St. Jude Children's Research Hospital®
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2025

COMMUNITY HEALTH NEEDS ASSESSMENT

REPORT DATE: ORIGINAL MAY 19, 2025; FINAL JUNE 20, 2025

ST. JUDE CHILDREN'S RESEARCH HOSPITAL
2025 COMMUNITY HEALTH NEEDS ASSESSMENT

St. Jude Children's Research Hospital

St. Jude Children's Research Hospital, Inc. (St. Jude) specializes in research and care for some of the most catastrophic pediatric diseases— cancer, blood disorders, neurological disorders, infectious diseases and other related life-threatening illnesses— all while investing in resources and technologies for cutting-edge scientific research. It is leading the way the world understands, treats, and cures childhood cancer, sickle cell disease, and other life-threatening disorders. It is the only National Cancer Institute-designated Comprehensive Cancer Center devoted solely to children. Treatments developed at St. Jude have helped push the overall childhood cancer survival rate from 20% to 80% since the hospital opened more than 60 years ago. St. Jude shares the breakthroughs it makes to help doctors and researchers at hospitals and cancer centers around the world improve the quality of treatment and care for even more children. (What is St. Jude?, 2025).

Mission, Values and Vision

The mission of St. Jude is to advance cures, and means of prevention, for pediatric catastrophic diseases through research and treatment. Consistent with the vision of the founder, Danny Thomas, no child is denied treatment based on race, religion, or a family's ability to pay.

The seven core values that guide St. Jude are:

- Always recognize that advancing treatment for children with catastrophic diseases is at the center of everything we do.
- Do what is right; take ownership of what you do.
- Work with purpose and urgency – your efforts matter.
- Embrace the challenge to create a new tomorrow.
- Work collaboratively and help others succeed.
- Always be respectful of your coworkers, our patients and their families, and visitors to our campus.
- Make the most of St. Jude resources and be mindful of those who provided them.

The vision of St. Jude is to accelerate progress for children with catastrophic diseases on a global scale. The current FY2022–FY2027 St. Jude Strategic Plan lays out a vision and charts a road map to live up to the mission of St. Jude through concentrating on fundamental science, childhood cancer, pediatric catastrophic diseases, global impact, and workforce and environment.

Purpose of the CHNA and Collaborators

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs within the St. Jude community. The priorities identified in this report guide the hospital's community health improvement programs, community benefit activities, and collaborative efforts with other organizations sharing the mission to improve community health. This CHNA meets the requirements of the Patient Protection and Affordable Care Act, mandating not-for-profit hospitals to conduct a CHNA at least every three years.

St. Jude collaborated with various community partners, members and healthcare providers to conduct the 2025 CHNA. The St. Jude CHNA Steering Committee contracted Conduent Healthy Communities Institute (Conduent HCI) to facilitate data collection, analysis, and to prepare the CHNA report.

Community Health Needs Assessment At-a-Glance

Data Analysis Overview

Secondary Data

Numerical health indicators from HCI's 200+ community health database.

Community Partner Listening Sessions

Conversations with community partners to understand health needs in the community.

Key Partner Interviews

Individual interviews with community partners to describe health needs.

Community Member Focus Groups

Conversations with community members to understand health needs of patients.

Community Health Assessment and Planning Cycle

Prioritized Health Needs

Executive Summary

St. Jude conducted this CHNA to identify and prioritize significant community health needs and to inform development of an implementation strategy (“Implementation Strategy”) to address current needs in accordance with the Affordable Care Act (Internal Revenue Service, 2025).Jude conducted this CHNA to identify and prioritize significant community health needs and to inform development of an implementation strategy (“Implementation Strategy”) to address current needs in accordance with the Affordable Care Act (Internal Revenue Service, 2025).

St. Jude, located in Memphis, Tennessee, is one of the world’s premier cancer research centers. Its mission is to find cures for children with cancer and other catastrophic diseases through research and treatment. St. Jude has treated children from all 50 states and from around the world. In addition, St. Jude provides care in Memphis, Tennessee and at its eight affiliate and satellite clinics (St. Jude Children's Research Hospital, 2025).

Community Definition

The community defined for this report includes the patients served from the local area. For this report, the local area was defined as Shelby County, where Memphis and St. Jude are located, as well as 24 additional surrounding counties in Tennessee, Arkansas, and Mississippi. These 25 counties represent 80% of the local service area for St. Jude.

Secondary Data Summary

Secondary data used for this assessment were collected and analyzed from Conduent HCI’s community indicator database. The database, maintained by researchers and analysts at Conduent HCI, includes 253 community indicators covering 45 topics in the areas of health, social determinants of health, and quality of life. The data were primarily derived from state and national public secondary data sources. The value for each of these indicators was compared to other communities, nationally set targets, and previous time periods. Data within this report were presented at the county level.

Health & Quality of Life topics scoring 1.5 or higher as indicators of concern were highlighted as significant health needs and include:

Health Topic	Score	Health Topic	Score
✓ Wellness & Lifestyle	1.76	✓ Economy	1.59
✓ Children’s Health	1.70	✓ Women’s Health	1.58
✓ Diabetes	1.67	✓ Cancer	1.57
✓ Older Adults	1.64	✓ Respiratory Diseases	1.56
✓ Prevention & Safety	1.64	✓ Mental Health & Mental Disorders	1.54
✓ Physical Activity	1.63	✓ Immunizations & Infectious Diseases	1.54
✓ Sexually Transmitted Infections	1.62	✓ Maternal, Fetal & Infant Health	1.53
✓ Heart Disease & Stroke	1.61	✓ Community	1.51

Primary Data Summary

Primary data collected from community members through Community Partner Listening Sessions, Community Member Focus Groups, and Key Partner Interviews comprised the primary data component of the CHNA and helped inform selection of the significant health needs.

Conduent HCI facilitated four listening sessions, five St. Jude patient and family focus groups, and 16 key partner interviews across a broad spectrum of patients, providers, affiliates, community-based organizations and public health departments. During each session, participants offered perspectives on the most important health problems in the community, recognized barriers and challenges to improving health, identified the most underserved populations, discussed potential solutions to health challenges faced and offered success stories from existing programs. Top needs arising from the community inputs include:

- ✓ Access to Healthcare and Social Services
- ✓ Mental Health
- ✓ Social, Economic & Community Context

Although cancers, chronic disease, infectious, and respiratory diseases were broadly discussed by participants, these diseases were not explicitly called out in the findings, as patients with those conditions are included in the community definition; instead, they are implied.

Prioritized Health Needs

Following completion of a three-step process of prioritization, St. Jude identified the following significant health needs:

- ✓ Cancer and Long-term Follow-up
- ✓ Children's Health, Access to Healthcare & Chronic (Neurologic) Diseases
- ✓ Education
- ✓ Infectious Diseases & Immunizations
- ✓ Mental Health, Wellness & Lifestyle

CHNA Process and Components

Plan and Engage

- Kick-off meeting
- Partner engagement
- Prepare discussion guides

Collect and Analyze Data

- Secondary data collection, analysis and presentation
- Collect community input

Synthesize Data and Prioritize

- Analyze primary data
- Synthesize secondary and primary data findings
- Prioritize health needs

Mobilize Shared Action

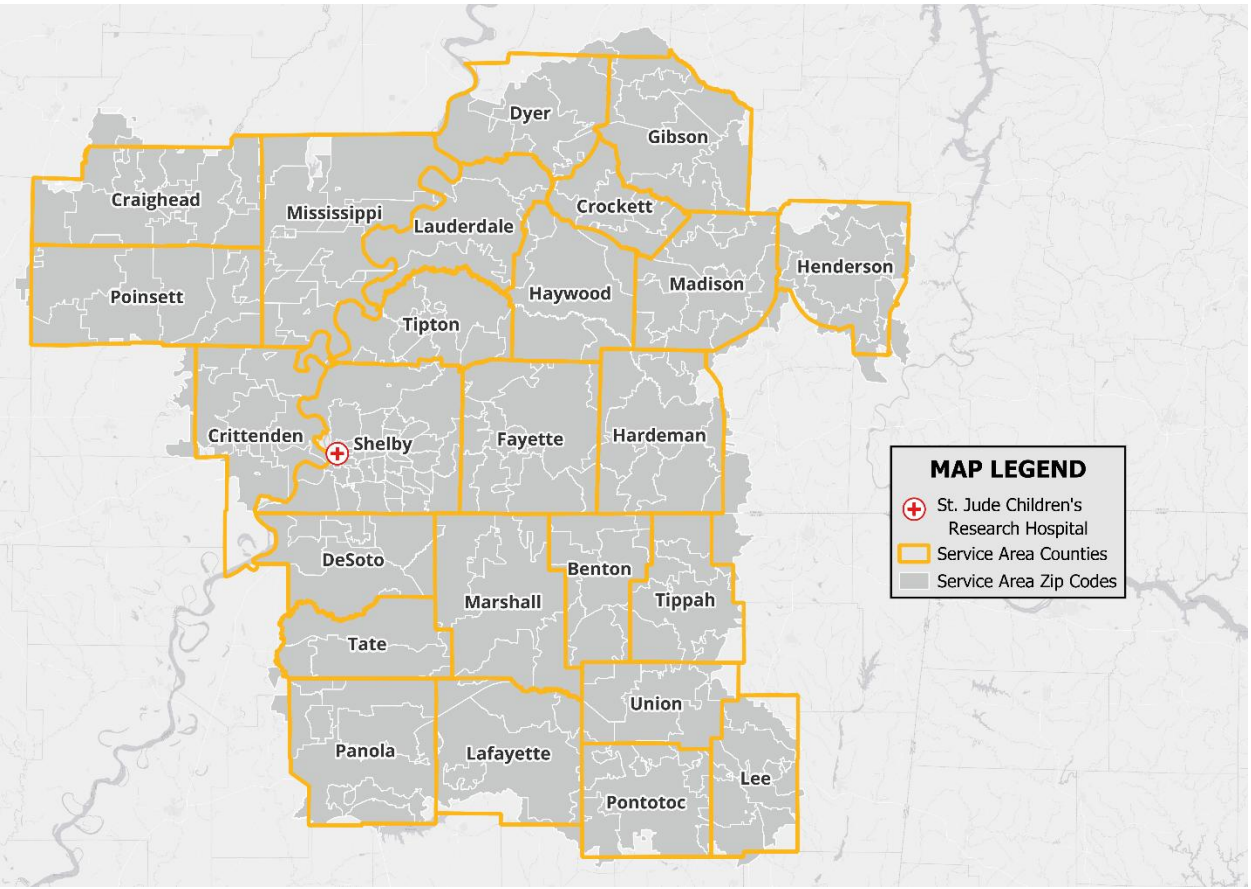
- Prepare CHNA report
- Publish final report for review

St. Jude Community Definition

Definition of Community Served

For this review and report, the community served is defined as St. Jude patients and their families residing in local community. The local community area was defined as Shelby County, where Memphis and St. Jude are located, as well as 24 additional surrounding counties in Tennessee, Arkansas, and Mississippi. These 25 counties represent 80% of patients that come from the local service area to St. Jude for care and treatment.

FIGURE 1. ST. JUDE CHILDREN'S RESEARCH HOSPITAL LOCAL SERVICE AREA



Demographics

Geography and Data Sources

A demographic profile of the St. Jude local service area, which includes 279 zip codes in Tennessee, Mississippi, and Arkansas, was conducted. A community's demographics are key indicators of its health profile (Parrish, 2010).

Unless otherwise indicated, all demographic estimates are sourced from Claritas® (2024 population estimates). Claritas demographic estimates are primarily based on U.S. Census and American Community Survey (ACS) data. Claritas uses proprietary formulas and methodologies to calculate estimates for the current calendar year.

Population

The local 25 county service area has an estimated population of 2,057,809 people and 525,451 children who constitute approximately a quarter of the population. Figure 2 identifies the most populous counties, and Figure 3 outlines the population breakdown for the service area by county.

25 COUNTIES
ST. JUDE COMMUNITY

2,057,809
TOTAL SERVICE AREA POPULATION

FIGURE 2. MOST POPULOUS COUNTIES

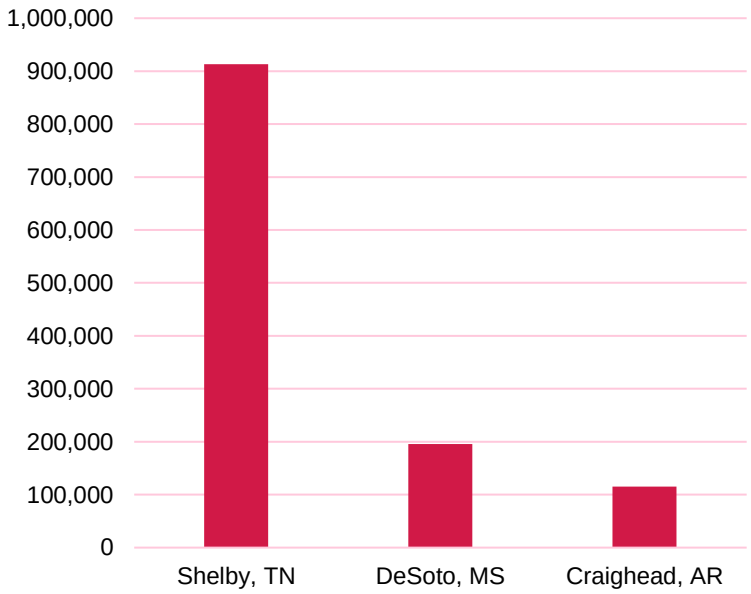
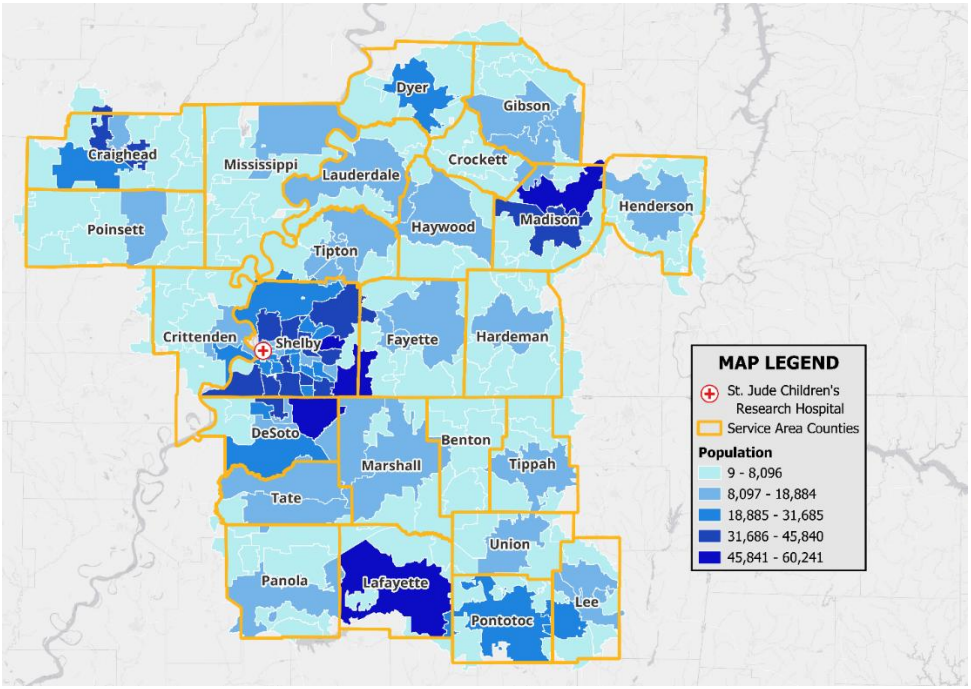


FIGURE 3. ST. JUDE LOCAL AREA POPULATION DISTRIBUTION BY COUNTY



Age

Figure 4 shows the pediatric population in the local service area ages 0-19 years. The pediatric population is relatively evenly distributed by age groups 0-4, 5-9, 10-14, and 15-19; however, Lafayette, MS has a higher percentage of 15–19-year-olds and a lower percentage of children under 10 years.

26.6%
POPULATION AGE 15-19

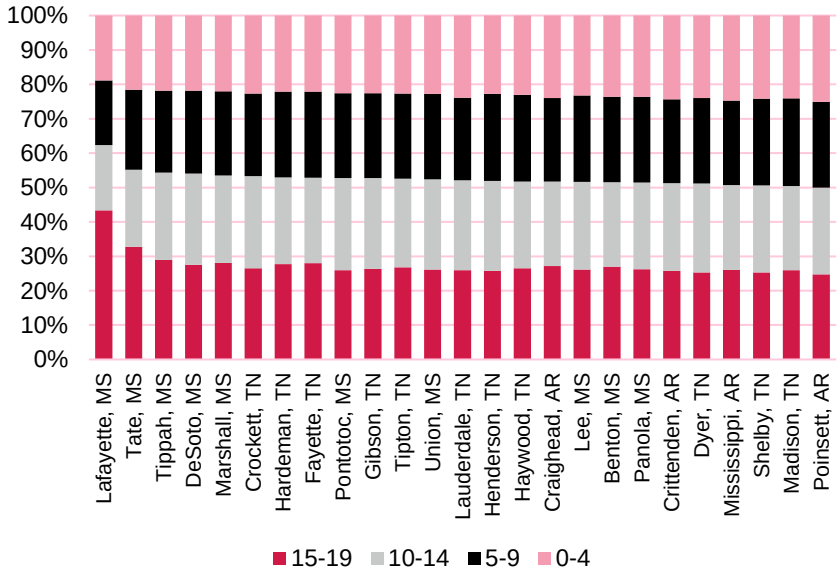
25.3%
POPULATION AGE 10-14

24.7%
POPULATION AGE 5-9

23.5%
POPULATION AGE 0-4

*Total service area

FIGURE 4. AGE DISTRIBUTION



Sex

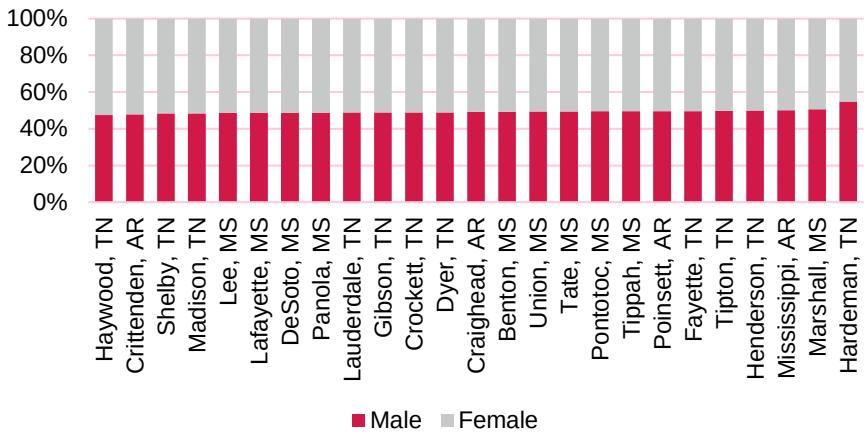
As seen in Figure 5, the local service area pediatric population is split between male (48.8%) and female with (51.2%); however, Hardeman, TN has a higher percentage of males.

51.2%
FEMALE

48.8%
MALE

*Total service area

FIGURE 5. PEDIATRIC POPULATION
MALE AND FEMALE



Race and Ethnicity

The local service area pediatric population is predominantly Black/African American (42.5%) and White (41.7%) as shown in Figure 6. The total Hispanic/Latino pediatric population is 10.1%.

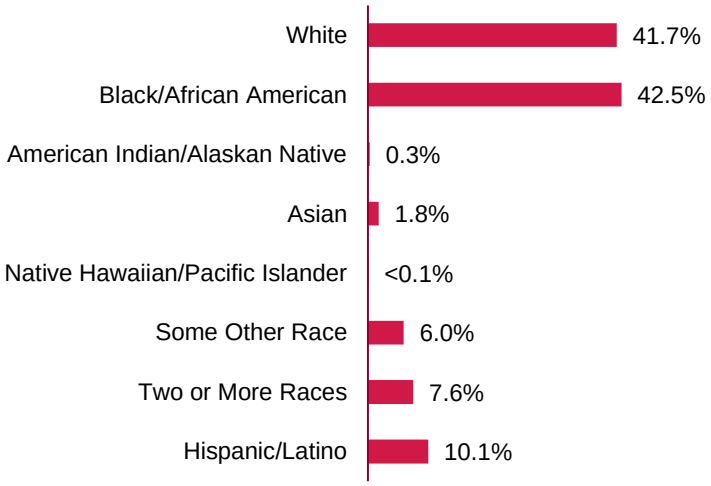
42.5%
TOTAL BLACK PEDIATRIC POPULATION

10.1%
TOTAL LATINO PEDIATRIC POPULATION

1.9%
TOTAL ASIAN PEDIATRIC POPULATION

*Total service area

FIGURE 6. RACE/ETHNICITY
AGE 0-19



Language and Immigration

Understanding countries of origin and language barriers such as limited English proficiency can help inform the cultural and linguistic context of our patents. Among the 5–17-year-old population, 91.7% speak English only at home, while 6.3% speak Spanish. Figure 7 outlines the highest Spanish-speaking counties. As shown in Figure 8, Crockett, TN has the largest population of Spanish speaking youth in the primary service area, (16.9%), whereas Panola County, MS has the lowest (<1%).

91.7%
SPEAKS ENGLISH ONLY AT HOME

6.3%
SPEAKS SPANISH AT HOME

2.0%
SPEAKS OTHER LANGUAGE AT HOME

*Total service area

FIGURE 7. COUNTIES WITH THE LARGEST PERCENT OF SPANISH-SPEAKING YOUTH, AGE 5-17

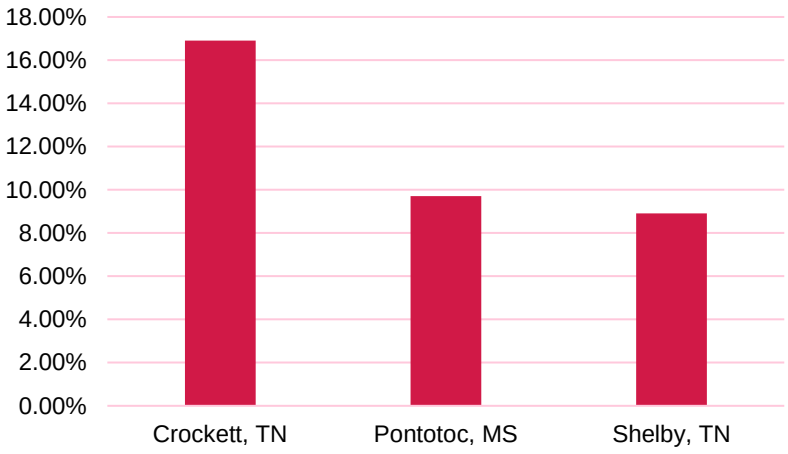
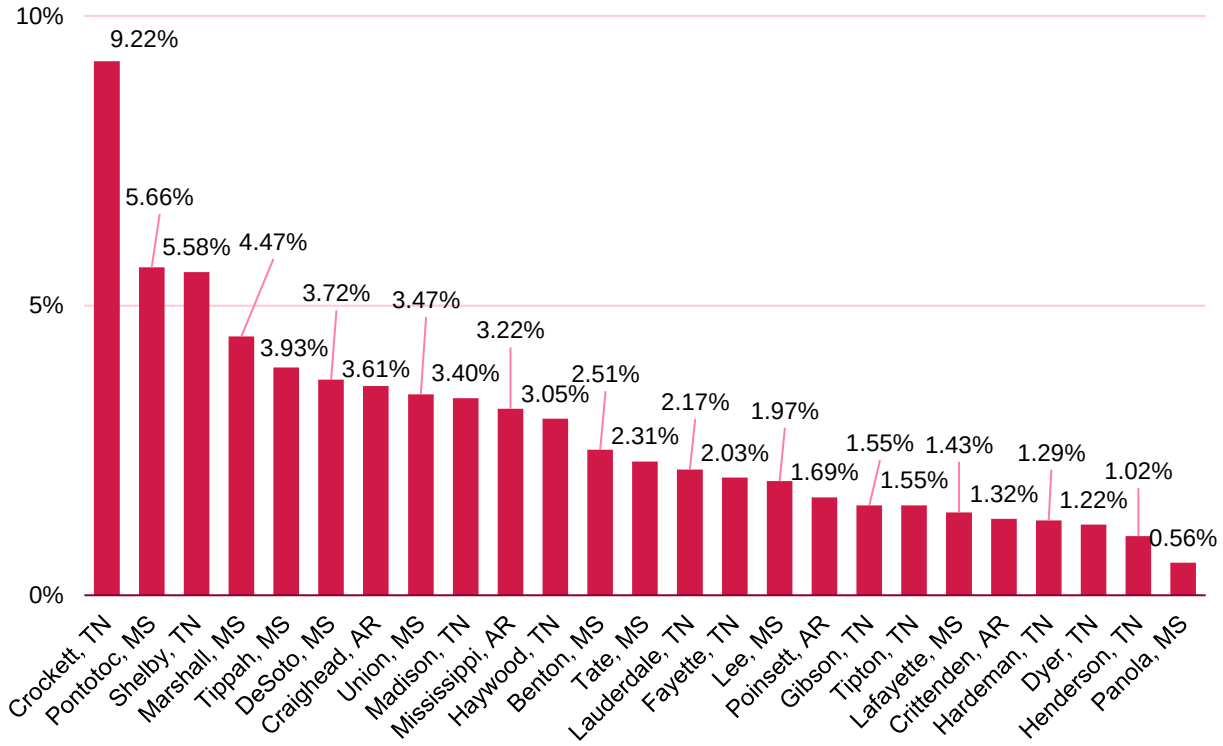


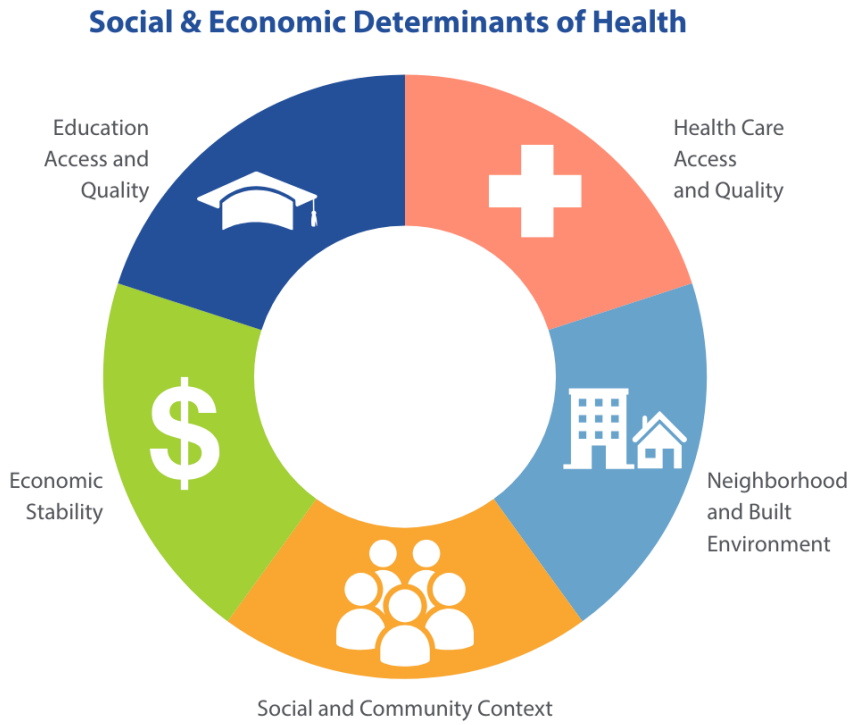
FIGURE 8. POPULATION AGE 5+ SPEAKING SPANISH AT HOME



Social Determinants of Health

An exploration of the economic, environmental, and social determinants of health impacting the St. Jude local service area was conducted. Social Determinants of Health (SDOH) are the conditions in which people are born, grow, work, live, and are the wider set of forces shaping the conditions of daily life. The SDOH can be grouped into five domains. Figure 9 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022).

FIGURE 9. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH



Economy

The U.S. Census Bureau sets federal poverty thresholds each year based on family size and age characteristics. A community's high poverty rate can be both a cause and a result of poor economic conditions. It suggests that there are not enough job opportunities in the area to support the local community. Poverty can lead to lower purchasing power, reduced tax revenues, and is often linked to lower-quality schools and struggling businesses.

Poverty rates vary by ZIP code within states and counties (Figure 10). Mississippi has the highest percentage of families living below the federal poverty level (10.5%) in the St. Jude local service area.

FIGURE 10. POVERTY LEVELS BY ZIP CODE

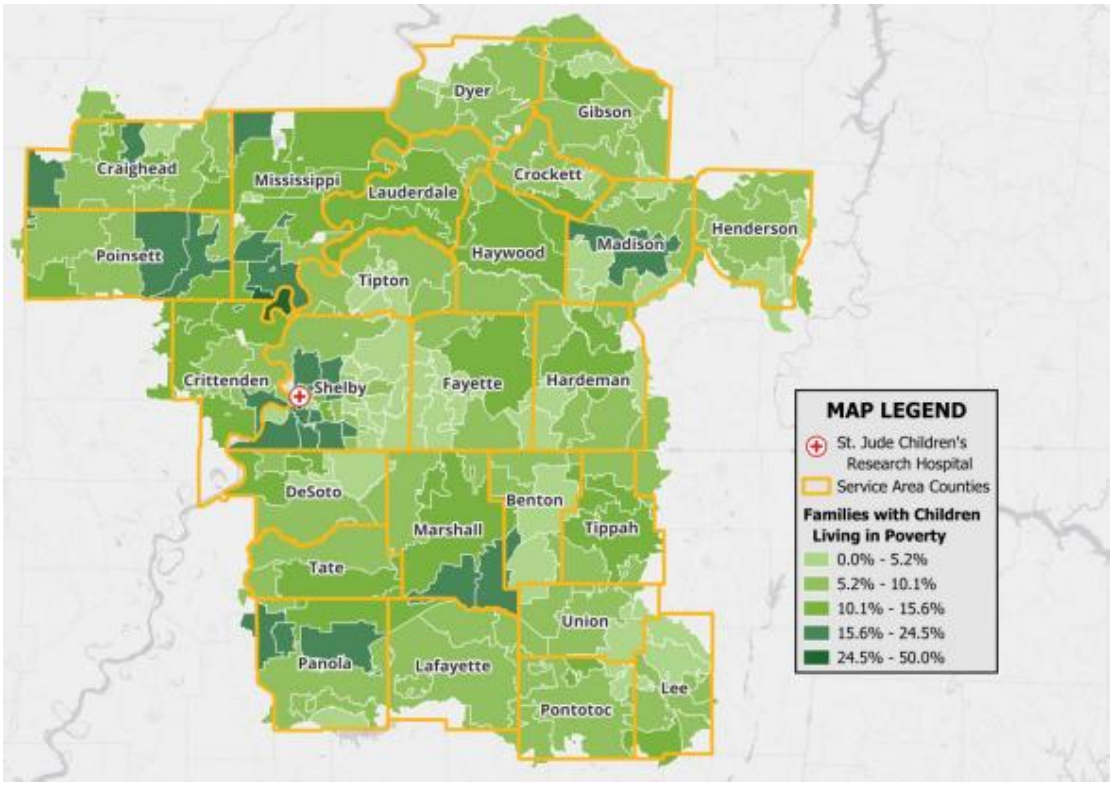
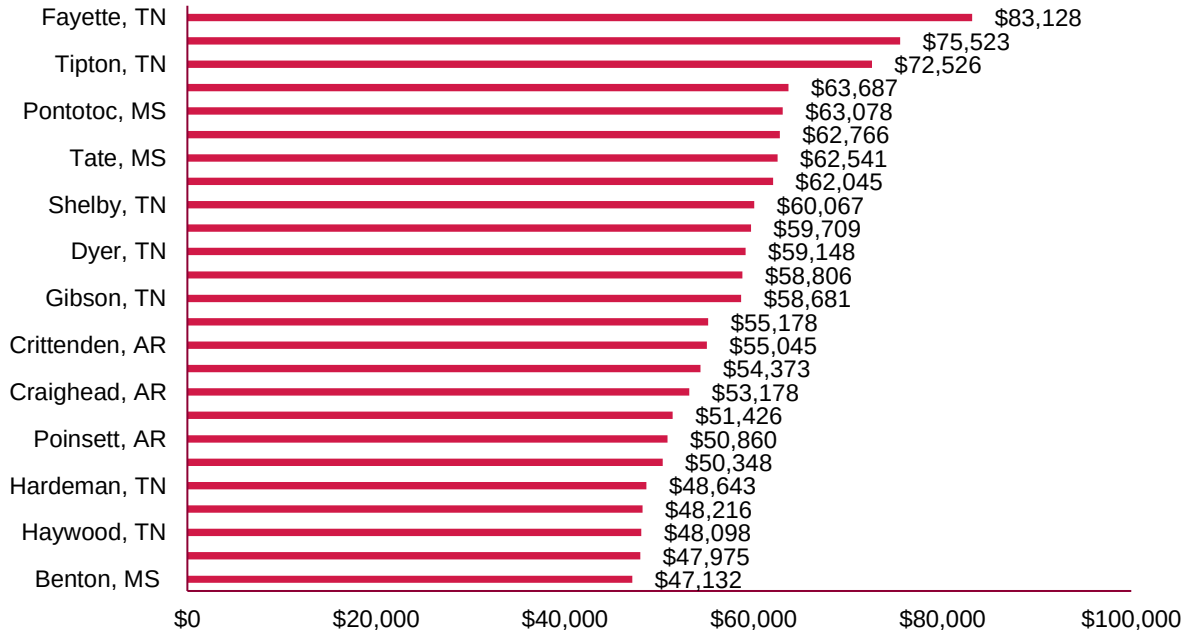


Figure 11 provides the median household income in the service area. Fayette TN has the highest median income level ($83,128) and Benson MS has the lowest ($47,132).

FIGURE 11. MEDIAN HOUSEHOLD INCOME



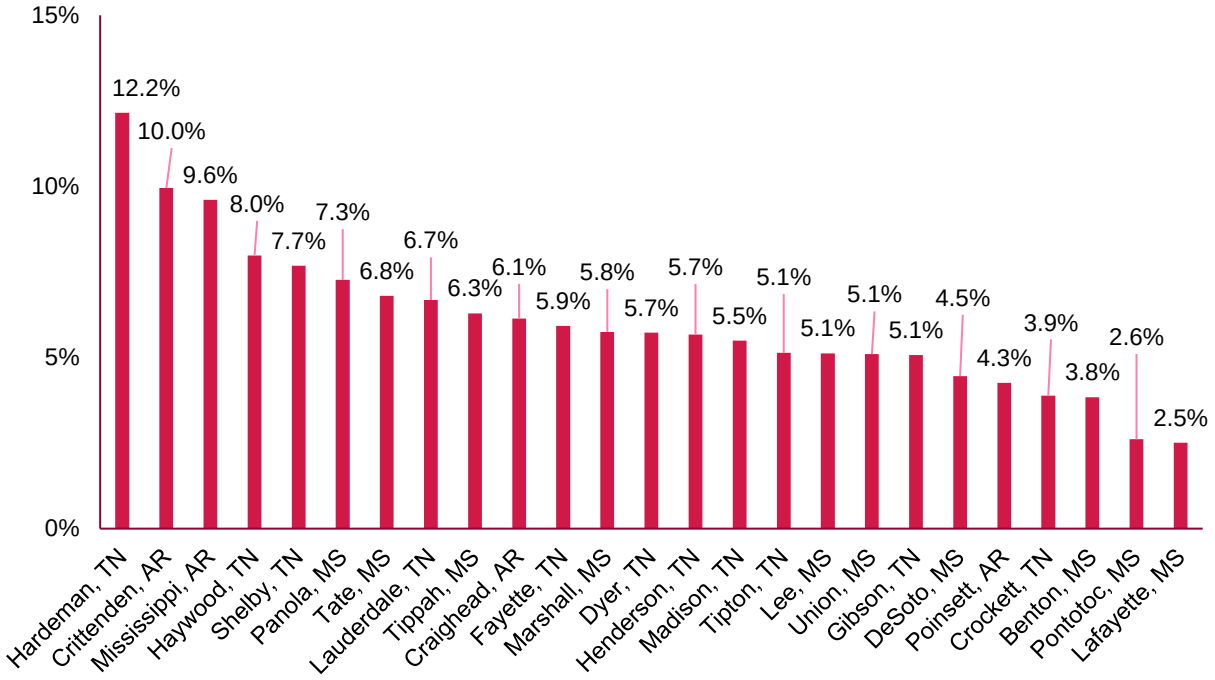
Employment

A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes. (U.S. Department of Health and Human Services, Healthy People 2030., n.d.)

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment. (U.S. Department of Health and Human Services, Healthy People 2030., n.d.) Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are ways an individual's working conditions can lead to poorer health. (U.S. Department of Health and Human Services, Healthy People 2030., n.d.)

Figure 12 shows the population 16 years old and over who are unemployed in the local service area counties. The unemployment rate is highest in Mississippi at 6.6%. Arkansas and Tennessee both have an unemployment rate of 5.2%, which is equal to the national average.

FIGURE 12. UNEMPLOYED WORKERS (AGE 16+) IN CIVILIAN LABOR FORCE

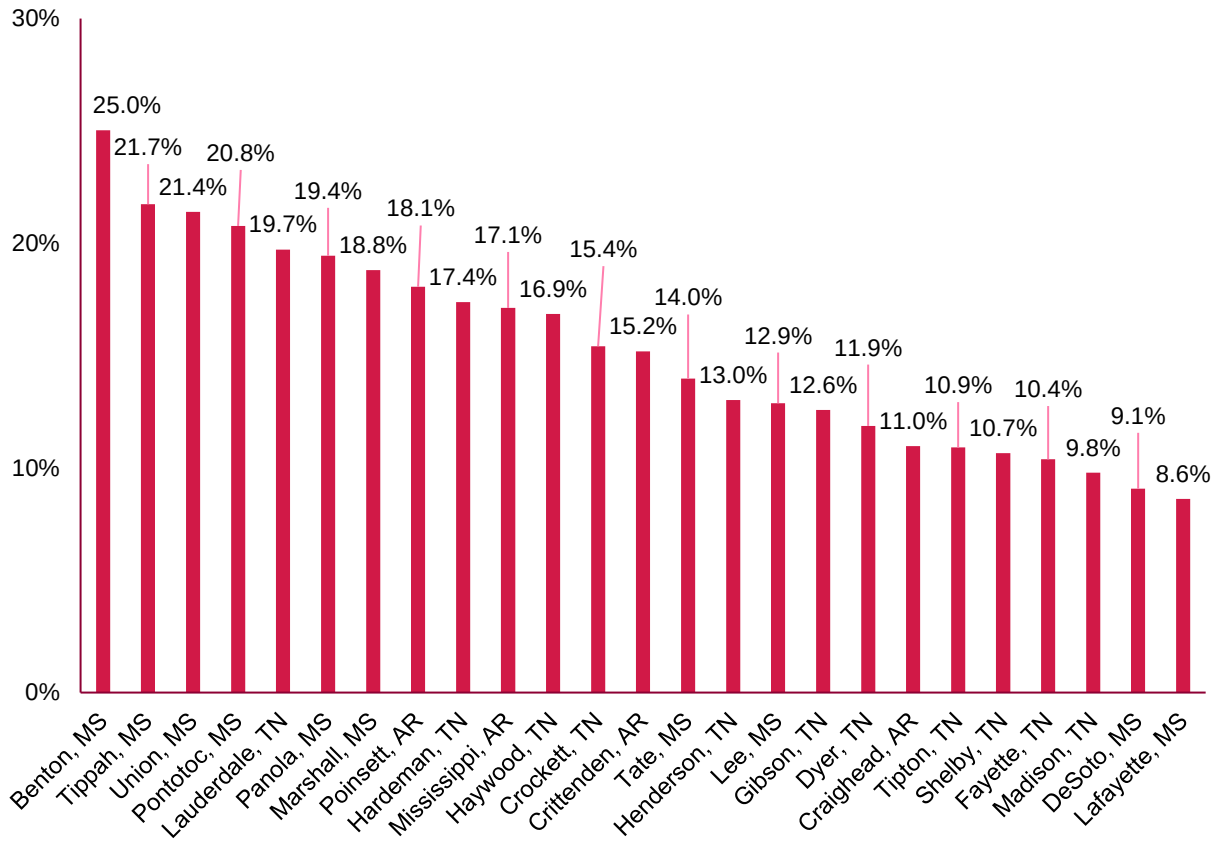


Education

Education is an important indicator for health and well-being across the lifespan. Education can lead to improved health outcomes by increasing health literacy, providing better job opportunities and higher income, and improving social and psychological factors linked to health. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty. (U.S. Department of Health and Human Services, Healthy People 2030. , n.d.) Further, people with high school and postsecondary-levels of education are likely to live longer, and to experience better health outcomes, and practice health-promoting behaviors. (Robert Wood Johnson Foundation, Education and Health., n.d.)

Figure 13 shows the percentage of the local service area population without a high school diploma, among those aged 25 and up. Generally, the local service area counties have a large percentage of their population without a high school diploma (8.6%: Lafeyette, MS – 25.0%: Benton, MS). The average percent of adults 25 and older without high school education in the United States is 10.6%. All service area counties except for Madison, TN, DeSoto, MS and Lafayette, MS are above the national average.

FIGURE 13. POPULATION AGE 25+ WITHOUT A HS DIPLOMA

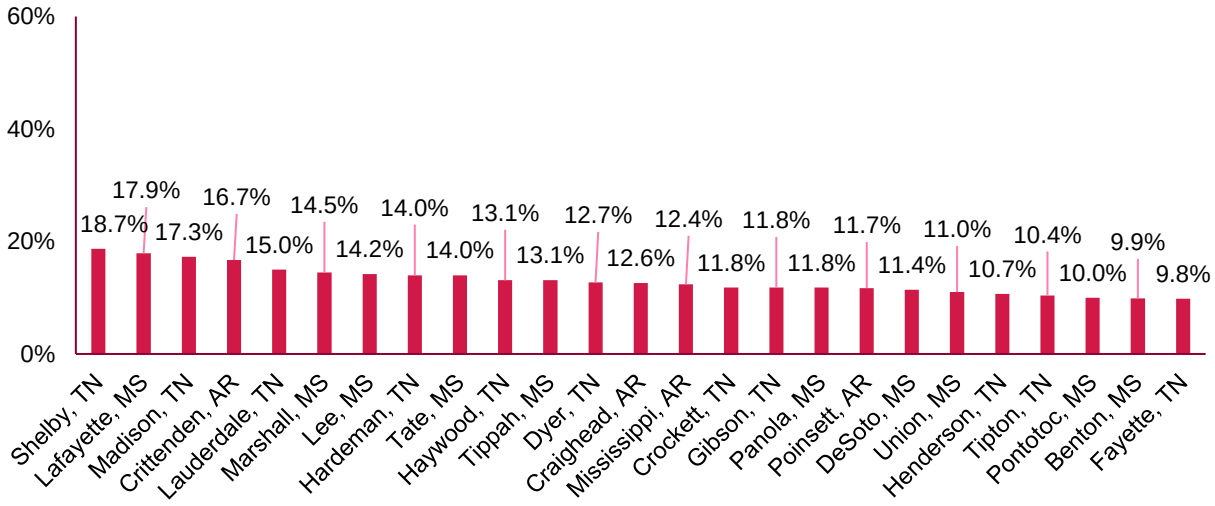


Housing

Safe, stable, and affordable housing provides a critical foundation for health and well-being. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health. (County Health Rankings, Housing and Transit., n.d.)

A severe housing problem is defined as a household indicating at least one of the following issues: overcrowding, high housing costs, lack of a kitchen, or lack of plumbing facilities. Shelby County, TN has the highest percentage (18.7%) of severe housing problems in the local service area (Figure 14). Shelby, TN along with Lafayette, MS, Madison, TN, and Crittenden, AR are all higher than the national average of 16.7%.

FIGURE 14. SEVERE HOUSING PROBLEMS

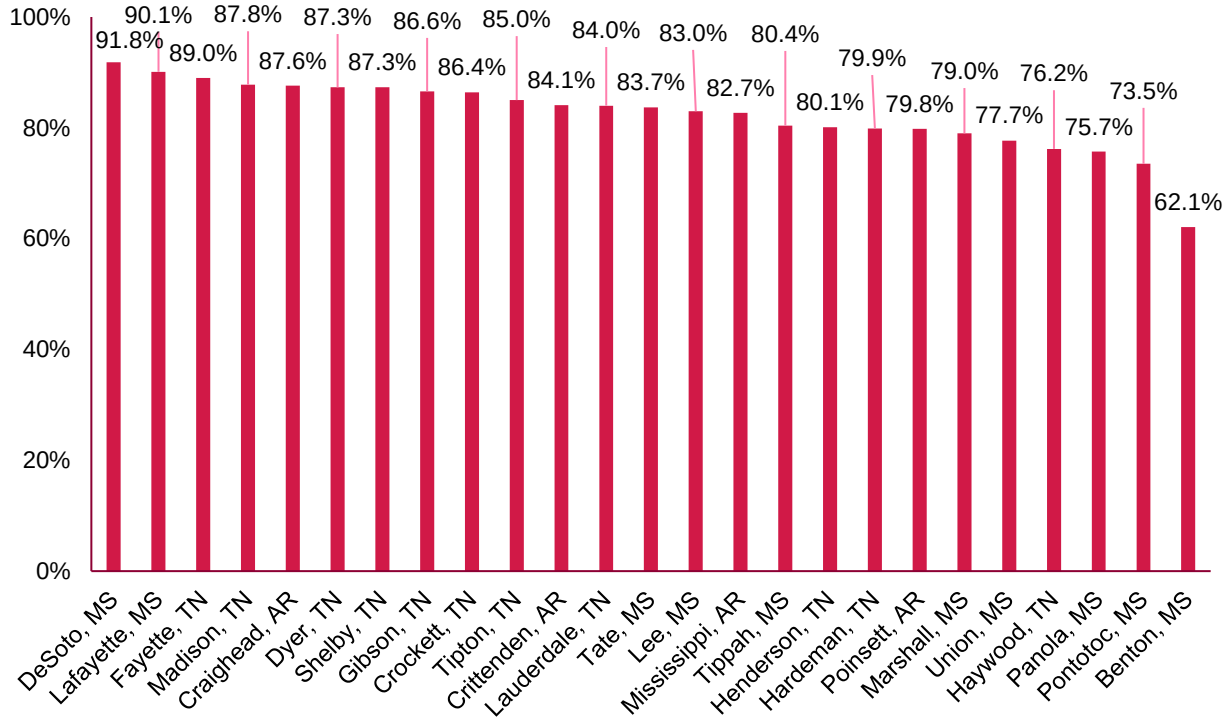


Neighborhood and Built Environment

Internet access is essential for basic health care access, including scheduling appointments with providers, getting test results, and accessing medical records. Internet connectivity also helps expand healthcare access through home-based telemedicine services, which was particularly critical during the COVID-19 pandemic. (U.S. Department of Health and Human Services, Healthy People 2030. , n.d.) Internet connectivity may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities. (U.S. Department of Health and Human Services, Healthy People 2030. , n.d.)

Figure 15 shows the percentage of households in each local service area county that have an internet subscription. Benson MS has the lowest percentage of households with internet subscriptions (62.1%), which is much lower than the national average of 89.9%.

FIGURE 15. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION



SocioNeeds Index

This assessment identified specific zip codes with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the SocioNeeds Index® Suite developed by Conduent HCI. This suite includes the Community Health Index (CHI), Food Insecurity Index (FII), and Mental Health Index (MHI). Each of these indices summarizes multiple socioeconomic indicators into a composite score correlated with preventable hospitalization and premature death, food insecurity, or poorer mental health outcomes. For each of these three indices, counties, zip codes and census tracts with a population over 300 persons are assigned an index value ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher needs is critical to targeting prevention and outreach activities.

Geographic differences were identified using three key indices:

- Community Health Index (CHI)
- Food Insecurity Index (FII)
- Mental Health Index (MHI)

Community Health Index

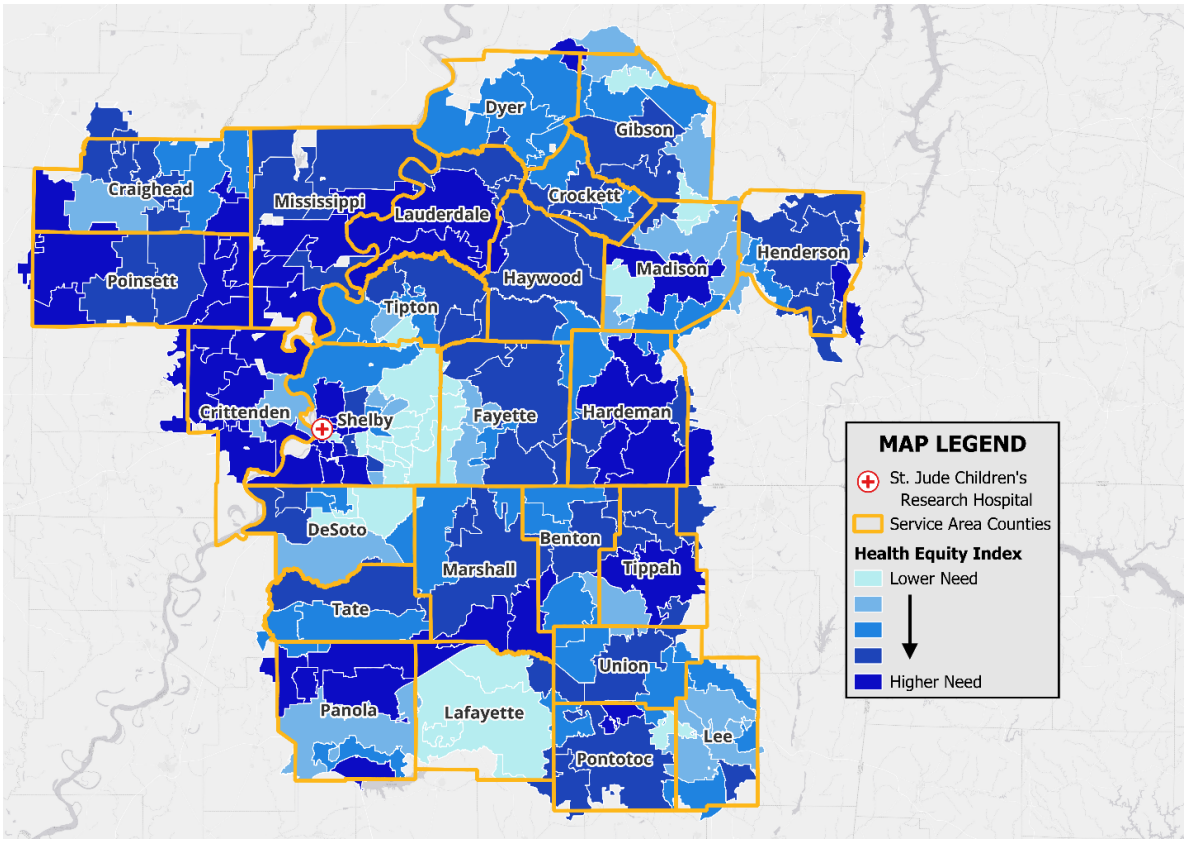
Conduent HCI's Community Health Index (CHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Each zip code is ranked based on its index value to identify relative levels of need.

What high index values mean: Communities with the highest values are estimated to have the highest socioeconomic needs correlated with:

- Preventable hospitalizations
- Premature death
- Self-reported poor health and well-being

Figure 16 displays ZIP codes exhibiting the highest need based on CHI.

FIGURE 16. ST. JUDE LOCAL SERVICE AREA COMMUNITY HEALTH



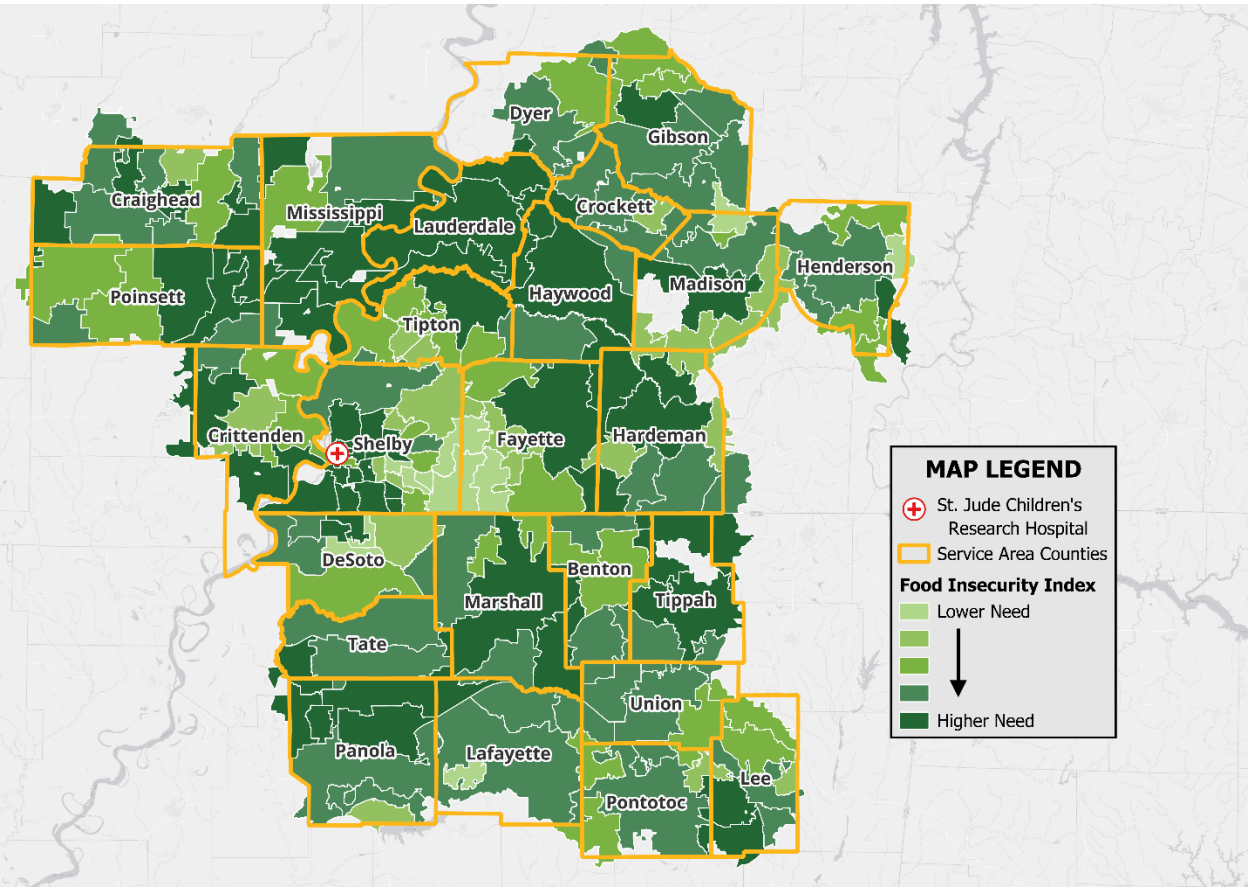
Food Insecurity Index

Access to food, particularly fresh whole food, is important to health. Food insecurity is defined as a social and economic condition of having limited access to sufficient food, or food of an adequate quality to meet one's basic needs (Healthy People 2030, n.d.).

Conduent HCI's Food Insecurity Index measures economic and household hardship correlated with food access. All ZIP codes are given an index value from 0 (low need) to 100 (high need) based on its value compared to all ZIP codes in the United States. ZIP codes are then ranked from 1 (low need) to 5 (high need) based on their index value compared to other ZIP codes within the local area (Figure 17).

What high index values mean: Communities with the highest index values are estimated to have the highest food insecurity correlated with household and community measures of food-related financial stress such as Medicaid and SNAP enrollment.

FIGURE 17. ST. JUDE LOCAL AREA FOOD INSECURITY INDEX



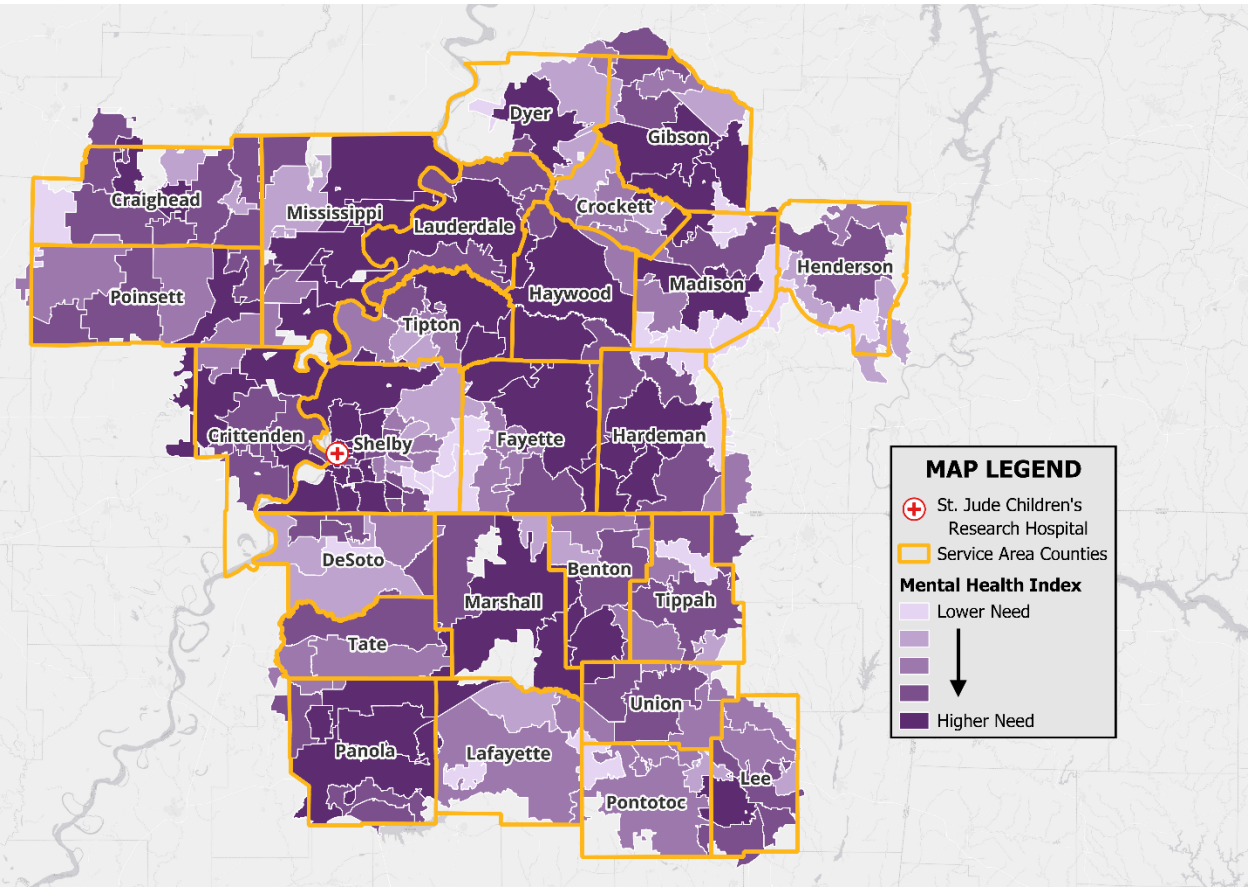
Mental Health Index

Crucial for overall wellbeing, mental health is a part of behavioral health that involves emotional, psychosocial, and social well-being. It reflects a state in which individuals can manage everyday stress, recognize their strengths, learn effectively, and work productively to contribute meaningfully to their communities (Centers for Disease Control and Prevention, 2025).

Conduent HCI's Mental Health Index measures social, economic, and health factors that are linked to people reporting poor mental health. ZIP codes are ranked based on their index value to show areas with the worst mental health outcomes. Figure 18 shows that three of the highest need ZIP codes are in Shelby County (38106, 38109, 38114) with an index of 99.8 out of 100.

What high index values mean: Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with self-reported poor mental health.

FIGURE 18. ST. JUDE LOCAL AREA MENTAL HEALTH INDEX



Data Synthesis Process and Outcomes

Secondary Data Collection and Analysis

The community health analysis used Conduent HCI's Data Scoring Tool to assess and rank secondary data associated with the local service area. Conduent HCI's Data Scoring Tool is based on 253 indicators in both health and quality of life topic areas. Each indicator's value was compared to other communities, national targets, and historical data. A detailed discussion of the data scoring methodology and outcomes related to children's health is outlined in the Appendix.

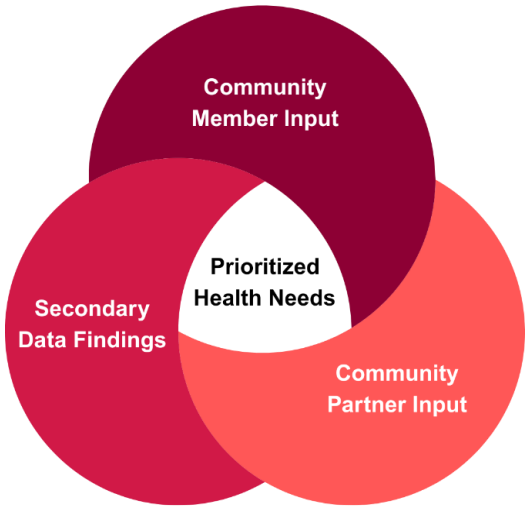
Primary Data Collection and Analysis

St. Jude collected community input via Community Partner Listening Sessions, Community Member Patient and Family Focus Groups, and Key Partner Interviews. Key findings across all three forms of community input included Access to Care & Social Services; Mental Health; and Social, Economic & Community Context. An overview of findings within each category can be found in Figure 19, and a detailed description of the data collection process, methodology, tools, and acknowledgements from participating organizations can be found in the Appendix.

FIGURE 19. ST. JUDE COMMUNITY INPUT FINDINGS

	Access to Care and Social Services	Mental Health	Social, Economic & Community Context
Partner Listening Sessions	People face difficulties **navigating their local healthcare systems** to access timely and continuous pediatric care for **complex medical needs**, especially in rural areas, and maintaining **continuity of care**.	Challenges with accessing **quality and affordable mental health care** include **shortages** of trained providers, long wait lists, and lack of **insurance** coverage.	**Lack of affordable housing and poor housing quality**, including issues like mold, asbestos, and lead, are prevalent problems that negatively impact the health of children in the community. Housing challenges are connected to access to care and SDOH.
Patient /Family Focus Groups	People facing challenges in transitioning from **specialized healthcare services** at St. Jude to local healthcare providers, lack of **healthcare resources and coordination**.	People struggle with mental health and the emotional **toll of chronic illness and treatment**. There is a lack of understanding and empathy from others in their local communities.	People face **education system**, **transportation, and childcare challenges** that make it difficult to access and navigate healthcare services.
Key Partner Interviews	People expressed a lack of access to **healthcare services** and subspecialties **and the awareness** of **resources** and **services.** **Chronic diseases** (cancer, sickle cell disease, other hematological disorders, and neurological diseases) were identified as leading to **cumulative complications and complex care** over time, making management difficult.	People expressed concerns about the growing **mental health needs of children** and access barriers. There is also a lack of access to **preventive care expressed by participants**	Lack of access to **affordable and safe housing**, as well as **environmental hazards in living conditions**, further contribute to the challenges faced by children in the community

Significant Health Needs



The data synthesis section combines various sources of both secondary and primary data to pinpoint and emphasize critical health challenges facing the community. This process involves a systematic examination of health indicators derived from secondary data sources, alongside insights obtained from community input sources comprised of community partner listening sessions, community member focus groups, and key partner interviews. By prioritizing the analysis with community insights, the data synthesis offers a thorough understanding of the health status within the community, effectively identifying the most urgent health needs.

The data synthesis visually represents health topics based on their scores from secondary data sources, with scores of 1.50 or higher indicating significant community concerns. This visualization communicates that health and quality of life topics have been recognized as prominent based on criteria that include statistical severity, stakeholder emphasis, and community priority. This integrated approach ensures that the assessment is firmly grounded in the community's reality, facilitating targeted and effective health improvement strategies. Findings from this process are shown in Figure 20.

FIGURE 20. ST. JUDE DATA SYNTHESIS FINDINGS

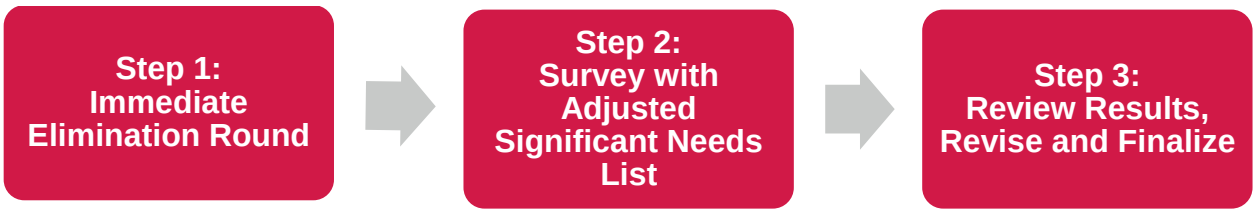
Significant Health Needs (Alphabetical Order)

Health Topic Areas ● Topic area was identified as a significant need across all four methods.	Health & Quality of Life Indicators	Community Focus Groups	Partner Listening Sessions	Key Partner Interviews
Access to Healthcare and Social Services (health literacy, systems navigation, mistrust in healthcare, provider availability, timely and continuous care)		●	●	●
Cancer ●	●	●	●	●
Children's Health ●	●	●	●	●
Chronic Diseases (diabetes, obesity, heart disease & stroke, sickle cell, case complexities associated with treatment) ●	●	●	●	●
Community (discrimination, racism, safety, violence, transportation) ●	●	●	●	●
Economy (food insecurity, high cost of living, lack of affordable housing, poverty/low income)	●		●	●
Education (STEM, funding for programs, school building condition)		●	●	●
Environmental Health (lead paint, mold, living conditions, green space)			●	●
Infectious Diseases (Immunizations, ID, STIs)	●		●	
Mental Health and Mental Disorders (poor mental health, trauma) ●	●	●	●	●
Prevention & Safety (violence, severe housing problems, firearms)	●		●	●
Respiratory Diseases (resultant from poor Environmental Health factors)	●			
Substance Use/Addiction (tobacco/-cigarettes, alcohol, drugs, addiction)	●	●	●	
Wellness & Lifestyle (wellness, disease prevention)	●		●	●

Prioritization Process

To better target activities to address the most pressing health needs in the community, St. Jude convened members from the Advisory Board and Steering Committee to participate in an Conduent HCI-facilitated presentation on significant health needs data. Following the presentation, participants were given access to web-based tools to complete Steps One and Two of the prioritization process outlined in Figure 21. The Appendix provides a detailed description of the prioritization criteria, process, methodology, and tools. The prioritized health needs are also presented in Figure 21.

FIGURE 21. PRIORITIZATION PROCESS OVERVIEW AND OUTCOMES



Prioritized Health Needs

Cancer & Long-Term Follow-up

Creating smooth transitions for cancer patients from St. Jude to local providers and specialists for long-term follow-up.

Children's Health, Access to Healthcare & Chronic (Neurologic) Diseases

Improving access to healthcare and social services for children

Education

Enhancing patient learning during treatment to prevent post-treatment learning gaps

Infectious Diseases and Immunizations

Increasing prevention measures to reduce HIV and HPV-associated cancers.

Mental Health, Wellness & Lifestyle

Addressing patient mental health challenges and access to services during and after treatment

Cancer & Long-Term Follow-up

Overview

Although childhood cancer is rare, its effects can be devasting, even if one survives an initial diagnosis. The late effects of the disease and its treatments can last a lifetime (American Cancer Society Cancer Action Network, 2024). The St. Jude community includes children, teens and young adults under treatment for different cancers as well as childhood cancer survivors. St. Jude is committed to finding cures and limiting side effects for young people wherever they live and helping adult survivors of childhood cancer enjoy the best possible quality of life. (St. Jude Children's Research Hospital, 2025).

Secondary Data

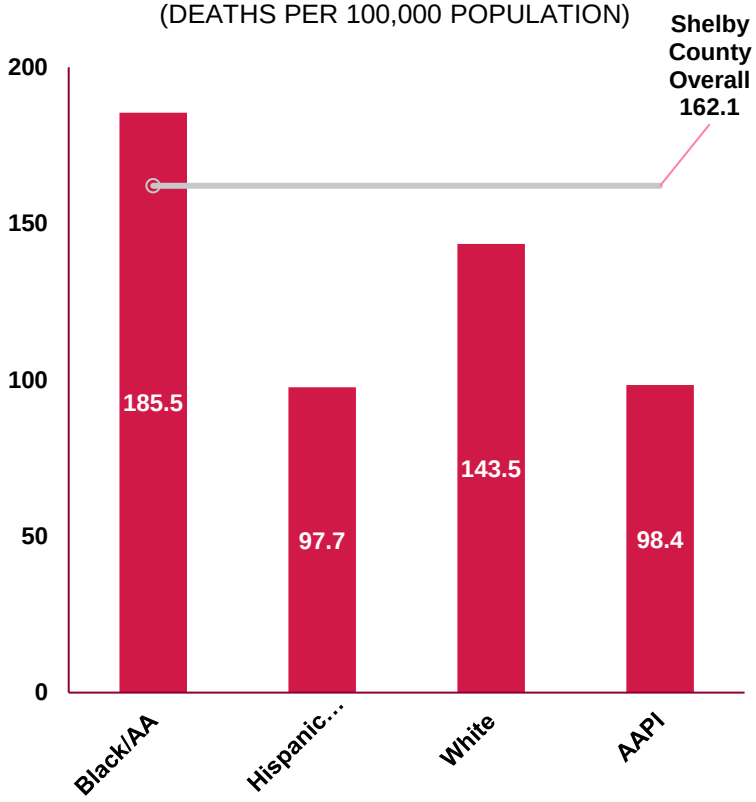
The secondary data scoring model included was built from adult cancers because a model with childhood cancers is not available. However, each year approximately 15,000 children under the age of 20 are diagnosed with cancer in the U.S. Data analysis was done to identify specific indicators of concern in Shelby County. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 1 below. See the Appendix for the full list of indicators categorized within this topic.

TABLE 1. SHELBY COUNTY DATA SCORING RESULTS: CANCER

Score	CANCER	UNITS	Shelby County	HP2030	TN	U.S.	TN Counties	U.S. Counties	Trend
2.47	Cancer: Medicare Population	*percent*	13.0		11.0	12.0			--
2.36	Mammography Screening: Medicare Population	*percent*	37.0		45.0	47.0			--
2.36	Prostate Cancer Incidence Rate	*Cases per 100,000 males*	140.4		115.1	113.2			
2.17	Age-Adjusted Death Rate due to Prostate Cancer	*Deaths per 100,000 males*	27.5	16.9	19.6	19.0			
2.11	Age-Adjusted Death Rate due to Colorectal Cancer	*Deaths per 100,000 population*	16.4	8.9	14.7	12.9			
2.00	Age-Adjusted Death Rate due to Breast Cancer	*Deaths per 100,000 females*	25.8	15.3	21.7	19.3			
1.86	Age-Adjusted Death Rate due to Cervical Cancer	*Deaths per 100,000 females*	2.9		2.6	2.2			
1.86	Colorectal Cancer Incidence Rate	*Cases per 100,000 population*	41.0		38.7	36.4			

The analysis indicates that the Black/African American population in Shelby County has a higher risk of death due to cancer than Hispanic, White, and AAPI persons and is higher than the overall Shelby County average of 162.1 deaths per 100,000.

FIGURE 22. AGE-ADJUSTED DEATH RATE DUE TO CANCER, BY RACE/ETHNICITY (DEATHS PER 100,000 POPULATION)



National Cancer Institute, 2018-2022

Primary Data

Although community input collected during this assessment did not explicitly mention cancer, the disease was implied in the relevant patient and family focus group conversations with patients currently under treatment and survivors; partner listening sessions with medical executives and partner institutions; and key partner interviews with clinical and social services providers. Key challenges and barriers to health and quality of life were access to healthcare and social services, mental health and social determinants of health.

Patient and family focus group participants highlighted the need for continued support for siblings of patients. Siblings can experience significant trauma, anxiety, and feelings of isolation that are often overlooked amidst the focus on the patient. Providing support, education, and therapeutic outlets for siblings is crucial to addressing the full impact of a child's illness on the entire family.

Community partners noted the impact of poverty, food insecurity, lack of insurance, lack of suitable housing, and rurality on health outcomes. These factors contribute to population differences in access to care and preventive services, emphasizing the need for targeted interventions. Associated barriers such as cost, transportation, language, cultural competency, and health literacy need to be intentionally addressed to improve health outcomes. Partnerships with local, state, and national organizations, as well as grassroots advocacy groups and co-locating services, are key to addressing differences in prevention between populations and to improve vaccination rates. Advocating for policies that support preventive care and vaccination support program success.

> *Something that I think is really missing though, is that social support for siblings. [My child] is 2.5 years in remission, and my older daughter is far more traumatized by [the patient sibling's] sickness than [the patient sibling] is.*
>
> **– Focus Group Participant**

> *There are parents every day who are making decisions about whether or not they can afford to take their child to see a primary care provider.*
>
> **– Key Partner Interview Participant**

Children's Health, Access to Healthcare & Chronic (Neurologic) Diseases

Overview

The St. Jude mission is to provide access to comprehensive, high quality, and timely healthcare for children with cancers and other catastrophic diseases, while fostering the understanding of the mechanisms of disease. During treatment, St. Jude provides whole patient care - including nutrition and education services – to support families and optimize patient outcomes.

Health care access and quality include key issues, such as access to preventative care, health insurance coverage, and health literacy. Access to healthcare is a critical component of the health and well-being of the St. Jude community. Limited access to health care providers and lower health literacy levels are also predictors of health outcomes (Centers for Disease Control and Prevention, 2023).

Secondary Data

From the secondary data scoring results, children's health ranked 2nd and Health Care Access & Quality ranked 21st in the data scoring of all topic areas, with scores of 1.70 and 1.40, respectively. Further analysis was done to identify specific indicators of concern in Shelby County. Those indicators with high data scores (scoring ≥1.50) were categorized as indicators of concern and are listed in Table 2. See the Appendix for the full list of indicators categorized within these topics.

TABLE 2. SHELBY COUNTY DATA SCORING RESULTS: CHILDREN'S HEALTH AND HEALTH CARE ACCESS & QUALITY

Score	CHILDREN'S HEALTH AND HEALTH CARE ACCESS & QUALITY	UNITS	Shelby County	HP2030	TN	U.S.	TN Counties	U.S. Counties	Trend
2.64	Child Food Insecurity Rate	*percent*	27.4		17.9	18.5			
2.06	Children with Health Insurance	*percent*	92.8		94.4	94.6			
2.03	Food Insecure Children Likely Ineligible for Assistance	*percent*	32.0		26.0	30.0			
1.78	Adults with Health Insurance	*percent*	83.7		86.7	89.0			
1.75	Adults who Visited a Dentist	*percent*	54.7			63.9			

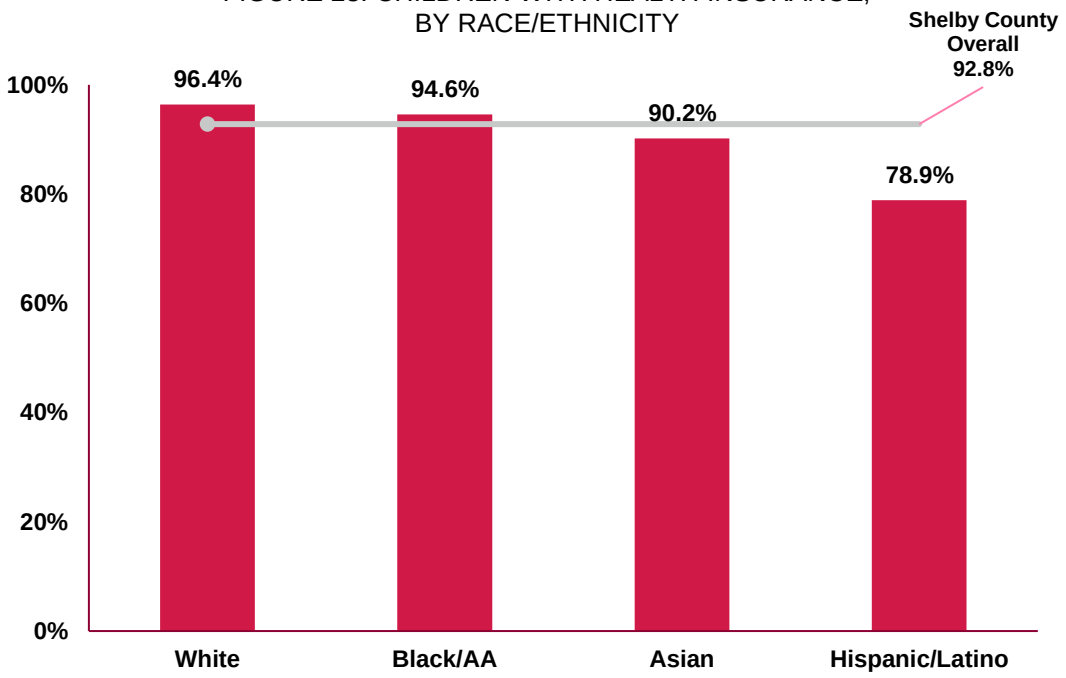
Secondary data indicate that more than one in four children in Shelby County (27.4%) experience food insecurity. Further, nearly a third of food insecure children in the county (32.0%) are likely ineligible for public assistance, based on their household income. Children

experiencing food insecurity are more likely to be hospitalized and may be at greater risk for developing chronic conditions such as anemia and asthma (Feeding America, 2025).

The Shelby County health insurance rate for children is 92.8% which is lower than 94.6% for both Tennessee and the United States.

In Figure 23, Hispanic and Latino children are most likely to be uninsured in Shelby County. More than one in five Hispanic/Latino children (21.1%) do not have health insurance, which is nearly three times higher than the overall county-wide rate (7.2%).

FIGURE 23. CHILDREN WITH HEALTH INSURANCE, BY RACE/ETHNICITY



American Community Survey, 2019-23

Primary Data

Patient and Family focus group participants expressed a need for accessing specialized care when they return to their home communities following treatment at St. Jude. Accessing therapy, educational support, and providers with experience following and managing complex cases – especially for those with limited financial means – was top of mind. People were also looking for ways to leverage technology and community resources to supplement the care they received at St. Jude. People also face challenges navigating healthcare systems outside of St. Jude, citing dealing with uninformed providers, experiencing insurance and disability benefits difficulties, and coordinating issues between different healthcare facilities. Accessing appropriate care and medication can be a challenge, with some individuals having to visit the emergency room or seek care at other facilities when local providers are unable to properly address their needs.

Community partner organization conversations focused on strengthening partnerships between organizations and resources to better support and refer families to available services.

Successful partnerships, such as with local health departments and community health navigator programs, were highlighted as effective coordination and collaboration models; sometimes using Memoranda of Understanding agreements to sustain the collaborations.

There were also significant concerns about the lack of affordable and quality mental health care, especially for children, as well as the impact of socioeconomic barriers like poverty and lack of affordable housing on people's ability to access and engage in healthcare. Improving health literacy and education was seen as critical to empower people to effectively manage their health, while the fragmentation and lack of coordination across providers and systems is hindering people's continuity of care. Overall, feedback emphasized the need for a more holistic, community-based approach to healthcare that addresses the social determinants of health and provides integrated, accessible services.

Health literacy was conveyed by community partners who highlighted a lack of awareness and understanding about support services to navigate the healthcare system, indicating a need for more targeted health education efforts.

> *I met a patient [who said] 'I wish that I was able to maybe access some of the things that help me cope with what I'm dealing with, but I don't always have the money to pay for that. When I'm at St. Jude, they help me obtain those things.*
> **–Focus Group Participant**

> *I've probably gone through five (5) pulmonologists. My gynecologist at the beginning of my journey argued with these journal articles [and] a letter from my [St. Jude] doctor…explaining my need for breast imaging because the risk of breast cancer is so high because of my radiation field. [My local provider] sat there and argued with me that this letter and all this information couldn't possibly be true.*
> **–Focus Group Participant**

> *We have had good success partnering with the local health department, and they had a program for health navigators within the community.*
> **– Listening Session Participant**

Education

Overview

Education is an often-neglected social determinant of health. Education is strongly associated with life expectancy, morbidity, and health behaviors. Additionally, educational attainment plays an important role in health by shaping opportunities, employment, and income. Studies show that education has a lifelong impact on health; differences in education and wealth established earlier in life are strongly associated with differences in healthy aging. Education is key to lifting people out of poverty and reducing socioeconomic differences (National Library of Medicince, 2020).

Secondary Data

From the secondary data scoring results, education ranked 22nd in the data scoring of all topic areas with a score of 1.39. Further analysis was done to identify specific indicators of concern in Shelby County. Those indicators with high data scores (scoring ≥ 1.50) were categorized as indicators of concern and are listed in Table 3. See the Appendix for the full list of indicators categorized within this topic.

TABLE 3. SHELBY COUNTY DATA SCORING RESULTS: EDUCATION

Score	EDUCATION	UNITS	Shelby County	HP2030	TN	U.S.	TN Counties	U.S. Counties	Trend
2.03	Student-to-Teacher Ratio	*students/ teacher*	16.2		15.3	15.4			
2.00	Students Proficient in Math: Grades 3-8	*percent*	18.5		39.1				
1.94	High School Graduation	*percent*	82.1	90.7	89.3	86.2			
1.86	Students Proficient in English Language Arts: Grades 3-8	*percent*	21.4		36.7				

Shelby County's ratio of students-to-teachers is 16.2, which is among the top 25% of all counties, nationally. Having a high student-to-teacher ratio may indicate larger class sizes in Shelby County schools and may be a barrier to academic achievement for students in the county. In fact, only about one in five Shelby County students in grades 3-8 are proficient in Math (18.5%) and Language Arts (21.4%). These are among the lowest county rates across Tennessee. Likewise, Shelby County also has a particularly low rate of high school graduation (82.1%), which is among the lowest county rates across Tennessee.

Primary Data

Community members stated that socioeconomic factors like poverty and lack of education were linked to increased violence and abuse, further exacerbating health challenges. Improving health literacy and outcomes by catering to various education levels was also identified by community partners who highlighted the importance of using appropriate communication and language to effectively reach and educate individuals with diverse education backgrounds. Health literacy as a key component to healthcare access is addressed more completely in the relevant prioritized health need.

St. Jude participants focusing on STEM and Education Outreach outlined challenges faced by children in the local Memphis area to include health issues, food insecurity, trauma, and access to healthcare. Underfunding and under-resourcing schools and communities exacerbate these challenges.

The discussion highlighted barriers such as poverty, food insecurity, transportation issues, literacy and digital literacy challenges, limited healthcare insurance coverage and sociocultural challenges, while also exploring potential solutions like community engagement, improved infrastructure, and expanded programming. The comments emphasize the importance of addressing these challenges holistically to support the health, education, and future opportunities of children in the community.

> *Students are faced with a lot of trauma. They're dealing with a lot of trauma, so that's a big one, seeing violence within their community or within families.*
> **–Key Partner Interview Participants**

> *Being a teacher and having some of the resources that my district provides me. I have found that some AI generated type things have definitely helped me be able to create some things that have been better suited for [the patient] but that's kind of me stumbling across it and not necessarily using it for what it was originally intended.*
> **– Focus Group Participant**

> *If you don't have money and you live in communities that are lower socioeconomic and are all struggling and desperate, that's going to lead to more violence, more abuse because you also don't have education about these things and how to change that. There's no choices here.*
> – **Listening Session Participant**

Infectious Diseases and Immunizations

Overview

Respiratory illness and HIV/AIDS are among the leading infectious causes of death worldwide. The St. Jude Department of Infectious Diseases seeks to focus on the pathogenesis of these infections with a breadth of commitment that extends from the research bench to the bedside (St. Jude Children's Research Hospital, 2025). Additionally, every year in the United States, HPV causes about 36,000 cases of cancer in both men and women. HPV vaccination provides safe, effective, and lasting protection against the HPV infections that most commonly cause cancer. HPV vaccines are recommended for children ages 11-12 (The Centers for Disease Control, 2025). St. Jude works to expand vaccination programs to reduce both rates of infection and associated cancers.

Secondary Data

From the secondary data scoring results, Infectious Diseases and Immunizations ranked 14th in the data scoring of all topic areas with a score of 1.54. Further analysis was done to identify specific indicators of concern in Shelby County. The highest scoring indicators within this topic area are listed in Table 4 below. See the Appendix for the full list of indicators categorized within this topic.

TABLE 4. SHELBY COUNTY DATA SCORING RESULTS: IMMUNIZATIONS & INFECTIOUS DISEASES

Score	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	Shelby County	HP2030	TN	U.S.	TN Counties	U.S. Counties	Trend
2.39	HIV Diagnosis Rate	*cases per 100,000 population*	44.9		14.4	13.3			
2.19	Tuberculosis Incidence Rate	*cases per 100,000 population*	3.7	1.4	1.7	2.9			
1.17	Cervical Cancer Incidence Rate	*cases per 100,000 females*	7.9		7.6	7.5			

In Shelby County, both HIV and Tuberculosis are infectious diseases of concern. In particular, the HIV incidence rate in Shelby County (44.9 cases per 100,000) is more than three times higher than both the Tennessee and United States rates (14.4 and 13.3, respectively). Further, this incidence has been increasing over time, although not significantly.

Certain populations in Shelby County are especially likely to be impacted by HIV. Adolescents and young adults are most likely to be diagnosed, as seen in Figure 24. Additionally, the county's male population is more than four times as likely to be diagnosed with HIV, compared to the female population (75.8 vs. 17.7 cases per 100,000) as indicated in Figure 25. Finally, the Black/African American and Hispanic/Latino populations of the county, as well as the county's

multiracial population, are substantially more likely to be diagnosed with HIV than other racial/ethnic groups, as seen in Figure 26.

FIGURE 24. HIV DIAGNOSIS RATE, BY AGE (CASES PER 100,000)

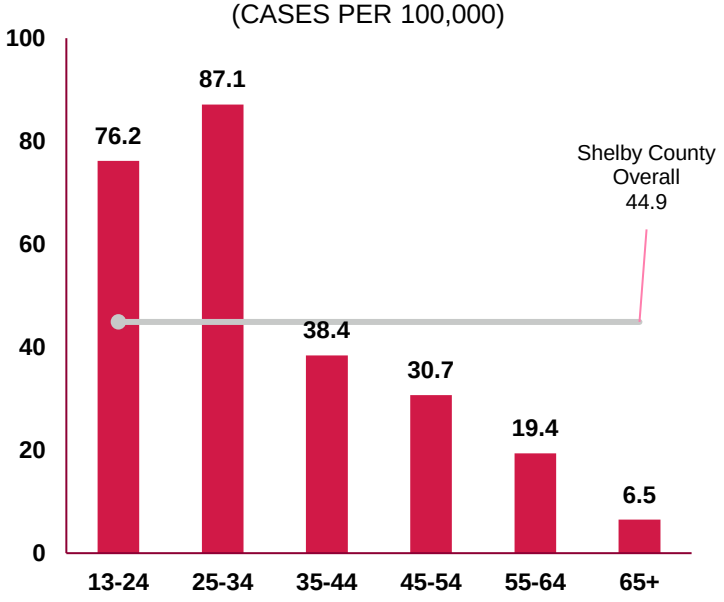


FIGURE 25. HIV DIAGNOSIS RATE, BY SEX (CASES PER 100,000)

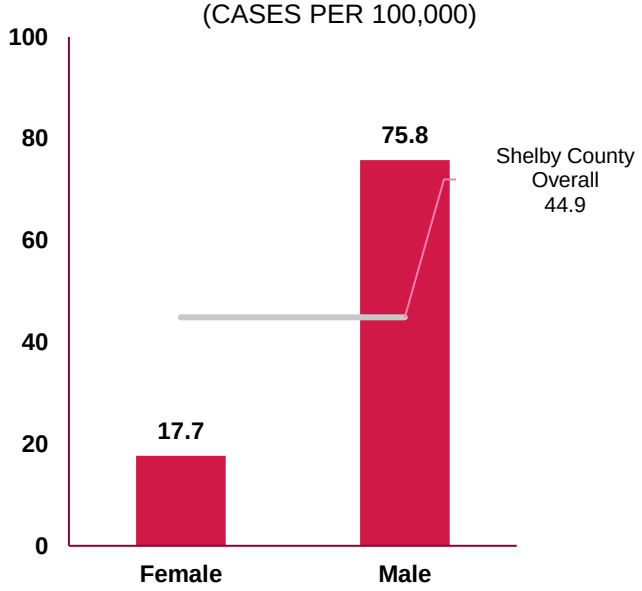
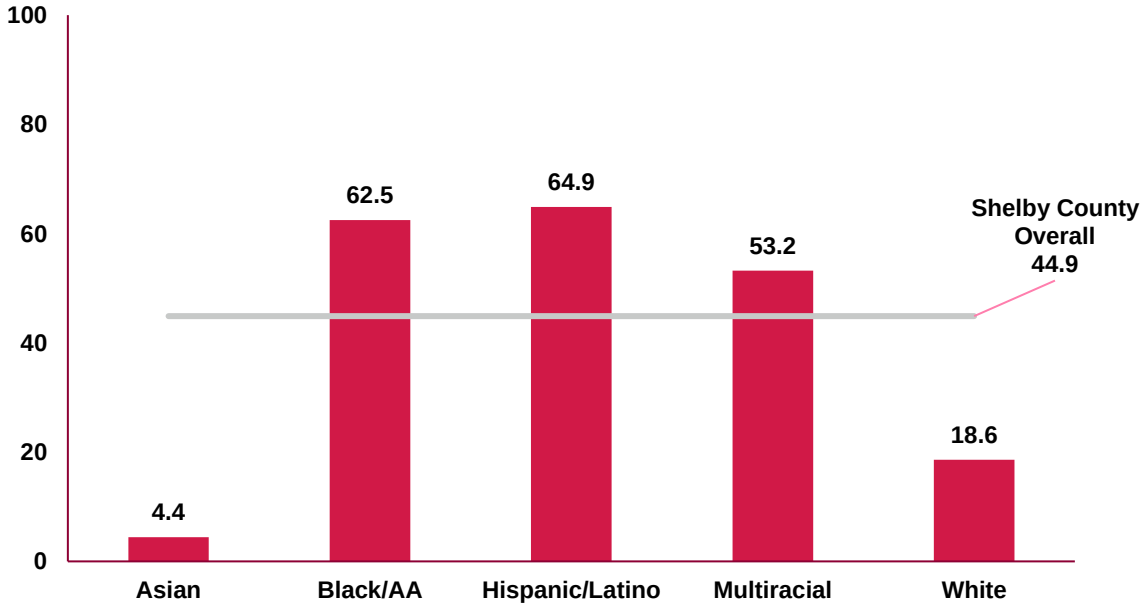


FIGURE 26. HIV DIAGNOSIS RATE, BY RACE AND ETHNICITY (CASES PER 100,000)



National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (2022)

Primary Data

Although community input collected during this assessment did not explicitly mention challenges associated with specific infectious diseases, it was implied broadly in the relevant patient and family focus group conversations with infectious disease patients; partner listening sessions with the St. Jude HIV and Infectious Diseases department and partner institutes; and key partner interviews with clinical and social services providers. Key challenges and barriers to health and quality of life that arose across these sources were access to healthcare and social services, mental health, and social determinants of health. Specific challenges related to those topics will not be addressed here but will be expanded upon in relevant parts of this section.

As discussed previously, patient and family focus group participants—comprised of Hematology and Infectious Disease patients—described transitioning out of St. Jude care as a major challenge, with families struggling to adapt to the differences in care quality, protocols, and financial responsibilities. They also reiterated the need for better mental health support, emphasizing the emotional toll of managing their children's complex medical needs. They suggested resources like therapy and peer support groups to help alleviate burnout and stress.

Social stigma related to hematologic disorders was also identified as a challenge by patient and family focus group participants. They highlighted the need for increased awareness and education about rare diseases, both for healthcare providers and the public. They emphasized the importance of understanding conditions like sickle cell disease and hematologic disorders to improve care and reduce stigma. Patient families also mentioned that they rely heavily on community and social support, including churches, advocacy organizations, and peer networks. These resources provide emotional and practical assistance, helping families navigate the challenges of caregiving and healthcare access.

> *Once they go through transplant and then they hit 3 years out, they will lose all coverage from St. Jude.*
>
> **–Focus Group Participant**

> *External partnership is key in making sure that we support patients and families.*
>
> **–Key Partner Interview Participant**

Mental Health, Wellness & Lifestyle

Overview

Physical health problems significantly increase our risk of developing mental health problems, and vice versa. Nearly one in three people with a long-term physical health condition also has a mental health problem – most often depression or anxiety. Research shows that people with a mental health problem are more likely to have preventable physical health conditions such as heart disease, low motivation, and difficulty with concentration and planning; and that they often lack support to change unhealthy behaviors and are less likely to receive medical help (Mental Health Foundation, 2025).

Mental health problems can also come with physical symptoms. Depression and anxiety can be associated with headaches, fatigue, and digestive problems. Other symptoms can include insomnia, restlessness, and difficulty concentrating (Mental Health Foundation, 2025).

Secondary Data

From the secondary data scoring results, Mental Health and Mental Disorders ranked 13th and Wellness & Lifestyle ranked 1st in the data scoring of all topic areas, with scores of 1.54 and 1.76, respectively. Further analysis was done to identify specific indicators of concern in Shelby County. Those indicators with high data scores (scoring ≥1.50) were categorized as indicators of concern and are listed in Table 5 below. See the Appendix for the full list of indicators categorized within these topics.

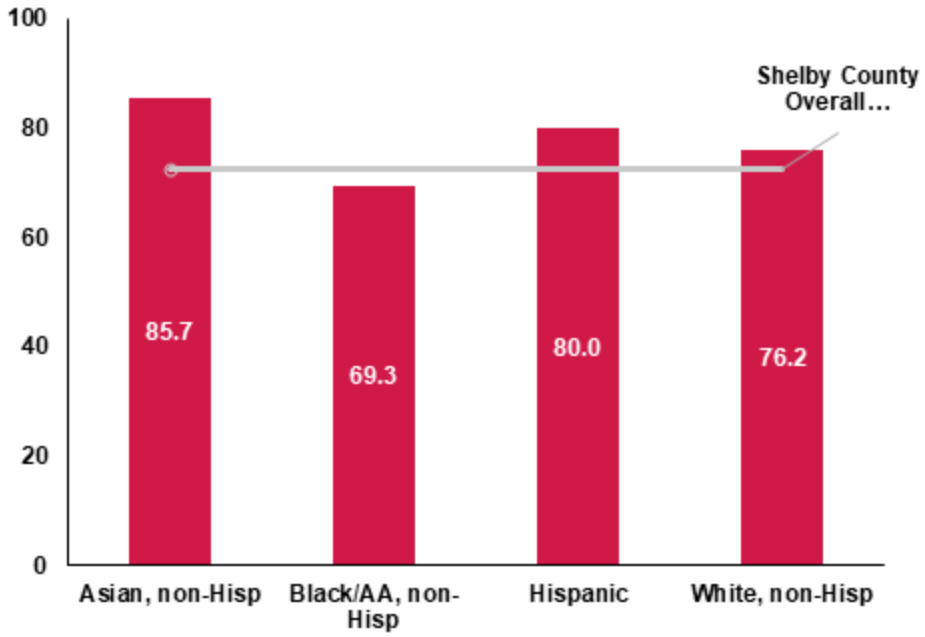
TABLE 5. SHELBY COUNTY DATA SCORING RESULTS: MENTAL HEALTH, WELLNESS & LIFESTYLE

Score	MENTAL HEALTH, WELLNESS & LIFESTYLE	UNITS	Shelby County	HP2030	TN	U.S.	TN Counties	U.S. Counties	Trend
2.33	Insufficient Sleep	*percent*	41.6	26.7		36.0			
2.08	Poor Mental Health: Average Number of Days	*days*	5.7		5.8	4.8			
2.06	High Blood Pressure Prevalence	*percent*	41.5	41.9		32.7			
2.00	Life Expectancy	*years*	72.5		74.1	77.6			
1.92	Poor Mental Health: 14+ Days	*percent*	20.4			15.8			
1.75	Self-Reported General Health Assessment: Poor or Fair	*percent*	23.2			17.9			
1.58	Poor Physical Health: 14+ Days	*percent*	14.7			12.7			
1.58	Adults Ever Diagnosed with Depression	*percent*	25.2			20.7			

A concerning indicator related to Mental Health, Wellness, and Lifestyle is Insufficient Sleep. More than two in five Shelby County adults (41.6%) report insufficient sleep, which is one of the highest county rates across all United States. Ongoing sleep deficiency has been linked to chronic health conditions including heart disease, kidney disease, high blood pressure, stroke, and psychiatric disorders such as depression and anxiety, risky behavior, and suicide. In fact, both high blood pressure and depression are more common in Shelby County (41.5% and 25.2%, respectively) than the national averages (32.7% and 20.7%).

Self-reported general health is a concerning issue in Shelby County. On average, county residents report having poor mental health on 5.7 of the past 30 days, and 20.4% of the population reports 14 or more days of poor mental health. Further, the average number of days of poor mental health has significantly increased over time. County residents are also more likely than the general U.S. population to report poor physical health. In fact, the overall life expectancy in Shelby County is about five years lower than the overall U.S. life expectancy (72.5 vs. 77.6 years, respectively). As seen in Figure 27, this life expectancy is particularly low for the county's Black/African American population (69.3 years).

FIGURE 27. LIFE EXPECTENCY,
BY RACE/ETHNICIY IN YEARS



County Health Rankings (2019-2021)

Primary Data

Patient and Family focus group participants expressed a strong need for increased mental health resources and support, both for patients and their care givers. Caregivers struggle with the mental health toll of supporting a child through treatment and need coping outlets, like therapy, peer support groups and strong social support networks. Mental health challenges are common both during and after treatment, with people experiencing issues like PTSD that require specialized support.

Community partners expressed concerns about the lack of mental health care access, especially for children, with pediatricians not properly diagnosing or referring to trained mental health providers for mental health issues. The limited availability and affordability of quality mental health providers in the community is a major barrier, exacerbated by lack of insurance coverage. People desire mental health providers who have specialized knowledge and experience in treating patients with chronic illnesses, like cancer. Furthermore, co-located services were proposed as a solution to address multiple health challenges, including mental health care, social services, and transportation. Participants highlighted the success of holistic care models and the need for partnerships.

> *If you can't take care of yourself, you can't take care of your kid.*
> **– Focus Group Participant**

> *I think exercise is a good outlet to relieve stress. Therapy for parents is also an outlet because so many times we don't have anyone else to really talk to outside of family and they don't always understand what we're going through.*
> **– Focus Group Participant**

> *The pediatricians are not diagnosing them or think that they will outgrow mental issues…I don't know what we can do to educate or train [providers] at different clinics.*
> **–Listening Session Participant**

Communities of Concern

Racial differences in healthcare are a significant concern, with African Americans, Hispanics and similar populations affected by health problems due to differences in education and income and otherwise unequal treatment.

Caregivers in particular struggle with the mental health toll of supporting a child through treatment and need outlets like therapy to cope.

People express a need for more support and resources specifically targeted at the siblings of children undergoing treatment.

Children from low-income families, particularly in urban centers, face greater health and social needs due to lack of stable living conditions and access to care. Youth were identified as disproportionately affected by health challenges due to gaps in healthcare systems, lack of advocacy, and barriers to accessing services.

> *We live in a society that judges based on how things look and seem and everyone carries implicit bias.*
>
> **–LS Participant**

> *I think it really just comes down to having a healthy, supportive environment to learn and grow in as well.*
>
> **–KPI Participant**

> *So the sibling who's here alone thinks her sister's dying, is just watching all of these gifts pile up. She already feels like she can't do anything to help. She already feels left out and now strangers are just highlighting the fact…and to her credit…my daughter said 'Daddy, I don't care if sissy gets all the presents forever, I just want her to come home and feel better.*
>
> ***– Focus Group Participant***

St. Jude Clinic and Affiliate Findings

The St. Jude Clinic and Affiliate Program Catchment Area is defined by 100-mile radii around the St. Jude Clinic in Huntsville and the seven St. Jude Affiliate locations in Tulsa, OK, Springfield, MO, Johnson City, TN, Baton Rouge, LA, Charlotte, NC, Shreveport, LA, and Peoria, IL.

The St. Jude Comprehensive Cancer Center completed an assessment in 2023 to define the demographic and health need characteristics of the St. Jude Clinic and Affiliate Program Catchment Area. The data presented in the report were aggregated to the St. Jude Comprehensive Cancer Center Catchment Area using geographic information system (GIS) spatial methods of population weighted data allocation. Data were available for different geographical hierarchies including census tract, county, and state, and were sourced from the United States Census Bureau, Centers for Disease Control and Prevention (CDC), Feeding America, United States Department of Agriculture (USDA), United States Cancer Statistics (USCS), County Health Rankings, Youth Risk Behavior Surveillance System (YRBSS), Agency for Healthcare Research and Quality's (AHRQ), Health Resources and Services Administration (HRSA), Agency for Toxic Substances and Disease Registry (ATSDR), National Center for Health Statistics (NCHS), and Surveillance, Epidemiology, and End Results (SEER) Program.

National versions of each of the catchment-level variables were compiled so comparisons could be made. Additionally, where available, earlier vintages of the data were compiled into catchment-level variables so that trends could be uncovered by calculating percent increases and percent decreases in the data. These earlier vintages averaged around five years prior.

A review of the findings demonstrates the combined St. Jude Clinic and Affiliate Program Catchment area has poorer health outcomes for children compared to national data but lower childhood cancer incidence rates and mortality:

Summary Findings

- Lower healthcare access with a high proportion of uninsured
- High social vulnerability with a medium to high Social Vulnerability Index (SVI)
- High childhood risk factors as demonstrated by high rates of obesity and smoking
- High childhood mortality rates with higher rates of death in accidents and adverse effects, homicide and legal intervention, and suicide and self-inflicted injury
- Low childhood cancer incidence rate of cancer and mortality

The detailed findings regarding these areas are as follows:

Healthcare Access

- The catchment area has a **higher** percentage of **people who are uninsured** (10.1%) compared to the national average of 8.8%.
- The percentage of **hospitals with chemotherapy** (81%) **and a pediatric ICU** (73%) in the catchment area is **higher** than the national average (24% and 19%, respectively).

Access Indices

- The **Social Vulnerability Index** (SVI) for the population that lives in the catchment area is **medium-high**. SVI refers to the potential negative effects on communities caused by

external stresses on human health (i.e., human-caused disasters and outbreak). The catchment area is higher than the national average.

Childhood Risk Factors

- 17.2% of high school students in the catchment area have **obesity,** which is **higher** than the national average of 15.5%.
- 26.6% of high school students in the catchment area have tried **smoking,** which is **higher** than the national average of 24.1%.
- 59.1% of high school students in the catchment area were **physically active** at least 60 minutes per day, which is **higher** than the national average of 55.9%.

Childhood Cancer

- The **incidence rates of the top three childhood cancer sites** per 100,000 children in the catchment area are **lower** than the national average (leukemia: 3.9, brain and other nervous system: 3.1, and lymphoma: 2.4).
- **Cancer incidence in people aged 0-19** in the catchment area (17.7 per 100,000) is **lower** than the national average (18.8).
- **Cancer mortality in people ages 0-19** in the catchment area (2.1 per 100,000) is **lower** than the national average (2.2).

HPV

- 59.4% of the population in the catchment area is **up to date with HPV vaccination coverage,** which is **lower** than the national average of 62.6%.
- **HPV-related cancers incidence** rate is 13.9%, which is higher than the national average of 12.5%.

Mortality

- The years of potential life lost before age 75 are **8,928**.
- The top five leading causes of death among children:
    - **Accidents and adverse effects deaths** per 100,000 children in the catchment area (11.2) are **higher** than the national average (8.5).
    - **Homicide and legal intervention deaths** per 100,000 children in the catchment area (5.2) are **higher** than the national average (3.4).
    - **Suicide and self-inflicted injury** deaths per 100,000 children in the catchment area (3.8) are **higher** than the national average (3.6).
    - **All malignant cancer deaths** per 100,000 children in the catchment area (2.1) are **lower** than the national average (2.2).
    - **Congenital anomalies deaths** per 1000,000 children in the catchment area (1.2) are **equivalent** to the national average (1.2) (Westat, October 2023).

Review of Current Community Benefit Initiatives

All significant health needs identified in the St. Jude Children's Research Hospital 2022 Community Health Needs Assessment (CHNA) are being addressed. All the actions taken were documented from July to August 2024. St. Jude Children's Research Hospital took the following actions during tax year 2023 with respect to its most recently conducted CHNA:

Aim 1: Improving access to mental health support and services in the community, beyond those related to patient diagnosis and treatment.

Action 1. Expand telemental health options for St. Jude patients and caregivers when the need is not related to diagnosis and treatment.

Accomplishments: St. Jude initiated the process to accept Medicaid for telemental health, which will be important for continuity of care of new referrals after coverage by St. Jude expires. St. Jude also launched telemental referrals for patients and caregivers in hematology clinic in February 2024.

Action 2. Enhance and expand available community mental health resources for patients and caregivers by leveraging partnerships and collaborative efforts.

Accomplishments: St. Jude Office of Government Affairs continues to engage and advocate with state-level public policy makers for interstate compacts that expand mental health practice (e.g., Psypact and social work interstate compacts).

Aim 2: Improving access to providers, resources, and coordinated care during the transition of care from St. Jude and its affiliates to community and/or adult care.

Action 1. Continue to improve transitions for St. Jude patients after completion of therapy.

Accomplishments: St. Jude successfully implemented the patient transition guide and the patient transition tab in the health record within three primary oncology clinics as part of the summer 2024 pilot. The organization developed an intranet site with training materials and all patient education materials together that increased accessibility for clinicians. Additionally, the institutional rollout of standardized transition processes began.

Aim 3: Improving access to clinical trials at St. Jude and its affiliates.

Action 1. Launch the U-DECIDE trial at the affiliate clinics (the decision to enroll in therapeutic clinical trials in a pediatric cancer clinical network).

Accomplishments: St. Jude enrolled approximately 175 patients in the U-DECIDE trial. Two aims of the study are enrolling patients, and the third aim is open for enrollment. St. Jude has verbally administered survey 1 regarding demographics to 103 trial participants and survey 2 regarding decision making preferences to 18 trial participants.

Action 2. Continue to implement operational strategies to increase local access to and enrollment in clinical trials at the affiliate locations.

Accomplishments: St. Jude Affiliate providers utilized the Together website (Together by St. Jude™ online resource) as well as the St. Jude Care and Treatment website (St. Jude Care & Treatment | St. Jude Care & Treatment) for locating available clinical trials. The Annual

Affiliate Physician Conference was held on March 22, 2024 and focused on patient enrollments. St. Jude enhanced the Clinical Outreach and Education coordinating committee (COE) to augment educational activities focused on clinical research awareness and participation. St. Jude created new voting members of clinical trial scientific review committee. Additionally, St. Jude improved underrepresented populations in clinical research and established a subcommittee of the cancer center advisory committee.

Aim 4: Conducting cancer prevention work through education and HPV vaccination.

Action 1. Strengthen partnerships with local education agencies to disseminate educational programs on cancer control and prevention.

Accomplishments: St. Jude expanded the after-school STEM clubs to two additional schools and piloted the virtual STEMM academy in one high school.

Action 2. Serve as a leader, convener, and catalyst for implementing evidence-based interventions to increase HPV vaccination coverage and prevent HPV-associated cancers.

Accomplishments: St. Jude developed and implemented a local HPV vaccination action plan for Memphis, Shelby County with approximately 150 local members. St. Jude also hosted 86 leaders across the southeast to prioritize three evidence-based interventions.

Action 3. Engage in strategic implementation of evidence-based interventions to increase HPV vaccination coverage.

Accomplishments: St. Jude developed and disseminated communications at the national and local level focused on HPV cancers. Additionally, St. Jude executed back to school vaccination events with Memphis Shelby County schools, Shelby County Health Department, Le Bonheur Children's Hospital, and the University of Tennessee Health Science Center. St. Jude organized and hosted a variety of seminars and conferences to educate and raise awareness of HPV and cancer vaccines.

Aim 5: Increasing awareness and education of sickle cell disease and infectious diseases (HIV/AIDS) in the community.

Action 1. Develop online educational modules on sickle cell testing and genetic counseling for TN Department of Health nurses to enable them to complete the training at their convenience.

Accomplishments: St. Jude launched an online educational module; 31 West Tennessee Rural Health Department nurses completed training with increases in assessment scores. St. Jude disseminated training modules at St. Jude nursing and psychology symposium, the Black Nurses' Association conference in Atlanta, Georgia, and at the annual Sickle Cell and Thalassemia conference in London.

Action 2. Create and execute a communication campaign that addresses the gaps in knowledge and awareness of HIV and the HIV prevention and care program at St. Jude that provides related prevention and treatment.

Accomplishments: St. Jude improved management of social media and achieved increases in followers across social media channels. St. Jude presented 4 times on HIV to various groups in Shelby County with efforts covered by the *Daily Memphian*. St. Jude also hosted tables at 52

events and met with 15 community partners to share information about HIV prevention and treatment programs at St. Jude.

Action 3. With a coalition of community stakeholders, identify the gaps in the continuum of HIV prevention and care and address those gaps with a focus on structural change.

Accomplishments: St. Jude implemented a fresh start with the 18-member End HIV 901 Community Advisory Board (CAB) to re-engage subcommittees. CAB members attended technical assistance training as part of membership responsibilities. St. Jude reinstated the in-person Connect to Protect (C2P) meeting to increase productivity and input from the community.

Aim 6: Strengthen community partnerships in the greater Memphis area to address social determinants of health for local patients.

Action 1. Collaborate with other healthcare organizations; local, state, and national government agencies; and local community organizations to improve identification and utilization of resources.

Accomplishments: St. Jude continued its contract with The Works, Inc. (TWI), a community organization that assists with securing affordable housing and social services. St. Jude continued partnership with Metropolitan Inter-Faith Association (MIFA) to assist families within and beyond Shelby County with emergency rent/mortgage and utility payments and other assistance. Additionally, St. Jude continued pro bono referral relationship with a national law firm for families to receive representation in issues like conservatorships, individual education plans, disability benefits, foreclosure, etc. St. Jude implemented formal assessment of domains of food security, financial security and income stability in the psychosocial assessment and reassessment of every patient. St. Jude worked with the Congressional Colorectal Cancer Caucus to sponsor legislation that would incorporate children's oncology group recommendations for early diagnostic screening for certain survivors of childhood cancer into United States Preventive Services Task Force guidelines.

Resources to Address Health Needs

Resources potentially available to address identified health needs include existing community programs, local nonprofit partnerships, healthcare infrastructure investments, and ongoing collaborations with community-based organizations targeting the identified significant health needs within the service area.

The patient and family focus groups, key informant interviews, and listening sessions provided participants with an opportunity to suggest ideas for improving community health. They highlighted the critical role of community partnerships and collaboration in addressing a range of healthcare needs, such as mental health support, housing assistance, and youth services. Additionally, there is a strong desire for comprehensive and integrated healthcare models that not only address medical and mental health needs but also provide vital support for caregivers and families.

Community Partnerships and Collaboration

People Emphasize the Importance of Community Partnerships and Collaboration to Address Healthcare Needs

Many expressed the significance of community partnerships and collaboration in meeting different healthcare needs, including mental health support, housing assistance, and youth services.

Collaborations with local organizations, universities, churches, and government agencies are deemed essential for delivering comprehensive and coordinated care. Such collaboration is also crucial for tackling the complex challenges families face, like the mental health impacts of cancer treatment.

Comprehensive and Integrated Care

People Desire Comprehensive and Integrated Healthcare Services to Address Different Needs

There is a strong demand for healthcare services that offer comprehensive and integrated care to address both medical and mental health needs.

Integrated care models that position services such as clinical care alongside mental health support are seen as particularly beneficial.

Participants also underscored the necessity of addressing the varied needs of families, especially those with lower incomes or a complex medical history.

Caregiver and Family Support

People Emphasize the Need for Increased Support and Resources for Caregivers and Families

There is a recognized need for enhanced support and resources for caregivers, with acknowledgment of the importance of caregiver mental health and well-being.

Opportunities for more deliberate partnerships and collaboration to bolster support for caregivers and their families were highlighted.

There is a specific call for more proactive communication and information-sharing from healthcare providers to assist families throughout their journey.

Accessibility and Affordability of Healthcare Services

People Emphasize the Importance of Improving Accessibility and Affordability of Healthcare Services

Participants noted the necessity of making healthcare services more affordable and accessible, especially regarding transportation to appointments and specialty care.

Barriers such as insufficient insurance coverage and high out-of-pocket costs for services like transportation are seen as significant challenges.

Emphasizing that healthcare should be accessible and affordable is considered critical, particularly for families with lower incomes.

Mental Health Support

People Emphasize the Importance of Comprehensive Mental Health Support for Patients and Families

There is a strong emphasis on the need for comprehensive mental health support for both patients and families, particularly considering the significant mental health impacts associated with cancer treatment and other chronic conditions.

A priority was placed on increasing mental health resources and services, especially for the youth.

The well-being of caregivers is also highlighted, as supporting their mental health is essential for enabling them to provide adequate care.

Conclusions

The St. Jude 2025 CHNA provides an in-depth analysis of the major health needs identified in the local service area. By thoroughly evaluating secondary data and gathering valuable primary data insights from community stakeholders, St. Jude has identified six (6) primary health concerns: Cancer & Long-Term Follow-up; Children's Health; Access to Healthcare & Chronic (Neurologic) Diseases; Education; Infectious Diseases and Immunizations; and Mental Health, Wellness & Lifestyle. Furthermore, transitioning from St. Jude to local facilities for post-treatment primary care and a lack of understanding of the complexity of patient care needs presented challenges to the St. Jude community.

Looking ahead, St. Jude will develop a comprehensive Implementation Strategy with associated goals and actions in compliance with the Internal Revenue Service (IRS) regulations for nonprofit hospitals. This next step will detail specific interventions, set measurable objectives, and cultivate strategic partnerships to effectively address the identified needs. The progress of these initiatives will be monitored and assessed to ensure accountability and alignment with the hospital's mission of providing high-quality healthcare and fostering a healthier, more resilient community.

Report Adoption, Availability and Comments

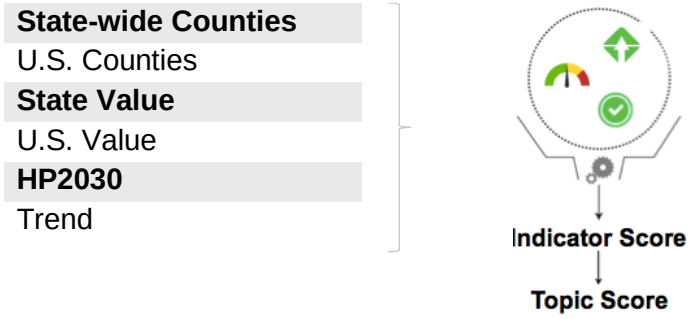
This CHNA was adopted by the St. Jude Children's Research Hospital Advisory Board in June 2025 and complies with IRS regulations 501(r) for charitable hospitals. This document is publicly available at stjude.org and a paper copy of the report is available upon request. Written comments may be submitted to St. Jude via email at communityrelations@stjude.org. As of June 2025, no comments have been received in response to the 2022 St. Jude CHNA report.

Appendix
Data Scoring Methodology and Tables

Data Scoring Tool

Conduent HCI's Data Scoring Tool systematically summarizes multiple comparisons and ranks indicators based on the highest need. For each indicator, the county values were compared to a distribution of other counties across the state and nation, overall state and national values, Healthy People 2030 targets, and significant trends, as shown in Figure 28. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and 3 indicates the poorest outcome. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs. Due to the limited availability of zip code, census tract, or other sub-county health data, the data scoring technique is only available at the county level. Each of the overall topic scores for the St. Jude local service area are based on a weighted average of topics scores from each of the 25 counties in the service area.

FIGURE 28: SECONDARY DATA SCORING



Data Scoring Results

Table 6 shows the topic scoring results for the SJCRH primary service area, with Wellness and Lifestyle as the poorest performing topic area with a score of 1.76, followed by Children's Health with a score of 1.70. Topics that received a score of 1.50 or higher were considered a significant health need. Sixteen health and quality of life topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Given the St. Jude local service area, Table 7 below provides data scores for key indicators related to child health and well-being for all 25 counties in the service area. As with the topic scores, the indicators below are scored on a scale of 0 to 3, where a score of 3 is most concerning.

To view all health and quality of life indicators available for Shelby County, see Table 8.

TABLE 6: SECONDARY DATA SCORING RESULTS

Health and Quality of Life Topics	Score
Wellness & Lifestyle	**1.76**
Children's Health	**1.70**
Diabetes	**1.67**
Older Adults	**1.64**
Prevention & Safety	**1.64**
Physical Activity	**1.63**
Sexually Transmitted Infections	**1.62**
Heart Disease & Stroke	**1.61**
Economy	**1.59**
Women's Health	**1.58**
Cancer	**1.57**
Respiratory Diseases	**1.56**
Mental Health & Mental Disorders	**1.54**
Immunizations & Infectious Diseases	**1.54**
Maternal, Fetal & Infant Health	**1.53**
Community	**1.51**

TABLE 7: SECONDARY DATA SCORING RESULTS: CHILDREN'S HEALTH

Indicator	Children Living Below Poverty Level	Young Children Living Below Poverty Level	Children in Single-Parent Households	Children with Health Insurance
Source	*American Community Survey (2019-2023)*	*American Community Survey (2019-2023)*	*American Community Survey (2019-2023)*	*American Community Survey (2023)*
Craighead, AR	2.75	2.92	2.47	1.72
Crittenden, AR	2.36	1.92	2.64	- -
Mississippi, AR	2.33	2.19	2.19	- -
Poinsett, AR	2.24	1.94	2.06	- -

Benton, MS	2.53	2.38	1.82	- -
DeSoto, MS	0.81	0.97	1.58	2.06
Lafayette, MS	0.42	0.36	0.86	- -
Lee, MS	1.75	1.33	2.08	1.33
Marshall, MS	2.47	1.08	2.14	- -
Panola, MS	2.31	1.36	2.47	- -
Pontotoc, MS	1.19	1.50	1.03	- -
Tate, MS	1.83	1.19	1.97	- -
Tippah, MS	2.31	1.42	1.03	- -
Union, MS	1.75	0.67	1.53	- -
Crockett, TN	2.71	2.56	1.88	- -
Dyer, TN	1.83	0.53	2.64	- -
Fayette, TN	1.53	0.53	0.75	- -
Gibson, TN	0.25	1.08	2.36	- -
Hardeman, TN	2.64	0.53	2.64	- -
Haywood, TN	2.71	2.56	2.41	- -
Henderson, TN	1.83	0.53	0.83	- -
Lauderdale, TN	2.19	2.50	2.64	- -
Madison, TN	2.36	2.36	2.36	2.06

Shelby, TN	2.08	2.08	2.36	2.06
Tipton, TN	1.36	2.31	2.92	- -

	Child Care Centers	Child Food Insecurity Rate	Food Insecure Children Likely Ineligible for Assistance	Substantiated Child Abuse Rate
	County Health Rankings (2022)	*Feeding America (2022)*	*Feeding America (2022)*	*Annie E. Casey Foundation (2023)*
Craighead, AR	1.42	2.31	1.97	- -
Crittenden, AR	1.42	2.64	1.36	- -
Mississippi, AR	0.75	2.64	0.86	- -
Poinsett, AR	1.06	2.38	0.94	- -
Benton, MS	1.94	1.68	1.24	- -
DeSoto, MS	1.92	0.50	2.64	- -
Lafayette, MS	2.25	0.64	1.31	- -
Lee, MS	0.75	0.97	2.31	- -
Marshall, MS	2.25	2.47	0.53	- -
Panola, MS	2.08	2.14	0.50	- -
Pontotoc, MS	2.25	0.69	0.64	- -
Tate, MS	2.25	1.03	0.81	- -
Tippah, MS	2.08	1.19	0.92	- -
Union, MS	2.25	0.53	0.81	- -
Crockett, TN	0.71	2.21	1.12	2.03
Dyer, TN	1.42	1.97	1.92	1.75
Fayette, TN	1.92	2.14	2.50	1.06

Gibson, TN	0.92	2.14	0.67	1.44
Hardeman, TN	1.58	2.64	0.53	0.78
Haywood, TN	2.12	2.71	0.47	1.53
Henderson, TN	1.42	1.50	1.00	1.33
Lauderdale, TN	2.08	2.64	0.69	1.92
Madison, TN	1.42	2.64	2.19	1.72
Shelby, TN	1.08	2.64	2.03	1.22
Tipton, TN	1.75	1.64	1.03	0.78

TABLE 8: SECONDARY DATA SOURCES KEY

Key	Source
1	American Community Survey 1-Year
2	American Community Survey 5-Year
3	American Lung Association
4	Annie E. Casey Foundation
5	CDC - PLACES
6	Centers for Disease Control and Prevention
7	Centers for Medicare & Medicaid Services
8	County Health Rankings
9	Feeding America
10	National Cancer Institute
11	National Center for Education Statistics
12	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
13	National Environmental Public Health Tracking Network
14	Purdue Center for Regional Development
15	Tennessee Bureau of Investigation
16	Tennessee Department Of Education
17	Tennessee Department of Health
18	Tennessee Department of Health- Communicable and Environmental Disease Services
19	Tennessee Department of Safety and Homeland Security
20	Tennessee Secretary of State
21	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Environmental Protection Agency
24	United For ALICE

Score	ALCOHOL & DRUG USE	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.42	Outpatient Visits due to Opioid Overdose (excluding Heroin)	*Age-Adjusted Rate per 100,000*	171.0		91.0		*2022*	17
2.25	Death Rate due to Drug Poisoning	*deaths per 100,000 population*	46.0	20.7	43.2	27.2	*2019-2021*	8
2.17	Inpatient Stays due to Opioid Overdose (excluding Heroin)	*Age-Adjusted Rate per 100,000*	26.0		20.0		*2022*	17
1.97	Liquor Store Density	*stores per 100,000 population*	11.8		9.7	10.9	*2022*	22
1.58	Adults who Binge Drink	*percent*	15.7			16.6	*2022*	5
1.33	Adults who Drink Excessively	*percent*	15.4		16.9	18.1	*2021*	8
1.11	Inpatient Stays due to Heroin Overdose	*Age-Adjusted Rate per 100,000*	1.0		5.0		*2022*	17
0.64	Alcohol-Impaired Driving Deaths	*percentage of driving deaths with alcohol involvement*	18.2		23.8	26.3	*2017-2021*	8
0.58	Outpatient Visits involving Heroin	*Age-Adjusted Rate per 100,000*	7.0		35.0		*2022*	17

Score	CANCER	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.47	Cancer: Medicare Population	*percent*	13.0		11.0	12.0	*2022*	7
2.36	Mammography Screening: Medicare Population	*percent*	37.0		45.0	47.0	*2022*	7
2.36	Prostate Cancer Incidence Rate	*cases per 100,000 males*	140.4		115.1	113.2	*2017-2021*	10
2.17	Age-Adjusted Death Rate due to Prostate Cancer	*deaths per 100,000 males*	27.5	16.9	19.6	19.0	*2018-2022*	10
2.11	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths per 100,000 population*	16.4	8.9	14.7	12.9	*2018-2022*	10
2.00	Age-Adjusted Death Rate due to Breast Cancer	*deaths per 100,000 females*	25.8	15.3	21.7	19.3	*2018-2022*	10
1.86	Age-Adjusted Death Rate due to Cervical Cancer	*death per 100,000 females*	2.9		2.6	2.2	*2018-2022*	10
1.86	Colorectal Cancer Incidence Rate	*cases per 100,000 population*	41.0		38.7	36.4	*2017-2021*	10
1.42	Colon Cancer Screening: USPSTF Recommendation	*percent*	63.5			66.3	*2022*	5
1.36	Breast Cancer Incidence Rate	*cases per 100,000 females*	125.0		124.6	129.8	*2017-2021*	10
1.17	Age-Adjusted Death Rate due to Cancer	*deaths per 100,000 population*	162.1	122.7	166.3	146.0	*2018-2022*	10

Score	CANCER (continued)	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
1.17	Cervical Cancer Incidence Rate	*cases per 100,000 females*	7.9		7.6	7.5	*2017-2021*	10
0.94	Mammogram in Past 2 Years: 50-74	*percent*	79.1	80.3		76.5	*2022*	5
0.92	Cervical Cancer Screening: 21-65	*Percent*	83.5			82.8	*2020*	5
0.75	Adults with Cancer (Non-Skin) or Melanoma	*percent*	6.5			8.2	*2022*	5
0.67	Age-Adjusted Death Rate due to Lung Cancer	*deaths per 100,000 population*	35.5	25.1	44.1	32.4	*2018-2022*	10
0.58	All Cancer Incidence Rate	*cases per 100,000 population*	438.2		457.3	444.4	*2017-2021*	10
0.58	Lung and Bronchus Cancer Incidence Rate	*cases per 100,000 population*	54.5		68.1	53.1	*2017-2021*	10
0.36	Oral Cavity and Pharynx Cancer Incidence Rate	*cases per 100,000 population*	10.5		13.0	12.0	*2017-2021*	10

Score	CHILDREN'S HEALTH	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.64	Child Food Insecurity Rate	*percent*	27.4		17.9	18.5	*2022*	9
2.06	Children with Health Insurance	*percent*	92.8		94.4	94.6	*2023*	1
2.03	Food Insecure Children Likely	*percent*	32.0		26.0	30.0	*2022*	9

	Ineligible for Assistance							
1.22	Substantiated Child Abuse Rate	*cases per 1,000 children*	3.4	8.7	3.6		*2023*	4
1.08	Child Care Centers	*per 1,000 population under age 5*	9.0		9.0	7.0	*2022*	8

Score	COMMUNITY	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.92	People 65+ Living Alone	*percent*	31.9		27.6	26.5	*2019-2023*	2
2.75	Age-Adjusted Death Rate due to Firearms	*deaths per 100,000 population*	33.6	10.7	18.5	12.0	*2018-2020*	6
2.67	Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	*deaths per 100,000 population*	20.7	10.1	16.3	11.4	*2018-2020*	6
2.58	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	588		455	612	*2019-2023*	2
2.36	Children in Single-Parent Households	*percent*	42.1		27.3	24.8	*2019-2023*	2
2.31	Total Employment Change	*percent*	0.9		5.3	5.8	*2021-2022*	22
2.25	Median Household Gross Rent	*dollars*	1170		1122	1348	*2019-2023*	2

2.25	Mortgaged Owners Median Monthly Household Costs	*dollars*	1642		1506	1902	*2019-2023*	2
2.22	Age-Adjusted Death Rate due to Homicide	*deaths per 100,000 population*	28.7	5.5	10.0	6.6	*2018-2020*	6
2.19	Youth not in School or Working	*percent*	3.0		1.9	1.7	*2019-2023*	2
2.14	Linguistic Isolation	*percent*	2.0		1.7	4.2	*2019-2023*	2
2.08	Children Living Below Poverty Level	*percent*	25.8		18.7	16.3	*2019-2023*	2
2.08	Young Children Living Below Poverty Level	*percent*	27.9		20.2	17.6	*2019-2023*	2
1.86	Domestic Violence Incidents per 1,000 Population	*incidents per 1,000 population*	18.6		8.4		*2023*	15
1.83	People Living Below Poverty Level	*percent*	17.5	8.0	13.8	12.4	*2019-2023*	2
1.83	Workers Commuting by Public Transportation	*percent*	0.5	5.3	0.5	3.5	*2019-2023*	2
1.69	Social Associations	*membership associations per 10,000 population*	9.3		11.0	9.1	*2021*	8
1.64	Pedestrian Deaths	*deaths*	476				*2023*	19
1.61	Voter Turnout: Presidential Election	*percent*	65.1	58.4	69.3		*2020*	20
1.53	Workers who Walk to Work	*percent*	1.3		1.2	2.4	*2019-2023*	2

1.50	Broadband Quality Score	*BQS Score*	58.4		78.4	50.0	*2022*	14
1.42	Median Household Income	*dollars*	62337		67097	78538	*2019-2023*	2
1.36	Bicyclist Deaths	*deaths*	2				*2023*	19
1.25	Workers who Drive Alone to Work	*percent*	78.3		77.2	70.2	*2019-2023*	2
1.22	Substantiated Child Abuse Rate	*cases per 1,000 children*	3.4	8.7	3.6		*2023*	4
1.08	Per Capita Income	*dollars*	37666		37866	43289	*2019-2023*	2
1.08	People with an Internet Subscription	*percent*	89.7		90.2	92.0	*2019-2023*	2
1.00	Digital Distress		1.0				*2022*	14
0.92	Households with an Internet Subscription	*percent*	87.3		87.6	89.9	*2019-2023*	2
0.92	Households with One or More Types of Computing Devices	*percent*	93.3		93.5	94.8	*2019-2023*	2
0.86	Population 16+ in Civilian Labor Force	*percent*	59.9		58.8	59.8	*2019-2023*	2
0.75	People 25+ with a High School Diploma or Higher	*percent*	89.8		89.6	89.4	*2019-2023*	2
0.69	Female Population 16+ in Civilian Labor Force	*percent*	61.1		57.3	58.7	*2019-2023*	2
0.67	Digital Divide Index	*DDI Score*	19.3		33.9	50.0	*2022*	14
0.64	Alcohol-Impaired Driving Deaths	*percentage of driving deaths with alcohol involvement*	18.2		23.8	26.3	*2017-2021*	8

0.42	People 25+ with a bachelor's degree or Higher	*percent*	34.2		30.4	35.0	*2019-2023*	2
0.25	Mean Travel Time to Work	*minutes*	22.5		25.7	26.6	*2019-2023*	2
0.25	Solo Drivers with a Long Commute	*percent*	29.0		36.1	36.4	*2018-2022*	8

Score	DIABETES	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.42	Adults 20+ with Diabetes	*percent*	12.0				*2021*	6
1.25	Age-Adjusted Death Rate due to Diabetes	*deaths per 100,000 population*	26.6		26.9	22.6	*2018-2020*	6
1.19	Diabetes: Medicare Population	*percent*	26.0		26.0	24.0	*2022*	7

Score	ECONOMY	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.75	People 65+ Living Below Poverty Level	*percent*	13.3		10.8	10.4	*2019-2023*	2
2.64	Child Food Insecurity Rate	*percent*	27.4		17.9	18.5	*2022*	9
2.64	Unemployed Veterans	*percent*	4.5		2.9	3.2	*2019-2023*	2
2.58	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	588		455	612	*2019-2023*	2

2.42	Renters Spending 30% or More on Household Income on Rent	*percent*	53.2	25.5	48.1	50.4	*2019-2023*	2
2.36	Unemployed Workers in Civilian Labor Force	*percent*	4.7		3.5	3.9	*October 2024*	21
2.31	Total Employment Change	*percent*	0.9		5.3	5.8	*2021-2022*	22
2.31	Veterans Living Below Poverty Level	*percent*	8.9		7.9	7.2	*2019-2023*	2
2.25	Median Household Gross Rent	*dollars*	1170		1122	1348	*2019-2023*	2
2.25	Mortgaged Owners Median Monthly Household Costs	*dollars*	1642		1506	1902	*2019-2023*	2
2.19	Youth not in School or Working	*percent*	3.0		1.9	1.7	*2019-2023*	2
2.17	Families Living Below 200% of Poverty Level	*percent*	30.9		25.7	22.4	*2019-2023*	2
2.08	Children Living Below Poverty Level	*percent*	25.8		18.7	16.3	*2019-2023*	2
2.08	Severe Housing Problems	*percent*	18.7		13.3	16.7	*2016-2020*	8
2.08	Young Children Living Below Poverty Level	*percent*	27.9		20.2	17.6	*2019-2023*	2
2.03	Food Insecure Children Likely Ineligible for Assistance	*percent*	32.0		26.0	30.0	*2022*	9
2.00	People Living Below 200% of Poverty Level	*percent*	37.4		32.1	28.5	*2019-2023*	2

1.92	Families Living Below Poverty Level	*percent*	13.4		9.9	8.7	*2019-2023*	2
1.83	People Living Below Poverty Level	*percent*	17.5	8.0	13.8	12.4	*2019-2023*	2
1.69	Households Living Below Poverty Level	*percent*	17.1		14.0		*2021*	24
1.64	Size of Labor Force	*persons*	431036				*October 2024*	21
1.50	Households that are Above Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	54.4		56.0		*2021*	24
1.42	Adults with Disability Living in Poverty	*percent*	28.4		26.5	24.6	*2019-2023*	2
1.42	Adults with Disability Living in Poverty	*percent*	28.4		26.5	24.6	*2019-2023*	2
1.42	Median Household Income	*dollars*	62337		67097	78538	*2019-2023*	2
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	28.5		30.0		*2021*	24
1.08	Per Capita Income	*dollars*	37666		37866	43289	*2019-2023*	2
1.00	Food Insecurity Rate	*percent*	13.4		14.0	13.5	*2022*	9
0.86	Population 16+ in Civilian Labor Force	*percent*	59.9		58.8	59.8	*2019-2023*	2
0.69	Female Population 16+ in Civilian Labor Force	*percent*	61.1		57.3	58.7	*2019-2023*	2
0.69	Households with Cash Public Assistance Income	*percent*	1.8		2.0	2.7	*2019-2023*	2

0.53	Gender Pay Gap	*cents on the dollar*	81.7		74.8	72.5	*2019-2023*	2
0.50	Students Eligible for the Free Lunch Program	*percent*	2.5		20.0	43.1	*2019-2020*	11
0.42	Homeowner Vacancy Rate	*percent*	0.7		1.0	1.0	*2019-2023*	2

Score	EDUCATION	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.03	Student-to-Teacher Ratio	*students to teacher*	16.2		15.3	15.4	*2022-2023*	11
2.00	Students Proficient in Math: Grades 3-8	*percent*	18.5		39.1		*2023*	16
1.94	High School Graduation	*percent*	82.1	90.7	89.3	86.2	*2020-2021*	8
1.86	Students Proficient in English Language Arts: Grades 3-8	*percent*	21.4		36.7		*2023*	16
1.08	Child Care Centers	*per 1,000 population under age 5*	9.0		9.0	7.0	*2022*	8
0.86	Veterans with a High School Diploma or Higher	*percent*	96.0		94.6	95.2	*2019-2023*	2
0.75	People 25+ with a High School Diploma or Higher	*percent*	89.8		89.6	89.4	*2019-2023*	2
0.42	People 25+ with a bachelor's degree or Higher	*percent*	34.2		30.4	35.0	*2019-2023*	2

Score	ENVIRONMENTAL HEALTH	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.25	Adults with Current Asthma	*percent*	12.4			9.9	*2022*	5
2.25	Proximity to Highways	*percent*	8.5		7.0		*2020*	13
2.08	Severe Housing Problems	*percent*	18.7		13.3	16.7	*2016-2020*	8
1.97	Liquor Store Density	*stores per 100,000 population*	11.8		9.7	10.9	*2022*	22
1.67	Daily Dose of UV Irradiance	*Joule per square meter*	3962.0		3869.0		*2020*	13
1.64	Number of Extreme Heat Days	*days*	15				*2023*	13
1.64	Number of Extreme Heat Events	*events*	12				*2023*	13
1.64	Recognized Carcinogens Released into Air	*pounds*	112137.9				*2023*	23
1.61	Annual Ozone Air Quality	*grade*	F				*2020-2022*	3
1.56	Annual Particle Pollution	*grade*	B				*2020-2022*	3
1.50	Broadband Quality Score	*BQS Score*	58.4		78.4	50.0	*2022*	14
1.36	Food Environment Index		7.3		6.5	7.7	*2024*	8
1.36	Houses Built Prior to 1950	*percent*	11.9		9.7	16.4	*2019-2023*	2

1.36	Weeks of Moderate Drought or Worse	*weeks per year*	0.0				*2021*	13
1.31	Asthma: Medicare Population	*percent*	6.0		6.0	7.0	*2022*	7
0.75	Access to Parks	*percent*	61.0		34.4		*2020*	13
0.67	Access to Exercise Opportunities	*percent*	86.2		67.4	84.1	*2024*	8
0.67	Digital Divide Index	*DDI Score*	19.3		33.9	50.0	*2022*	14

Score	HEALTH CARE ACCESS & QUALITY	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.06	Children with Health Insurance	*percent*	92.8		94.4	94.6	*2023*	1
1.78	Adults with Health Insurance	*percent*	83.7		86.7	89.0	*2023*	1
1.75	Adults who Visited a Dentist	*percent*	54.7			63.9	*2022*	5
1.75	Adults without Health Insurance	*percent*	10.8			10.8	*2022*	5
1.53	Preventable Hospital Stays: Medicare Population	*discharges per 100,000 Medicare enrollees*	2869.0		2841.0	2677.0	*2022*	7
0.92	Adults who have had a Routine Checkup	*percent*	79.8			76.1	*2022*	5
0.92	Mental Health Provider Rate	*providers per 100,000 population*	189.4		187.9	313.9	*2023*	8
0.64	Primary Care Provider Rate	*providers per 100,000 population*	85.7		69.6	74.9	*2021*	8

0.25	Dentist Rate	*dentists per 100,000 population*	77.6		56.2	73.5	*2022*	8
0.25	Non-Physician Primary Care Provider Rate	*providers per 100,000 population*	179.0		175.5	131.4	*2023*	8

Score	HEART DISEASE & STROKE	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.64	Stroke: Medicare Population	*percent*	7.0		6.0	6.0	*2022*	7
2.22	Age-Adjusted Death Rate due to Heart Attack	*deaths per 100,000 population 35+ years*	124.4		86.4		*2021*	13
2.06	High Blood Pressure Prevalence	*percent*	41.5	41.9		32.7	*2021*	5
1.97	Hyperlipidemia: Medicare Population	*percent*	67.0		65.0	65.0	*2022*	7
1.81	Hypertension: Medicare Population	*percent*	71.0		69.0	65.0	*2022*	7
1.58	Adults who Experienced a Stroke	*percent*	4.2			3.6	*2022*	5
1.53	Ischemic Heart Disease: Medicare Population	*percent*	23.0		22.0	21.0	*2022*	7
1.33	Age-Adjusted Death Rate due to Heart Disease	*deaths per 100,000 population*	209.2		218.3		*2022*	17

1.08	Adults who Have Taken Medications for High Blood Pressure	*percent*	82.0			78.2	*2021*	5
0.97	Atrial Fibrillation: Medicare Population	*percent*	13.0		14.0	14.0	*2022*	7
0.92	Adults who Experienced Coronary Heart Disease	*percent*	6.8			6.8	*2022*	5
0.92	Cholesterol Test History	*percent*	87.3			86.4	*2021*	5
0.92	High Cholesterol Prevalence	*percent*	33.2			35.5	*2021*	5
0.86	Age-Adjusted Hospitalization Rate due to Heart Attack	*hospitalizations per 10,000 population 35+ years*	24.5		31.7		*2020*	13
0.86	Heart Failure: Medicare Population	*percent*	11.0		11.0	11.0	*2022*	7

Score	IMMUNIZATIONS & INFECTIONS	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.39	HIV Diagnosis Rate	*cases per 100,000 population*	44.9		14.4	13.3	*2022*	12
2.19	Tuberculosis Incidence Rate	*cases per 100,000 population*	3.7	1.4	1.7	2.9	*2023*	18
1.17	Cervical Cancer Incidence Rate	*cases per 100,000 females*	7.9		7.6	7.5	*2017-2021*	10
1.14	Pneumonia Vaccinations: Medicare Population	*percent*	8.0		8.0	8.0	*2022*	7

0.83	Flu Vaccinations: Medicare Population	*percent*	53.0		51.0	50.0	*2022*	7

Score	MENTAL HEALTH & MENTAL DISORDERS	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.08	Poor Mental Health: Average Number of Days	*days*	5.7		5.8	4.8	*2021*	8
1.92	Poor Mental Health: 14+ Days	*percent*	20.4			15.8	*2022*	5
1.86	Alzheimer's Disease or Dementia: Medicare Population	*percent*	7.0		7.0	6.0	*2022*	7
1.58	Adults Ever Diagnosed with Depression	*percent*	25.2			20.7	*2022*	5
0.92	Mental Health Provider Rate	*providers per 100,000 population*	189.4		187.9	313.9	*2023*	8
0.81	Depression: Medicare Population	*percent*	14.0		18.0	16.0	*2022*	7

Score	OLDER ADULTS	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.92	People 65+ Living Alone	*percent*	31.9		27.6	26.5	*2019-2023*	2
2.75	People 65+ Living Below Poverty Level	*percent*	13.3		10.8	10.4	*2019-2023*	2
2.64	Stroke: Medicare Population	*percent*	7.0		6.0	6.0	*2022*	7
2.47	Cancer: Medicare Population	*percent*	13.0		11.0	12.0	*2022*	7

2.36	Mammography Screening: Medicare Population	*percent*	37.0	45.0	47.0	*2022*	7
2.36	Prostate Cancer Incidence Rate	*cases per 100,000 males*	140.4	115.1	113.2	*2017-2021*	10
2.25	Adults 65+ with Total Tooth Loss	*percent*	21.0		12.2	*2022*	5
1.97	Hyperlipidemia: Medicare Population	*percent*	67.0	65.0	65.0	*2022*	7
1.86	Alzheimer's Disease or Dementia: Medicare Population	*percent*	7.0	7.0	6.0	*2022*	7
1.81	Hypertension: Medicare Population	*percent*	71.0	69.0	65.0	*2022*	7
1.53	Ischemic Heart Disease: Medicare Population	*percent*	23.0	22.0	21.0	*2022*	7
1.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.0	37.0	35.0	*2022*	7
1.31	Asthma: Medicare Population	*percent*	6.0	6.0	7.0	*2022*	7
1.19	Diabetes: Medicare Population	*percent*	26.0	26.0	24.0	*2022*	7
0.97	Atrial Fibrillation: Medicare Population	*percent*	13.0	14.0	14.0	*2022*	7
0.97	Osteoporosis: Medicare Population	*percent*	9.0	10.0	11.0	*2022*	7
0.94	Age-Adjusted Death Rate due to Falls	*deaths per 100,000 population*	9.0	10.6	9.8	*2018-2020*	6

0.86	Heart Failure: Medicare Population	*percent*	11.0		11.0	11.0	*2022*	7
0.81	COPD: Medicare Population	*percent*	10.0		13.0	11.0	*2022*	7
0.81	Depression: Medicare Population	*percent*	14.0		18.0	16.0	*2022*	7
0.53	Chronic Kidney Disease: Medicare Population	*percent*	16.0		19.0	18.0	*2022*	7

Score	ORAL HEALTH	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.25	Adults 65+ with Total Tooth Loss	*percent*	21.0			12.2	*2022*	5
1.75	Adults who Visited a Dentist	*percent*	54.7			63.9	*2022*	5
0.36	Oral Cavity and Pharynx Cancer Incidence Rate	*cases per 100,000 population*	10.5		13.0	12.0	*2017-2021*	10
0.25	Dentist Rate	*dentists per 100,000 population*	77.6		56.2	73.5	*2022*	8

Score	OTHER CONDITIONS	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.50	Age-Adjusted Death Rate due to Kidney Disease	*deaths per 100,000 population*	16.1		13.2	12.8	*2018-2020*	6
1.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.0		37.0	35.0	*2022*	7

1.42	Adults with Arthritis	*percent*	30.7			26.6	*2022*	5
0.97	Osteoporosis: Medicare Population	*percent*	9.0		10.0	11.0	*2022*	7
0.53	Chronic Kidney Disease: Medicare Population	*percent*	16.0		19.0	18.0	*2022*	7

Score	PHYSICAL ACTIVITY	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.11	Adults 20+ Who Are Obese	*percent*	34.1	36.0			*2021*	6
1.86	Adults 20+ who are Sedentary	*percent*	22.6				*2021*	6
1.53	Workers who Walk to Work	*percent*	1.3		1.2	2.4	*2019-2023*	2
0.75	Access to Parks	*percent*	61.0		34.4		*2020*	13
0.67	Access to Exercise Opportunities	*percent*	86.2		67.4	84.1	*2024*	8

Score	PREVENTION & SAFETY	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.75	Age-Adjusted Death Rate due to Firearms	*deaths per 100,000 population*	33.6	10.7	18.5	12.0	*2018-2020*	6
2.25	Death Rate due to Drug Poisoning	*deaths per 100,000 population*	46.0	20.7	43.2	27.2	*2019-2021*	8
2.08	Severe Housing Problems	*percent*	18.7		13.3	16.7	*2016-2020*	8
1.64	Pedestrian Deaths	*deaths*	476				*2023*	19

0.94	Age-Adjusted Death Rate due to Falls	*deaths per 100,000 population*	9.0		10.6	9.8	*2018-2020*	6

Score	RESPIRATORY DISEASES	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.25	Adults with Current Asthma	*percent*	12.4			9.9	*2022*	5
2.25	Proximity to Highways	*percent*	8.5		7.0		*2020*	13
2.19	Tuberculosis Incidence Rate	*cases per 100,000 population*	3.7	1.4	1.7	2.9	*2023*	18
1.83	Adults who Smoke	*percent*	19.3	6.1		12.9	*2022*	5
1.42	Adults with COPD	*percent of adults*	8.7			6.8	*2022*	5
1.31	Asthma: Medicare Population	*percent*	6.0		6.0	7.0	*2022*	7
0.81	COPD: Medicare Population	*percent*	10.0		13.0	11.0	*2022*	7
0.67	Age-Adjusted Death Rate due to Lung Cancer	*deaths per 100,000 population*	35.5	25.1	44.1	32.4	*2018-2022*	10
0.58	Lung and Bronchus Cancer Incidence Rate	*Cases per 100,000 population*	54.5		68.1	53.1	*2017-2021*	10

Score	WELLNESS & LIFESTYLE	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.33	Insufficient Sleep	*percent*	41.6	26.7		36.0	*2022*	5
2.06	High Blood Pressure Prevalence	*percent*	41.5	41.9		32.7	*2021*	5
2.00	Life Expectancy	*years*	72.5		74.1	77.6	*2019-2021*	8

1.75	Self-Reported General Health Assessment: Poor or Fair	*percent*	23.2			17.9	*2022*	5
1.58	Poor Physical Health: 14+ Days	*percent*	14.7			12.7	*2022*	5
1.36	Poor Physical Health: Average Number of Days	*days*	4.0		4.1	3.3	*2021*	8

Score	WOMEN'S HEALTH	UNITS	Shelby County	HP2030	TN	U.S.	Measurement Period	Source
2.36	Mammography Screening: Medicare Population	*percent*	37.0		45.0	47.0	*2022*	7
2.00	Age-Adjusted Death Rate due to Breast Cancer	*deaths per 100,000 females*	25.8	15.3	21.7	19.3	*2018-2022*	10
1.86	Age-Adjusted Death Rate due to Cervical Cancer	*deaths per 100,000 females*	2.9		2.6	2.2	*2018-2022*	10
1.36	Breast Cancer Incidence Rate	*cases per 100,000 females*	125.0		124.6	129.8	*2017-2021*	10
1.17	Cervical Cancer Incidence Rate	*cases per 100,000 females*	7.9		7.6	7.5	*2017-2021*	10
0.94	Mammogram in Past 2 Years: 50-74	*percent*	79.1	80.3		76.5	*2022*	5
0.92	Cervical Cancer Screening: 21-65	*percent*	83.5			82.8	*2020*	5

SocioNeeds Index Tables

TABLE 9. COMMUNITY HEALTH INDEX BY ZIP CODE

Zip Code	County	Index Value	Zip Code	County	Index Value	Zip Code	County	Index Value	Zip Code	County	Index Value
38603	Benton	75.4	38330	Gibson	82.7	38391	Madison	61.8	38109	Shelby	99.8
38633	Benton	90.8	38343	Gibson	94.3	38392	Madison	21.9	38111	Shelby	96.1
38642	Benton	56.5	38355	Gibson	20.5	38611	Marshall	75.8	38112	Shelby	93.4
38647	Benton	69.6	38358	Gibson	89.9	38635	Marshall	91.4	38114	Shelby	99.8
72401	Craighead	96.4	38369	Gibson	61.4	38642	Marshall	56.5	38115	Shelby	92.1
72404	Craighead	81.3	38382	Gibson	97.4	38659	Marshall	94.9	38116	Shelby	99.0
72411	Craighead	80.6	38008	Hardeman	99.4	72315	Mississippi	97.3	38117	Shelby	67.6
72414	Craighead	56.4	38039	Hardeman	95.4	72330	Mississippi	60.2	38118	Shelby	96.2
72416	Craighead	77.1	38042	Hardeman	96.9	72350	Mississippi	96.4	38119	Shelby	81.1
72417	Craighead	40.2	38044	Hardeman	29.0	72351	Mississippi	91.0	38120	Shelby	48.6
72419	Craighead	78.9	38052	Hardeman	85.6	72358	Mississippi	93.6	38122	Shelby	80.9
72421	Craighead	35.5	38061	Hardeman	72.2	72370	Mississippi	98.8	38125	Shelby	84.4
72437	Craighead	77.1	38067	Hardeman	92.4	72395	Mississippi	90.2	38126	Shelby	99.7
72447	Craighead	77.5	38075	Hardeman	84.3	72426	Mississippi	47.0	38127	Shelby	99.3
72301	Crittenden	99.2	38381	Hardeman	80.0	72428	Mississippi	50.9	38128	Shelby	97.0
72327	Crittenden	78.4	38012	Haywood	98.3	72438	Mississippi	80.6	38133	Shelby	56.8
72331	Crittenden	98.4	38069	Haywood	98.0	72442	Mississippi	56.6	38134	Shelby	88.1
72364	Crittenden	77.2	38345	Henderson	55.8	38606	Panola	90.6	38135	Shelby	74.7
72376	Crittenden	80.5	38351	Henderson	84.7	38619	Panola	93.8	38138	Shelby	36.3
72384	Crittenden	98.5	38368	Henderson	36.5	38620	Panola	82.8	38139	Shelby	12.9
38001	Crockett	72.7	38371	Henderson	54.8	38621	Panola	88.1	38141	Shelby	88.6
38006	Crockett	67.9	38374	Henderson	41.5	38658	Panola	88.2	38618	Tate	86.6
38034	Crockett	45.5	38388	Henderson	65.9	38666	Panola	95.4	38665	Tate	65.4
38337	Crockett	49.8	38601	Lafayette	46.1	72354	Poinsett	87.3	38668	Tate	72.8
38632	DeSoto	54.3	38655	Lafayette	60.2	72365	Poinsett	93.5	38610	Tippah	74.9
38637	DeSoto	87.2	38673	Lafayette	28.2	72386	Poinsett	70.4	38625	Tippah	42.1
38641	DeSoto	52.1	38037	Lauderdale	79.5	72429	Poinsett	83.4	38629	Tippah	63.4
38651	DeSoto	16.4	38040	Lauderdale	78.8	72432	Poinsett	84.4	38663	Tippah	85.1
38654	DeSoto	70.2	38041	Lauderdale	88.4	72472	Poinsett	73.0	38674	Tippah	22.6
38671	DeSoto	79.7	38063	Lauderdale	95.6	72479	Poinsett	75.0	38683	Tippah	88.8
38672	DeSoto	48.1	38801	Lee	89.7	38841	Pontotoc	63.5	38004	Tipton	49.0
38680	DeSoto	82.8	38804	Lee	85.8	38863	Pontotoc	70.3	38011	Tipton	70.3
38024	Dyer	93.8	38826	Lee	43.4	38871	Pontotoc	25.6	38015	Tipton	84.4
38047	Dyer	23.3	38849	Lee	60.5	38002	Shelby	50.5	38019	Tipton	93.6
38059	Dyer	46.3	38857	Lee	54.1	38016	Shelby	72.3	38023	Tipton	60.5
38259	Dyer	68.5	38862	Lee	87.9	38017	Shelby	35.6	38049	Tipton	93.7
38028	Fayette	27.4	38866	Lee	72.0	38018	Shelby	69.3	38058	Tipton	47.9
38057	Fayette	86.9	38868	Lee	79.8	38053	Shelby	94.1	38627	Union	61.9
38060	Fayette	68.7	38301	Madison	98.5	38103	Shelby	38.0	38650	Union	78.0
38066	Fayette	61.1	38305	Madison	86.8	38104	Shelby	88.2	38652	Union	82.6
38068	Fayette	93.4	38313	Madison	37.0	38105	Shelby	99.0	38828	Union	69.4
38076	Fayette	67.8	38356	Madison	26.6	38106	Shelby	99.9			
38233	Gibson	78.7	38362	Madison	7.8	38107	Shelby	99.3			
38316	Gibson	53.5	38366	Madison	29.1	38108	Shelby	98.9			

TABLE 10. FOOD INSECURITY INDEX BY ZIP CODE

Zip Code	County	Index Value	Zip Code	County	Index Value	Zip Code	County	Index Value	Zip Code	County	Index Value
38603	Benton	60.5	38330	Gibson	89.6	38366	Madison	43.0	38108	Shelby	98.9
38633	Benton	79.8	38343	Gibson	76.9	38392	Madison	50.9	38109	Shelby	98.0
38642	Benton	59.5	38355	Gibson	29.1	38611	Marshall	79.3	38111	Shelby	88.9
38647	Benton	78.5	38358	Gibson	74.5	38635	Marshall	92.8	38112	Shelby	91.4
72401	Craighead	96.0	38369	Gibson	70.1	38642	Marshall	59.5	38114	Shelby	98.7
72404	Craighead	75.8	38382	Gibson	73.9	38659	Marshall	92.6	38115	Shelby	97.9
72405	Craighead	83.6	38008	Hardeman	89.1	38661	Marshall	64.2	38116	Shelby	97.6
72411	Craighead	84.8	38039	Hardeman	90.7	38685	Marshall	80.4	38117	Shelby	51.5
72414	Craighead	94.4	38042	Hardeman	54.9	72315	Mississippi	85.5	38118	Shelby	98.8
72416	Craighead	75.2	38044	Hardeman	48.0	72330	Mississippi	95.6	38119	Shelby	43.8
72417	Craighead	51.2	38052	Hardeman	77.4	72350	Mississippi	94.3	38120	Shelby	9.2
72419	Craighead	91.0	38061	Hardeman	84.2	72351	Mississippi	98.6	38122	Shelby	96.3
72421	Craighead	90.9	38067	Hardeman	85.0	72358	Mississippi	95.0	38125	Shelby	64.9
72437	Craighead	59.3	38075	Hardeman	86.8	72370	Mississippi	97.4	38126	Shelby	99.9
72447	Craighead	83.2	38381	Hardeman	94.3	72395	Mississippi	87.5	38127	Shelby	99.5
72301	Crittenden	96.5	38012	Haywood	93.2	72438	Mississippi	95.2	38128	Shelby	98.9
72327	Crittenden	43.2	38069	Haywood	74.3	72442	Mississippi	71.2	38133	Shelby	57.0
72331	Crittenden	94.9	38328	Henderson	18.4	38606	Panola	85.4	38134	Shelby	90.1
72364	Crittenden	64.9	38345	Henderson	77.4	38619	Panola	92.8	38135	Shelby	53.8
72376	Crittenden	91.4	38351	Henderson	79.4	38620	Panola	74.2	38138	Shelby	8.7
72384	Crittenden	61.1	38368	Henderson	71.2	38621	Panola	98.7	38139	Shelby	0.2
38001	Crockett	79.2	38371	Henderson	68.9	38658	Panola	47.0	38141	Shelby	88.2
38006	Crockett	83.6	38374	Henderson	87.7	38666	Panola	95.1	38618	Tate	81.9
38034	Crockett	78.2	38388	Henderson	69.0	72354	Poinsett	87.5	38665	Tate	89.3
38337	Crockett	49.5	38601	Lafayette	79.2	72365	Poinsett	95.7	38668	Tate	83.8
38632	DeSoto	66.0	38655	Lafayette	75.0	72386	Poinsett	83.8	38610	Tippah	80.8
38637	DeSoto	90.8	38673	Lafayette	16.2	72429	Poinsett	85.0	38625	Tippah	77.0
38641	DeSoto	85.1	38037	Lauderdale	89.2	72432	Poinsett	70.5	38629	Tippah	90.4
38651	DeSoto	10.7	38040	Lauderdale	87.6	72472	Poinsett	92.3	38663	Tippah	88.4
38654	DeSoto	52.1	38041	Lauderdale	93.8	72479	Poinsett	65.0	38683	Tippah	92.7
38671	DeSoto	91.2	38063	Lauderdale	92.5	38841	Pontotoc	80.4	38004	Tipton	45.9
38672	DeSoto	15.1	38801	Lee	87.4	38863	Pontotoc	77.5	38011	Tipton	61.3
38680	DeSoto	75.7	38804	Lee	83.0	38864	Pontotoc	59.6	38015	Tipton	63.7
38024	Dyer	81.0	38826	Lee	32.0	38871	Pontotoc	56.2	38019	Tipton	89.9
38059	Dyer	67.4	38849	Lee	68.7	38002	Shelby	42.9	38023	Tipton	69.1
38259	Dyer	83.0	38857	Lee	52.9	38016	Shelby	76.7	38049	Tipton	67.5
38028	Fayette	15.7	38862	Lee	82.6	38017	Shelby	12.0	38058	Tipton	50.9
38057	Fayette	65.4	38866	Lee	65.0	38018	Shelby	63.8	38627	Union	76.1
38060	Fayette	34.7	38868	Lee	87.9	38053	Shelby	79.4	38650	Union	79.5
38066	Fayette	18.0	38301	Madison	97.5	38103	Shelby	15.8	38652	Union	77.6
38068	Fayette	88.0	38305	Madison	78.2	38104	Shelby	56.0	38828	Union	67.0
38076	Fayette	50.2	38313	Madison	50.1	38105	Shelby	96.9			
38233	Gibson	64.2	38356	Madison	45.1	38106	Shelby	97.8			
38316	Gibson	73.5	38362	Madison	58.4	38107	Shelby	95.2			

TABLE 11. MENTAL HEALTH INDEX BY ZIP CODE

Zip Code	County	Index Value	Zip Code	County	Index Value	Zip Code	County	Index Value	Zip Code	County	Index Value
38603	Benton	75.4	38330	Gibson	82.7	38391	Madison	61.8	38109	Shelby	99.8
38633	Benton	90.8	38343	Gibson	94.3	38392	Madison	21.9	38111	Shelby	96.1
38642	Benton	56.5	38355	Gibson	20.5	38611	Marshall	75.8	38112	Shelby	93.4
38647	Benton	69.6	38358	Gibson	89.9	38635	Marshall	91.4	38114	Shelby	99.8
72401	Craighead	96.4	38369	Gibson	61.4	38642	Marshall	56.5	38115	Shelby	92.1
72404	Craighead	81.3	38382	Gibson	97.4	38659	Marshall	94.9	38116	Shelby	99.0
72411	Craighead	80.6	38008	Hardeman	99.4	72315	Mississippi	97.3	38117	Shelby	67.6
72414	Craighead	56.4	38039	Hardeman	95.4	72330	Mississippi	60.2	38118	Shelby	96.2
72416	Craighead	77.1	38042	Hardeman	96.9	72350	Mississippi	96.4	38119	Shelby	81.1
72417	Craighead	40.2	38044	Hardeman	29.0	72351	Mississippi	91.0	38120	Shelby	48.6
72419	Craighead	78.9	38052	Hardeman	85.6	72358	Mississippi	93.6	38122	Shelby	80.9
72421	Craighead	35.5	38061	Hardeman	72.2	72370	Mississippi	98.8	38125	Shelby	84.4
72437	Craighead	77.1	38067	Hardeman	92.4	72395	Mississippi	90.2	38126	Shelby	99.7
72447	Craighead	77.5	38075	Hardeman	84.3	72426	Mississippi	47.0	38127	Shelby	99.3
72301	Crittenden	99.2	38381	Hardeman	80.0	72428	Mississippi	50.9	38128	Shelby	97.0
72327	Crittenden	78.4	38012	Haywood	98.3	72438	Mississippi	80.6	38133	Shelby	56.8
72331	Crittenden	98.4	38069	Haywood	98.0	72442	Mississippi	56.6	38134	Shelby	88.1
72364	Crittenden	77.2	38345	Henderson	55.8	38606	Panola	90.6	38135	Shelby	74.7
72376	Crittenden	80.5	38351	Henderson	84.7	38619	Panola	93.8	38138	Shelby	36.3
72384	Crittenden	98.5	38368	Henderson	36.5	38620	Panola	82.8	38139	Shelby	12.9
38001	Crockett	72.7	38371	Henderson	54.8	38621	Panola	88.1	38141	Shelby	88.6
38006	Crockett	67.9	38374	Henderson	41.5	38658	Panola	88.2	38618	Tate	86.6
38034	Crockett	45.5	38388	Henderson	65.9	38666	Panola	95.4	38665	Tate	65.4
38337	Crockett	49.8	38601	Lafayette	46.1	72354	Poinsett	87.3	38668	Tate	72.8
38632	DeSoto	54.3	38655	Lafayette	60.2	72365	Poinsett	93.5	38610	Tippah	74.9
38637	DeSoto	87.2	38673	Lafayette	28.2	72386	Poinsett	70.4	38625	Tippah	42.1
38641	DeSoto	52.1	38037	Lauderdale	79.5	72429	Poinsett	83.4	38629	Tippah	63.4
38651	DeSoto	16.4	38040	Lauderdale	78.8	72432	Poinsett	84.4	38663	Tippah	85.1
38654	DeSoto	70.2	38041	Lauderdale	88.4	72472	Poinsett	73.0	38674	Tippah	22.6
38671	DeSoto	79.7	38063	Lauderdale	95.6	72479	Poinsett	75.0	38683	Tippah	88.8
38672	DeSoto	48.1	38801	Lee	89.7	38841	Pontotoc	63.5	38004	Tipton	49.0
38680	DeSoto	82.8	38804	Lee	85.8	38863	Pontotoc	70.3	38011	Tipton	70.3
38024	Dyer	93.8	38826	Lee	43.4	38871	Pontotoc	25.6	38015	Tipton	84.4
38047	Dyer	23.3	38849	Lee	60.5	38002	Shelby	50.5	38019	Tipton	93.6
38059	Dyer	46.3	38857	Lee	54.1	38016	Shelby	72.3	38023	Tipton	60.5
38259	Dyer	68.5	38862	Lee	87.9	38017	Shelby	35.6	38049	Tipton	93.7
38028	Fayette	27.4	38866	Lee	72.0	38018	Shelby	69.3	38058	Tipton	47.9
38057	Fayette	86.9	38868	Lee	79.8	38053	Shelby	94.1	38627	Union	61.9
38060	Fayette	68.7	38301	Madison	98.5	38103	Shelby	38.0	38650	Union	78.0
38066	Fayette	61.1	38305	Madison	86.8	38104	Shelby	88.2	38652	Union	82.6
38068	Fayette	93.4	38313	Madison	37.0	38105	Shelby	99.0	38828	Union	69.4
38076	Fayette	67.8	38356	Madison	26.6	38106	Shelby	99.9			
38233	Gibson	78.7	38362	Madison	7.8	38107	Shelby	99.3			
38316	Gibson	53.5	38366	Madison	29.1	38108	Shelby	98.9			

Community Input Assessment Methodology and Tools

Community input for SJCRH was collected to expand upon the information gathered from the secondary data. Primary data used in this assessment consisted of a community partner listening sessions, community member focus groups and key partner interviews.

Community Partner Listening Sessions

Four listening sessions were conducted in February and March of 2025. The purpose of the sessions was to understand the current and future capacity of community partners and potential actions to improve health and address disparities among the St. Jude pediatric population. The groups were organized by the St. Jude CHNA Steering Committee members and facilitated by Conduent HCI. Participants were recruited via email invitation.

The facilitator asked the following questions during each listening session, collecting responses using live polling software. Sessions were recorded, transcribed and analyzed using Qualtrics Insights Explorer.

1. What are the top health-related problems our patients and families face in their communities that you want to change or improve?
2. What are the leading socioeconomic factors that contribute to the health needs of the patients and families we have discussed? [Probe: What are the root causes of the particular health needs that patients and families face?]
3. What barriers or challenges might prevent our patients and families from accessing health care or social services?
4. Are there any groups of patients that are disproportionately affected by the health problems we have talked about? [Probe: Are there patients and families we serve that are more difficult to reach than others or who are underserved?]
5. What can be done to address some of the challenges we have discussed that our patients and families face?
6. What strengths and assets exist within our community that can be leveraged to promote better health outcomes for our patients and families?
7. Can you think of other ways we could improve the health of our patients and families in our local community that we haven't already discussed?

Community Member Patient and Family Focus Groups

Five community member Patient and Family focus groups were conducted in March 2025. The purpose of the conversations with St. Jude community members was to understand assets, needs, challenges, and potential solutions for improving health from the community members' perspective. The groups were organized by the St. Jude CHNA Steering Committee members and facilitated by Conduent HCI. Participants were recruited via email invitation.

During the focus group discussion, the facilitator asked the questions outlined below. Responses were recorded, transcribed and analyzed using Qualtrics Insights Explorer.

For purposes of this discussion "community" refers to where you live, play and work. We also realize, however, there are challenges specific to St. Jude patients that would allow you to further define your community through the lens of what it's like being a St. Jude patient or patient family in the place where you live, work and play.

(General Health Concerns and Challenges)

1. **What challenges do you (or you on behalf of your minor child/the patient) face accessing healthcare services?** [*Probe: What might prevent someone from accessing care for these health challenges? Examples could include lack of transportation, lack of health insurance coverage, doctor's office hours, language or cultural barriers, etc.]*

2. **Now, looking more broadly than the healthcare services to overall health and wellness, what are the most significant health challenges or concerns impacting you, your family, or your community?** *[Probe: Why do you think this is the most important health issue for our St. Jude families?]*

3. **From the health issues and challenges, we've just discussed which do you think are the hardest to overcome?** *[Probe: What are the barriers related to addressing these health challenges? If so, why?]*

(Access to Care)

4. **Are there specific populations or groups in within the St. Jude community that have particular health issues or challenges that aren't being addressed?** [*Probe: Are these health challenges different if the person is a particular age, gender*, *race, ethnicity or lives in certain neighborhoods? How do health challenges change when patients have a disability related to diagnosis or treatment like hearing loss, vision loss, neuropathy, mobility challenges, changes in cognitive function, etc.?*

(*Social Community Context*)

5. **What types of social support or community resources (e.g. local organizations, faith-based, food bank) do you rely on?**

(Assets and Solutions)

6. **And what additional resources would be helpful?** *[Probe: Are there specific community organizations or agencies that you see taking a strong leadership role in improving the health of people in the community?]* **How could St. Jude improve our services and better meet the healthcare needs of our patients/the community?** *[Probe: Are there gaps in service provisions that you could identify?]*

Key Partner Interviews

Sixteen key partner interviews were conducted in February and March 2025. The purpose of the conversations with community partners and leaders was to understand top health needs and capacity to improve health. The interviews were organized by the St. Jude CHNA Steering Committee members and facilitated by Conduent HCI. Participants were recruited via email invitation. During the interviews, the facilitator asked the questions outlined below. Responses were recorded, transcribed and analyzed using Qualtrics Insights Explorer.

1. To begin, could you please tell us a little about the organization you work for and the geographic location and community members it serves?
2. In your opinion, what are the top health issues affecting children in the hospital community?
3. What do you think are the leading factors that contribute to these health issues? [Probe: What are the root causes of poor health among children?]
4. Which subgroups within the child population in your community seem to struggle the most with the health issues that you've identified? [Probe: Are there specific challenges that

impact low-income, under-served/uninsured, racial or ethnic groups, age or gender groups in the community? How does it impact their lives?]

5. What parts of the community have greater health or social need? [Probe: Which neighborhoods or populations in your community need additional support services or outreach?]
6. What barriers or challenges might prevent someone in the community from accessing health care or social services? [Probe: Are there social factors do you believe have a notable impact or present significant challenges to the health of our community?]
7. What could be done to overcome these barriers? [Probe: What are the potential solutions?]
8. Could you tell us about some of the pediatric and family focused strengths and resources in your community that address these issues, such as groups, partnerships/initiatives, services, or programs? [Probe: What services or programs could potentially have an impact on the needs that you've identified, if not yet in place? Are there any community resources or initiatives that have been particularly successful in addressing health disparities?]
9. Is there anything additional that should be considered for assessing the needs of the community? [Probe: What challenges do you face on a daily basis that you would like to see addressed?]

Prioritization Process and Criteria

As part of the CHNA process, hospital facilities are required to identify and prioritize significant community health needs and identify resources potentially available to address them. A hospital may use any criteria to prioritize the significant health needs and must consider secondary and primary data inputs

Prioritization Criteria:

The Steering Committee set an objective for the prioritization session to identify the top three (3) priority areas for St. Jude to work on in the next three (3) years. In accordance with industry standards, they selected two criteria to guide decision making – Magnitude of the Issue and Ability to Impact. Rather than define each criterion, the CHNA Steering Committee elected to pose framing questions to assist prioritization session participants with completing Step 1.

Magnitude of the Issue

- ✓ How concerning is this issue to St. Jude's patients and families?
- ✓ How many St. Jude patients and families are or will be impacted?
- ✓ How does the identified need impact health and quality of life?
- ✓ Has the need increased or decreased over time?

Ability to Impact

- ✓ Can actionable and measurable goals be defined to address the health need? Are those goals achievable in a reasonable time frame?
- ✓ Does St. Jude have the *expertise* to address the identified health need?
- ✓ Does St. Jude have the *resources* to address the identified health need?
- ✓ Is there another organization working on this that we could collaborate with for impact?

In the topic scoring survey conducted in Step 2, the Steering Committee created a scoring scale from 1 to 5 using the following definitions:

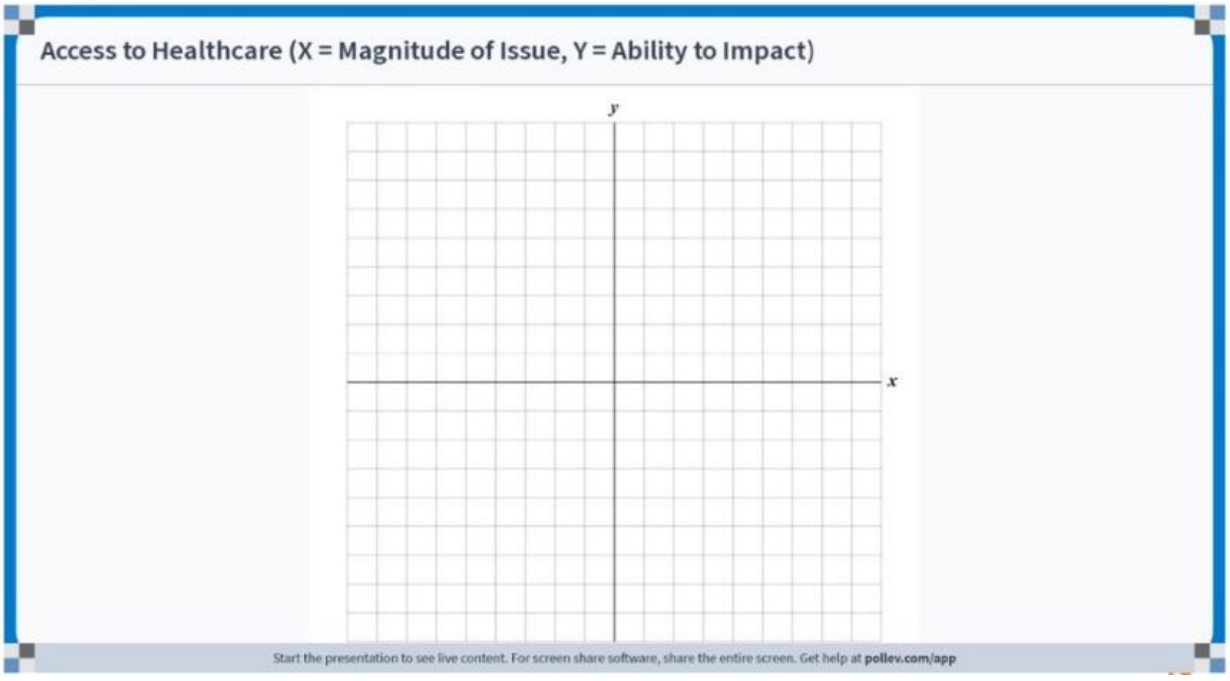
Magnitude of the Issue
1 – Remotely Concerning
2 – Minimally Concerning
3 – Moderately Concerning
4 – Very Concerning
5 – Catastrophic

Ability to Impact
1 – Negligible Ability to Impact
2 – Low Ability to Impact
3 – Moderate Ability to Impact
4 – Significant Ability to Impact
5 – Consequential Ability to Impact

Prioritization Process Step 1: Immediate Elimination

In a process modeled after the National Association for County and City Health Offices (NACCHO) Strategy Grids prioritization technique (The National Association of County and City Health Offices , 2025), Conduent HCI developed a prioritization exercise using live polling. The aim was to eliminate health topics that participants agreed had both low magnitude and low ability to impact. In the exercise, participants reviewed each health topic independently and placed a digital flag in the quadrant of the grid they thought best described its magnitude and ability to impact via the designated criteria. With participant agreement, facilitators eliminated health needs that fell in the “Low Magnitude of the Issue/Low Ability to Impact” quadrant (lower left) prior to moving on to Step 2 of the voting process.

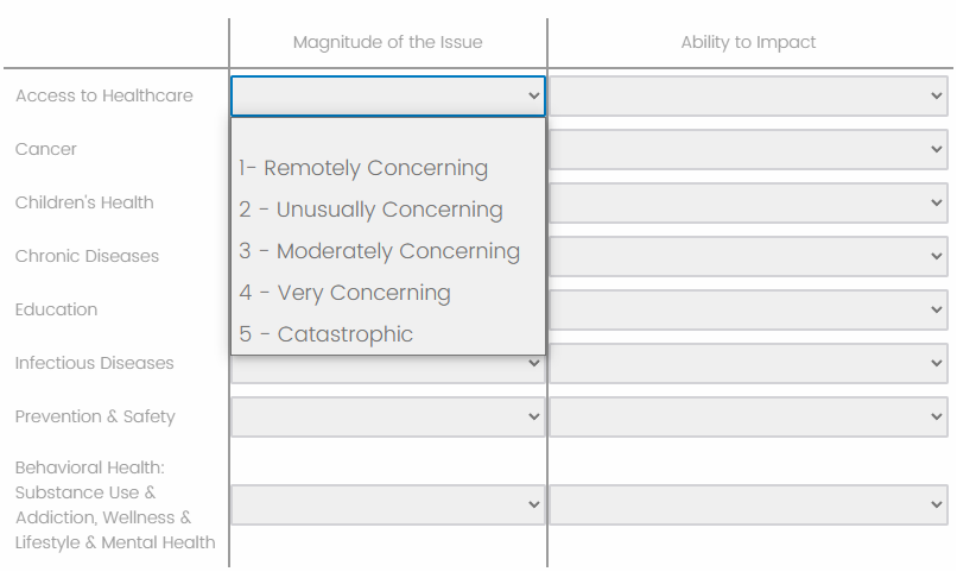
FIGURE 29. STRATEGY GRIDS EXERCISE



Prioritization Process Step 2: Survey with Adjusted Significant Needs List

In Step 2, participants took a survey modeled after the Prioritization Matrix Method (The National Association of County and City Health Offices , 2025)

FIGURE 30. PRIORITIZATION MATRIX EXERCISE



Prioritization Process Step 3: Review Results, Revise and Finalize

The Executive Leadership Committee reviewed the results of the prioritization exercises (steps 1 and 2) and revised the final list that reflected the capacity of St. Jude relative to the community health needs.

Acknowledgements

The groups and organizations listed in this section participated in collective and individual discussions, sharing valuable insights related to the health of the community, barriers and challenges, strengths and resources and recommendations for future planning. St. Jude wishes to extend its sincere gratitude, as it could not have completed this CHNA without the gift of their feedback.

Community Partner Listening Sessions

St. Jude hosted four (4) Community Partner Listening Sessions. Participating groups included:

- ✓ St. Jude Medical Executive Committee (MEC)
- ✓ Le Bonheur Childhood Advocacy Institute
- ✓ St. Jude Psychosocial Department
- ✓ St. Jude HIV and Infectious Diseases

Community Member Focus Groups

St. Jude hosted conversations with five (5) groups of community members. These groups included participants from the following patient demographics:

- ✓ Patient Survivors
- ✓ Hematology and Infectious Diseases

- ✓ Active Patients
- ✓ Affiliates and Local Families
- ✓ Patient Family Advisory Council (PFAC)

Key Partner Interviews

St. Jude hosted sixteen (16) conversations with community partners and leaders**.** Individuals and groups interviewed represented the perspectives of the following organizations:

- ✓ Christ Community Health Services
- ✓ Church Health
- ✓ MIFA
- ✓ Shelby County Community Services
- ✓ Shelby County Health Department
- ✓ St. Jude Hematology Providers
- ✓ St. Jude HPV and Cancer Outreach
- ✓ St. Jude Huntsville Clinic
- ✓ St. Jude Patient Assistance Coordinator
- ✓ St. Jude STEM and Education Outreach
- ✓ St. Jude Survivorship
- ✓ Tennessee Hospital Association
- ✓ The Works
- ✓ U of M Epidemiology
- ✓ U of T: Health Science Center (UTHSC)
- ✓ Urban Child Institute

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