presented to community leaders

Appendix G: Community Leader Conversation Participants

The Rehabilitation Institute of St. Louis and The Rehabilitation Institute of Southern Illinois: Community Leader Conversation Participants			
Organization	**First Name**	**Last Name**	**Title**
Amada Senior Care	Lisa	Sesti	Senior Housing Advising
Blue Day 2	Tiffany	Dill	Founder
Blue Day 2	Anna	Brondyke	Fellow
Encompass Health	Shivani	Bass	Chief Executive Officer
Encompass Health	Jeffrey	Reese	Chief Executive Officer
Encompass Health	Angela	Vallek	Area Director of Quality and Risk Management
Encompass Health	Kristin	Heinke	Director of Case Management
Grab Bar Guys	Joel	Manesberg	Owner
Paraquad	Briana	Conley	Public Policy & Advocacy Manager
Paraquad	Annie	Morrow	Sr. Director of Stephen A. Orthwein Center
SSM Health Day Institute	Sarah	Ray	Director of Business Development
St. Charles County Department of Public Health	Emily	Varner	Epidemiologist
St. Louis Society for the Blind and Visually Impaired	Megan	Connelly	Director of Development
St. Louis Society for the Blind and Visually Impaired	Sharon	Mertzlufft	President and Chief Executive Officer
WellHome	Ben	Jarrett	

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** | The Rehabilitation Institute of St. Louis-West County – April 28, 2025 – 15 participants
- **Community Members** | Paraquad – June 17, 2025 – 14 participants

Community Leader Conversation on Health Needs

Mental Health

- Mental Health
- Isolation and anxiety for those who are visually impaired

Obesity and Maintaining Healthy Weight

- Obesity

Diabetes and High Blood Sugar

- Diabetes – driven by obesity

Chronic Pain and Pain Management

- Chronic pain

Community Leader Conversation on Health Resources

Public Transportation

- Challenge for those who are visually impaired
- Hard to get transportation for older Medicaid participants

Aging Services

- Need services/resources to allow people to age in place
- Home modifications
- Adaptive equipment
- Need a nurse in the house
- Insurance coverage is lacking – won't cover grab bars, shower chairs, etc.

Affordable, Healthy Food

- Food is a continuous problem

Community Member Conversation on Health Needs

Mental Health

- Isolation/lack of personal interaction
- Loss of independence
- Caregiver exhaustion
- Mental health
- Need autonomy

Heart Conditions

- Strokes
- People that are younger are having strokes

Community Member Conversation on Health Resources

Public Transportation

- Transportation access is a big issue
- Call A Ride won't always come
- Need benches near bus stops
- Take Uber
- Some places have a community bus that will come

Aging Services

- Aging population is going through a lot of transition – need assistance with how to adjust
- OASIS is a resource

Good Paying Jobs

- Limited accessibility creates fewer opportunities
- Lack of job opportunities

Affordable, Healthy Food

- Access to healthy foods
- Lack of grocery stores
- There has not been a lot of progress as far as getting access to healthier options and healthier grocery stores/restaurants
- Food deserts

Safe Community

- Need sidewalks, accessible entries and exits for buildings
- Handicapped parking spaces that are near the front door
- Need strip all the way across not just pedestrian dots
- Need talking stop guide

- Need potholes fixed for wheelchair accessibility
- Need ramps

Health Care Services

- Lack of healthcare
- Need transition of care assistance/planning
- Need assistance with insurance – there is a log out there and it is daunting and intimidating
- Navigating the healthcare system
- Applying for disability is very challenging
- Long wait times (e.g., months)
- High spenddowns with Medicare programs
- Healthcare systems need to focus ore on accessibility
- Need advocates
- Need education for healthcare workers to work with people with special needs
- Starting to see some clinics come to the neighborhood

Places to be Physically Active

Can't take a walk around the neighborhood

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

The Rehabilitation Institute of St. Louis and The Rehabilitation Institute of Southern Illinois 2025 Community Health Needs Selection Team Attendees 08/29/2025			
Last Name	**First Name**	**Title**	**Location**
Bass	Shivani	Chief Executive Officer	The Rehabilitation Institute of St. Louis - St. Peters and West County
Brehm	Ashton	Director of Business Development	The Rehabilitation Institute of St. Louis - Central West End
DiCroce	Emily	Director of Business Development	The Rehabilitation Institute of Southern Illinois
Griffith	Molly	Director of Case Management	The Rehabilitation Institute of St. Louis - Central West End
Henke	Kristen	Director of Case Management	The Rehabilitation Institute of St. Louis - St. Peters and West County
Hoelscher	Cassidy	Chief Executive Officer	The Rehabilitation Institute of Southern Illinois
Ott	Jennifer	Director of Case Management	The Rehabilitation Institute of Southern Illinois
Reese	Jeff	Chief Executive Officer	The Rehabilitation Institute of St. Louis - Central West End
Sigler	Jenny	Director of Business Development	The Rehabilitation Institute of St. Louis - St. Peters and West County
Valleck	Angela	Director of Quality and Risk	The Rehabilitation Institute of St. Louis - West County

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			