2025 Community Health Needs Assessment
Compression Planning® Session
Summary Report

GUIDING YOU TO BETTER
Hannibal Regional

UNITED WAY
Mark Twain Area

HANNIBAL REGIONAL
EDC
ECONOMIC DEVELOPMENT COUNCIL

Public Health
MARION COUNTY
Health Department

Ralls County
Health Department
WE CARE!

Monroe County
HEALTH DEPARTMENT

SHELBY COUNTY
HEALTH DEPARTMENT

May 1, 2025
9:00 AM - 2:00 PM
Hannibal Regional Hospital

STRONG
CONSULTING

TABLE OF CONTENTS

	Page
Session Participants & Introductions	3-4
Facilitators	5
McNellis® Compression Planning	6
Compression Planning Session Design	7
Session Background	8-20
Session Questions & Answers	21
• Priority Health Needs: What's the most important health need the plan should address? Be specific.	22-23
• What are the existing assets and interventions (programs, infrastructure, resources) that are addressing our top health issues?	24-26
• Strategies: What's working now? Where are we seeing areas of promise around our top health issues?	27-28
• Gaps: Where are the gaps? Where do we need to focus our energy and resources to improve our top health issues?	29-30
• What's the single greatest thing we can do, that if we do it well, will help everything else?	31
• What absolutely has to happen for us to be happy with our progress in three years?	32-33
Session Debrief	34

SESSION PARTICIPANTS

1. Todd Ahrens, Hannibal Regional Healthcare System
2. Cathy Arrowsmith, Marion County Services for the Developmentally Disabled
3. Kevin Arthaud, Hannibal Regional Healthcare System
4. Andrea Campbell, Hannibal Public Schools
5. Denise Damron, United Way of the Mark Twain Area
6. Kyra Davis, Abilities
7. Paula Delaney, Monroe County Health Department
8. Andrew Dorian, City of Hannibal
9. Stephanie Dunker, Ralls County Northeast Community Action Corporation
10. Jolie Foreman, Shelby County Cares
11. Katie Foster, Hannibal Regional Healthcare System
12. Kim Gamm, Pike County Health Department
13. Audrey Gough, Shelby County Health Department
14. Jason Harper, Palmyra R-1 School District
15. Wendy Harrington, Hannibal Regional Healthcare System
16. Larry Hinds, Harvest Outreach Ministries
17. Wendy Johnson, Moberly Area Community College
18. Shammy Johnson, Preferred Family Healthcare
19. Chris Maune, Hannibal Regional Healthcare System
20. Crystal McWilliams, Marion County Health Department
21. Lacey Miller, Marion County Commission
22. Marshall Miller, Marion and Ralls County Ambulance Districts
23. Becky Miller, Watlow
24. Eric Murfin, Marion and Ralls County Ambulance Districts
25. Chief Jacob Nacke, Hannibal Police Department
26. Michele Nunemacher, Marion County Health Department
27. Craig Parsons, Marion County Health Department
28. Angela Peters. CENTURY 21 Broughton Team
29. Darin Redd, Commerce Bank
30. Mary Lynne Richards, Hannibal Parks and Recreation
31. Janet Taylor, Hannibal Regional Auxiliary
32. Emily Trevathan, Douglass Community Services
33. Billie Vavra, Harvest Outreach Ministries
34. Sharon Webster, Hannibal Free Clinic
35. Beth Wiemelt, Clarity Healthcare

Participant Introductions

Session participants introduced themselves to each other at their tables and discussed the question: "What is one thing our community is doing really well to help address these issues?" referring to the top health issues included in the Community Health Needs Assessment. These are the themes of those discussions:

- Medicare expansion has allowed more people to access care
- Removing silos between organizations
- Mental Health awareness is growing
- Services are there, need to match with the clients that need them
- Collaboration between all organizations and counties is going well
- Social/emotional health (specifically in schools) is growing
- Collaboration and partnerships
- Access to the hospital; health care in the region is close
- Collaboration between nonprofit organizations
- The results are not surprising from the health assessment
- Health departments are active and work to find and address immunization needs
- Outpatient mental health services are improving
- Crisis response is improving
- Components of the services needed are available, but need to take them a step further

After-Lunch Thoughts

- Need to talk about the other issues not just mental health
- How to recruit quality health care providers into the field and into the community
- Tour the agencies to have the agencies know what the other organizations do
    - Including board members, not just Nonprofit organization staff
- Need to address housing needs because there is no stability with housing.
    - Numbers for unhoused are a lot higher than any of us realize
    - Quality of housing is an issue
    - Affordable housing not available
    - Low-income housing is not energy efficient, so they have the highest electricity bills and that snowballs into other issues
- Increase in non-English speaking clients

FACILITATORS

STRONG CONSULTING

Firm Profile
Strong Consulting is a Quincy, Illinois-based strategy, and communications firm with expertise in community and economic development, planning, and public engagement. We position our clients for growth through effective planning and communication; and we help communities and nonprofit organizations solve problems by leveraging local talent, forging strong public-private partnerships, and engaging stakeholders.

We believe a thriving community empowers all people. And that healthy organizations contribute to healthy communities. That's why we're focused on fostering action that lifts people up, strengthens organizations, and creates stronger, more resilient, and more vibrant communities.

Maggie Strong, MBA
Maggie Strong Consulting

Julie Boll, M.Ed., GPC
Julie Boll Consulting

Lucy Bordewick
Thread Digital, Inc.

Thank you to Elizabeth Ohnemus for providing in-room support.

MCNELLIS® COMPRESSION PLANNING

Compression Planning is a visual brainstorming process to bring out a group's best thinking and energy on a specific issue in an environment of fair play and equal participation. It is an effective tool for securing stakeholder buy-in, reducing emotional bias in decision-making, and establishing priorities for new initiatives or growing services.

Compression Planning Guidelines:

- Suspend judgment.
- Churn "kernels" into rich ideas.
- No speeches.
- Trust the process.
- Be fully present.
- Have fun!

COMPRESSION PLANNING SESSION DESIGN

Topic:

Today, we are ensuring a unified approach to enhancing health, well-being, and economic vitality across the region.

Overall Purpose:

1. To collaboratively identify and prioritize both significant health needs and broader community challenges.
2. To identify resources potentially available to address the significant health needs identified.
3. To identify any action taken or strategies underway to address the significant health needs identified.
4. To help guide decision-making and resource allocation to achieve meaningful, positive change through coordinated community action.

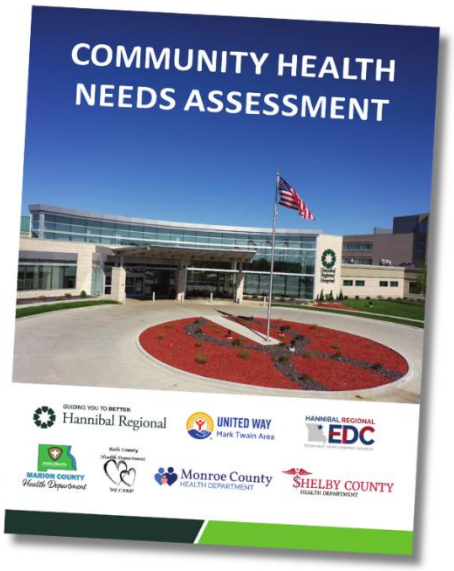
Purpose of this Session:

1. To identify 3-5 health needs and broader community challenges to be prioritized in the community plan.
2. To identify 2-3 significant strategies underway that should be leveraged and supported by the plan.
3. To identify 2-3 significant resource needs that the plan will address.
4. To inform the implementation strategies to be included in the community plan.

Non-Purpose of this Session:

1. To introduce new data or debate the existing data.
2. To prioritize strategies to address identified needs.
3. To create an action plan.
4. To replace work that has already been done.

Background:
2025 CHNA Report



CHNA vs. CHIP

Community Health Needs Assessment (CHNA)
a process that identifies key health challenges and resources in a community to guide strategies that improve health outcomes and reduce disparities.

Community Health Improvement Plan (CHIP)
a collaborative, action-oriented strategy document that outlines how a community will address its most pressing health priorities identified in the CHNA.

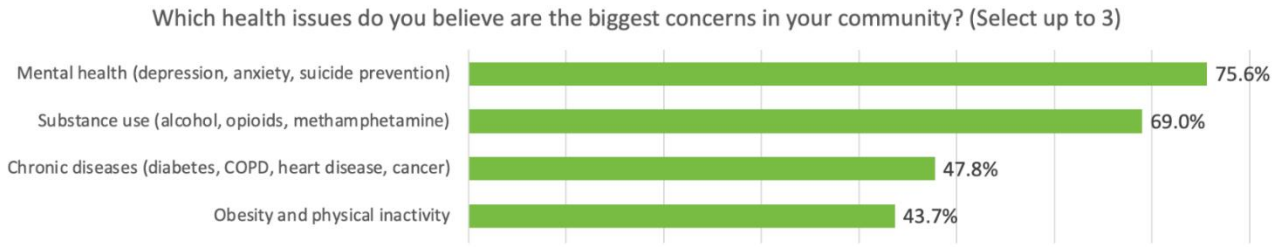
Key Health Priorities

Source: Primary Data from public surveys, partner surveys, and interviews

1. **Mental Health**
2. **Substance Use & Addiction**
3. **Access to Care**
4. **Affordability**
5. **Chronic Diseases**

Key Health Priorities

Source: Primary Data from public surveys



Quality of Life Challenges

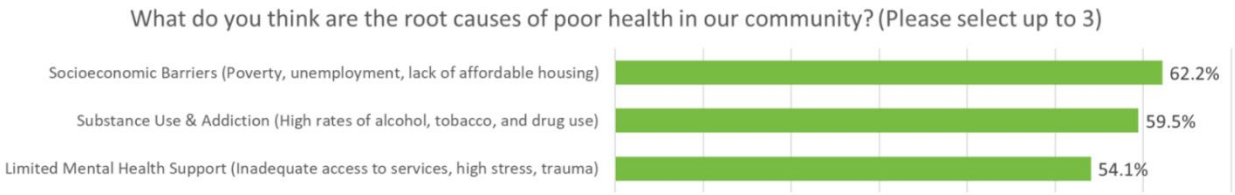
Source: Primary Data from public surveys, partner surveys, and interviews

1. **Housing & Homelessness**
2. **Transportation**
3. **Childcare**
4. **Food Insecurity**
5. **Economic Struggles**

Quality of Life Challenges

(Social Determinants of Health)

Source: Primary Data from partner surveys



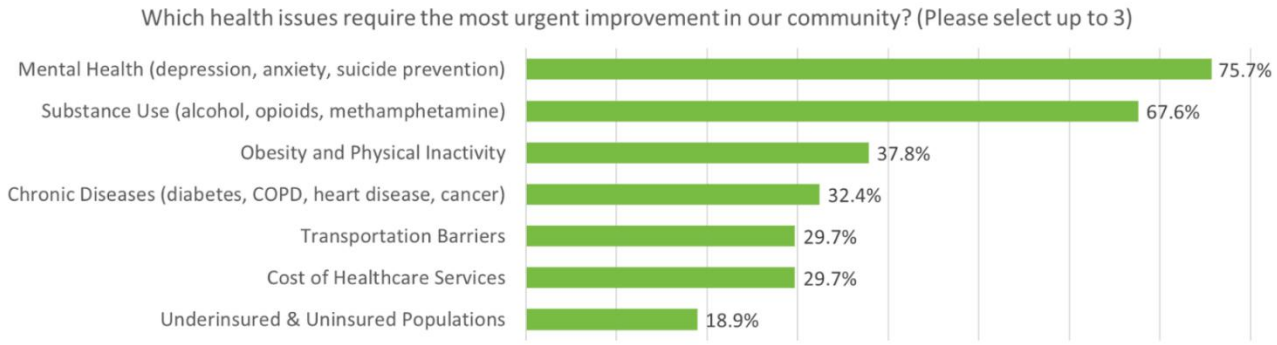
Most Urgent Priorities for Action

Source: Primary Data from public surveys, partner surveys, and interviews

1. **Expand Mental Health Services**
2. **Improve Healthcare Access & Affordability**
3. **Substance Use Treatment**
4. **Transportation Solutions**
5. **Health Education & Prevention**
6. **Housing & Social Services**

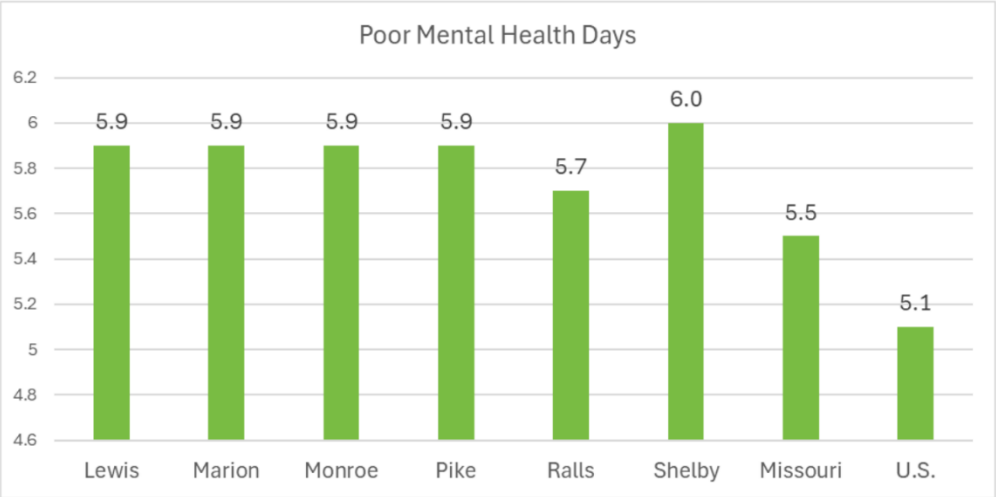
Most Urgent Priorities for Action

Source: Primary Data from partner surveys



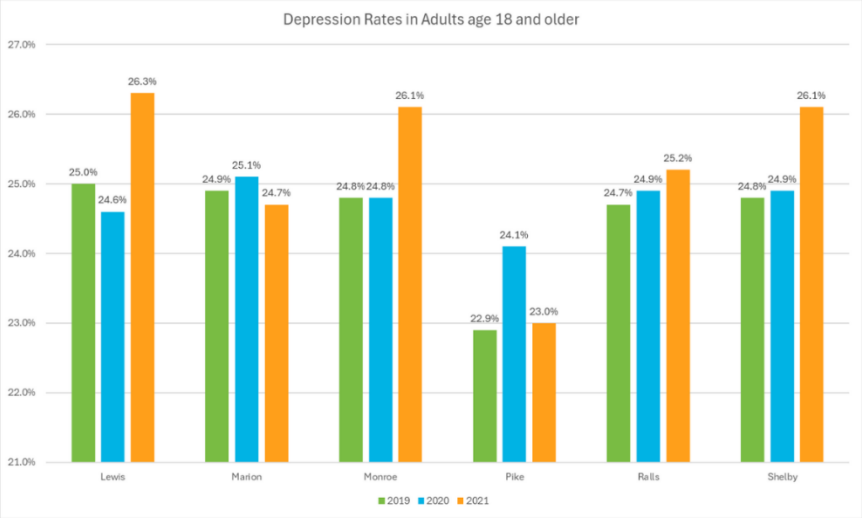
Mental Health Burden

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



Depression Rates

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



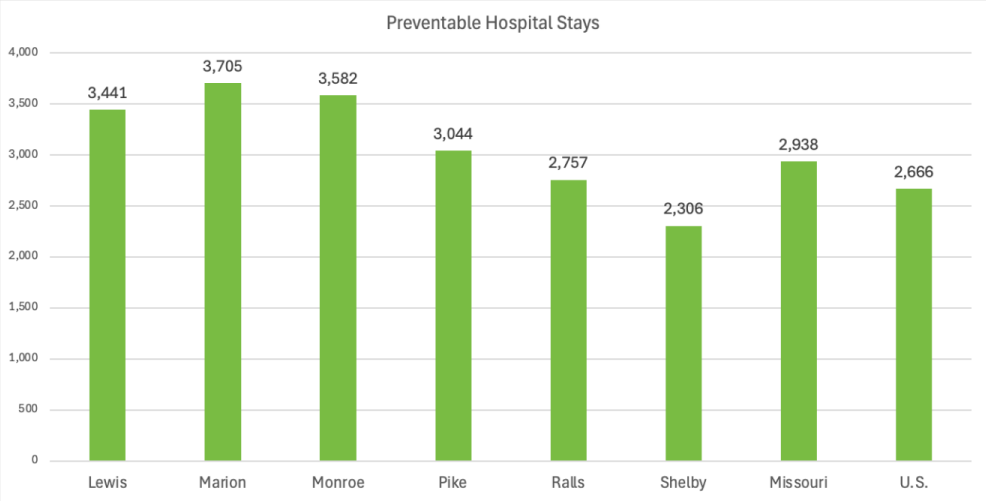
Mental Health Providers

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets

Location	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Lewis	10,032	1	4	39.87
Marion	28,525	12	93	326.03
Monroe	8,666	0	2	23.08
Pike	17,587	6	12	68.23
Ralls	10,355	2	11	106.23
Shelby	6,103	0	1	16.39
Missouri	6,154,913	2,150	17,964	291.86
U.S.	334,735,155	143,553	1,057,118	315.81

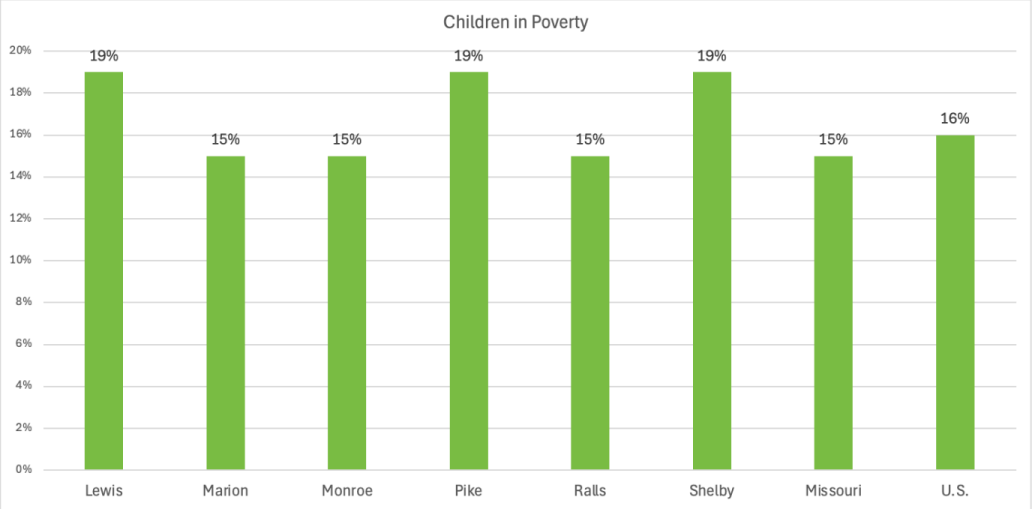
Preventable Hospital Stays

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



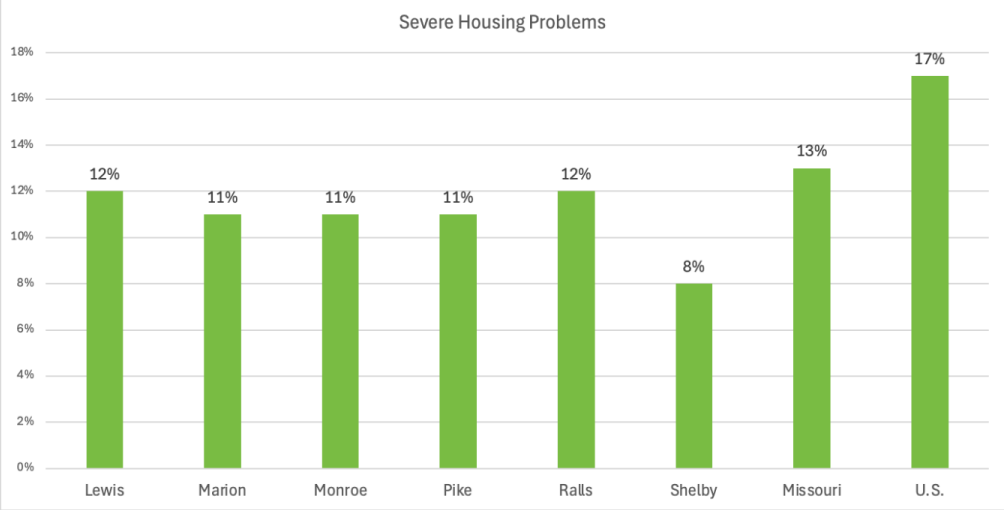
Children in Poverty

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



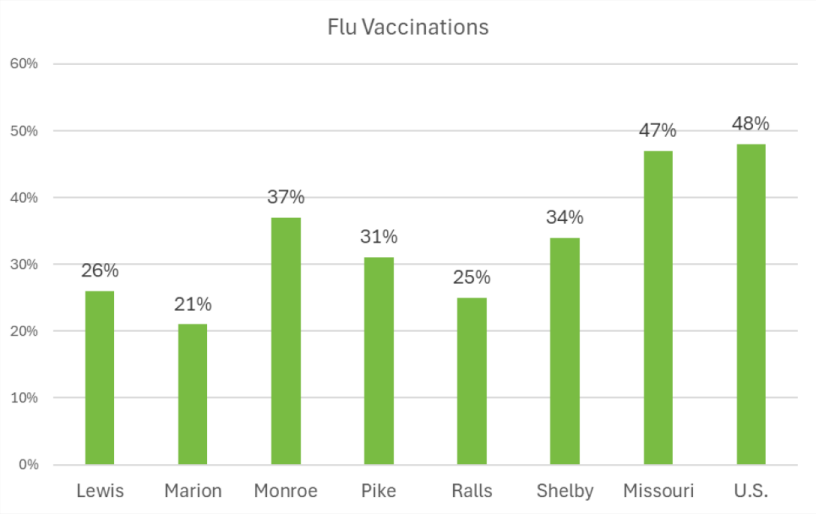
Severe Housing Problems

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



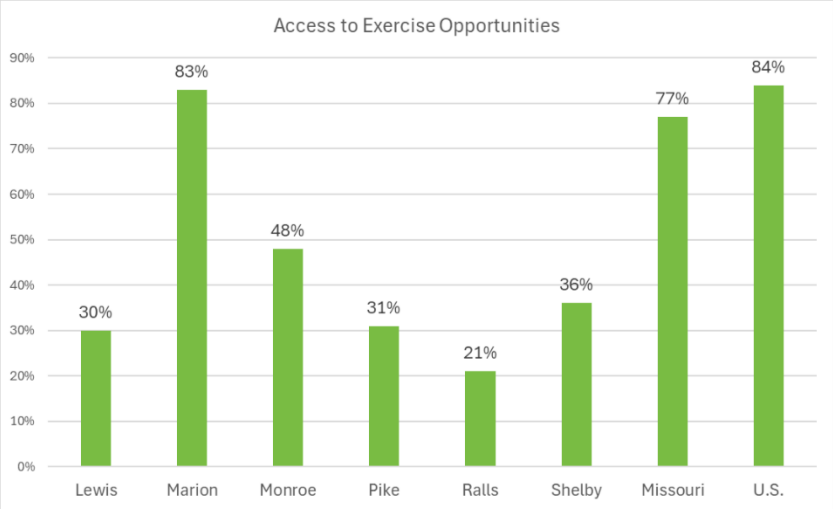
Flu Vaccinations

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



Access to Exercise Opportunities

Secondary Data: Supporting Trends from County Health Rankings & Public Health Datasets



Strengths to Build On

- **Strong cross-sector collaboration**
- **Community pride, resilience, and readiness to act**
- **Existing healthcare, nonprofit, and civic infrastructure**

2025 CHNA COMPRESSION PLANNING SESSION

May 1, 2025 | Hannibal Regional Hospital

Today, we are ensuring a unified approach to enhancing health, well-being, and economic vitality across the region.

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On behalf of the following partners, we would like to thank you for sharing your time and expertise today.

GUIDING YOU TO BETTER Hannibal Regional

UNITED WAY Mark Twain Area

HANNIBAL REGIONAL EDC ECONOMIC DEVELOPMENT COUNCIL

Public Health MARION COUNTY Health Department

Ralls County Health Department WE CARE!

Monroe County HEALTH DEPARTMENT

SHELBY COUNTY HEALTH DEPARTMENT

2025 COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Covering the Missouri Counties of Lewis, Marion, Monroe, Pike, Ralls, and Shelby

Key Health Priorities

Primary Data from public surveys, partner surveys, and interviews:

Top 5 Most Critical Health Issues:

1. **Mental Health** – Overwhelming need, especially among youth and elderly; provider shortages; long wait times
2. **Substance Use & Addiction** – Opioids, meth, alcohol; limited treatment and prevention
3. **Access to Care** – Especially primary, mental, and dental care; cost, insurance, and transportation barriers
4. **Affordability** – High cost of care deters use, even for insured individuals
5. **Chronic Diseases** – Obesity, diabetes, heart disease, and cancer concerns

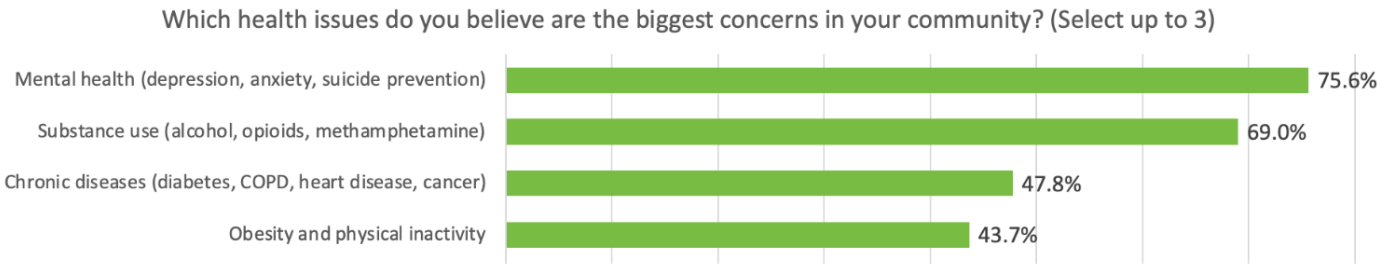
Quality of Life Challenges

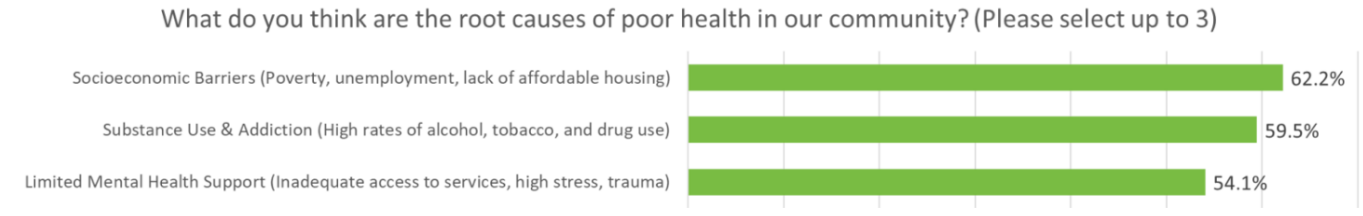
(Social Determinants of Health)

Primary Data from public surveys, partner surveys, and interviews:

Top Issues Identified by the Community:

1. **Housing & Homelessness** – Lack of affordable, safe, quality housing
2. **Transportation** – Limited options, especially in rural areas
3. **Childcare** – Unaffordable and unavailable; impacts workforce participation
4. **Food Insecurity** – Limited access to nutritious, affordable food
5. **Economic Struggles** – Low wages, poverty, limited job access





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2025 COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Covering the Missouri Counties of Lewis, Marion, Monroe, Pike, Ralls, and Shelby

Most Urgent Priorities for Action

From partner and stakeholder input:

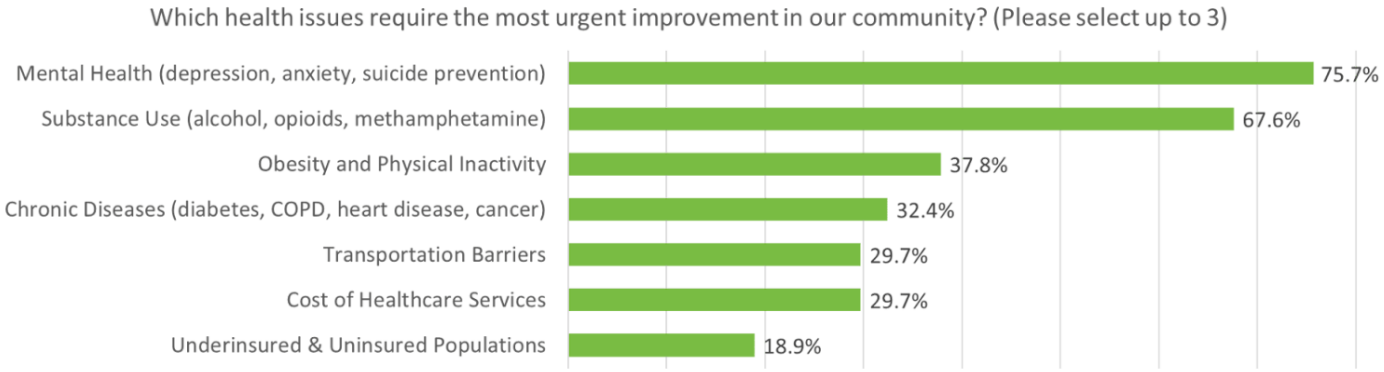
- **Expand Mental Health Services** – In-person options, more providers, crisis response
- **Improve Healthcare Access & Affordability** – Lower costs, better insurance, rural availability
- **Substance Use Treatment** – Prevention, treatment, reintegration
- **Transportation Solutions** – Public and volunteer transit, rideshare support
- **Health Education & Prevention** – Community education, early intervention
- **Housing & Social Services** – Holistic support addressing root causes of health disparities

What the Data Say

Secondary Sources

Supporting Trends from County Health Rankings & Public Health Datasets:

1. **Mental Health Burden:** Frequent mental distress days (5.9 days avg. across counties vs. U.S. 5.1)
2. **Suicide & Depression:** Elevated depression rates; suicide is a leading cause of death
3. **Provider Shortages**: Extremely low mental health provider ratios in several counties (e.g., 5,930:1 in Shelby vs. 300:1 U.S. avg.)
4. **Preventable Hospital Stays:** Rates above national average—an indicator of inadequate outpatient care
5. **Socioeconomic Disparities:** High child poverty, housing problems, low flu vaccination rates, and lack of access to exercise opportunities



Strengths to Build On

- Strong cross-sector collaboration (e.g., United Way, healthcare, schools, economic development, health departments, nonprofits, business)
- Community pride, resilience, and readiness to act
- Existing healthcare, nonprofit, and civic infrastructure

Population Health and Well-Being Snapshot

Secondary Data Source: 2025 County Health Rankings & Roadmaps

Population Health and Well-Being								
Length of Life	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Premature Death	9,100	11,100	9,800	10,300	8,500	9,000	10,000	8,400
Quality of LIfe								
Poor Physical Health Days	5.1	4.8	5	4.6	5.2	4.8	4.2	3.9
Low Birth Weight	9%	9%	10%	10%	7%	9%	9%	8%
Poor Mental Health Days	5.9	5.9	5.9	5.7	6	5.9	5.5	5.1
Poor or Fair Health	23%	19%	21%	18%	22%	21%	17%	17%
Community Conditions								
Health Infrastructure	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Flu Vaccinations	26%	21%	37%	25%	34%	31%	47%	48%
Access to Exercise Opportunities	30%	83%	48%	21%	36%	31%	77%	84%
Food Environment Index	6.7	7.4	7.4	8.2	6.5	7	6.6	7.4
Primary Care Physicians	5,000:1	980:1	2,900:1	10,360:1	5,980:1	5,920:1	1,420:1	1,330:1
Mental Health Providers	2,450:1	310:1	4,350:1	1,750:1	5,930:1	1,380:1	380:1	300:1
Dentists	9,890:1	1,180:1	8,650:1	10,420:1	2,990:1	2,940:1	1,600:1	1,360:1
Preventable Hospital Stays	3,441	3,705	3,582	2,757	2,306	3,044	2,938	2,666
Mammography Screening	41%	52%	46%	49%	44%	40%	46%	44%
Uninsured	13%	10%	13%	10%	13%	13%	10%	10%
Physical Environment	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Severe Housing Problems	12%	11%	11%	12%	8%	11%	13%	17%
Driving Alone to Work	78%	78%	82%	82%	83%	82%	76%	70%
Long Commute- Driving Alone	39%	20%	39%	25%	26%	28%	31%	37%
Air Polution: Particulate matter	7.9	7.9	7.6	7.8	7.5	7.9	7.5	7.3
Drinking Water Violations	No	Yes	Yes	Yes	No	Yes	N/A	N/A
Broadband Access	72%	89%	80%	89%	82%	84%	88%	90%
Library Access	<1	2	6	<1	2	3	2	2
Social and Economic Factors	**LEWIS**	**MARION**	**MONROE**	**RALLS**	**SHELBY**	**PIKE**	**MISSOURI**	**U.S.**
Some College	53%	56%	49%	54%	56%	36%	67%	68%
High School Completion	87%	90%	90%	91%	90%	87%%	92%	89%
Unemployment	2.9%	3.1%	3.2%	2.8%	2.7%	3.2%	3.1%	3.6%
Income Inequality	4.5	4.2	5.7	4.3	4.6	4.7	4.5	4.9
Children in Poverty	19%	15%	15%	15%	19%	19%	15%	16%
Injury Deaths	83	100	65	109	90	84	104	84
Social Associations	12.1	17.2	9.2	8.6	28.4	13	11.4	9.1
Child Care Cost Burden	25%	31%	28%	26%	24%	29%	31%	28%

Session Questions & Answers

The following section includes an unedited (except for limited spelling and edits for clarity) report of all the answers and ideas captured during the May 1, 2025, Hannibal Regional Community Health Needs Assessment Compression Planning Session. This is presented in this way to demonstrate that all voices were heard and will be considered during the development of the Community Health Improvement Plan. On behalf of Hannibal Regional, United Way of the Mark Twain Area, Hannibal Regional Economic Development Council, the County Health Departments, and Strong Consulting, we would like to thank all the participants for sharing their time and expertise.

Priority Health Needs

What's the most important health need the plan should address? Be specific.

(Column 2 = # of Dots; Individual cards are separated by a /)

In-Patient Mental Health Care: Mental Health – in-patient not available (access) / Add in-patient mental health facility / In-patient mental health services	**15**
More mental health providers: Increase trauma-informed care providers / Increase number of behavioral health providers across the service area / Recruitment and retention of qualified mental health professionals to reduce the time to receive services / Access to mental health providers	**14**
Mental Health Awareness: Knowing where to go for specific mental health needs / Promoting greater awareness of what someone can receive mental health services for / Mental health awareness (providers, access) / Normalizing mental health needs / Breaking down the stigma of seeking help for mental health needs	**13**
Community Care Coordination (Unaffiliated): Create unaffiliated community health workers to connect individuals to needed resources / Developing centralized triage process to ID specific mental health needs / Create a better response system for those with mental health crises / Facilitating access by putting all resources together / Developing and distributing leave-behind informational resources for services for anyone that encounters patients in the field	**13**
Affordable housing: reasonable rental rates	**13**
Preventative Care: Access to affordable preventative care for the underinsured / Preventative care – early screenings, detection (annual visits)	**12**
Addressing Root Cause Issues like generational poverty and lack of education	**12**
In-Patient Treatment Centers for Substance Use (Drugs): Increase inpatient and outpatient recovery services	**8**
Training for educators in mental health	7
Child development – Need for parenting classes for all ages / Educate parents about effect of screen time on both mental and physical health of kids	5
Food Insecurity – healthy food / Access to affordable, healthy nutrition	5
Healthy lifestyles – importance of moving/staying active, healthy diet (education)	4
Provide more education to communities to overcome vaccination hesitation / Immunizations – importance of vaccines and education (eliminating miseducation)	4
Dental care – affordable, providers accepting adult medicate	4
Youth access to activities / Educate students at elementary and high school levels of the importance of healthy eating and exercise on well-being / Access to exercise for children at school and at home	3

Providing mental health care where people physically are	3
Targeted therapy – sex trafficking, domestic violence, PTSD	3
More nursing homes with 1) increased/more specific services and 2) number of beds	3
Need improved collaboration and communication among healthcare providers for individual case management	3
Avoid politics, take economic factors out of access to healthcare	3
Community recovery services and support / Substance abuse/use, no access to treatment, loss of driving privileges so can't get to providers, self-treatment	3
Overcoming stigma of seeking services for rural men	2
Transportation assistance to get to resources for rural counties / Improve transportation solutions	2
Physical activity relates to mental health	2
Social and emotional education for children	1
Involve family component for mental health issues / Affordable trauma-informed care training for families	1
Reduce barriers to access basic healthcare – transportation, affordability, and number of providers	1
Ongoing training for mental health needs, not just once a year	1
Creative way to expand creating individualized plan(s) to improve well-being (i.e.. community health worker)	1
Normalization of preventative care	1
Access to medication for homeless population	1
Protect Medicaid program – needed for family unit (legislation)	1
Education specific to how obesity impacts chronic health conditions	
Providers going to where the clients are – setting up a "booth"	
Improve trust with providers – mental health providers, caseworkers	
Mental health – addressing proactively regular mental health breaks, not just once a year (self care)	
Chronic disease resources for elderly population	
Walking clubs at school	

What are the existing assets and interventions (programs, infrastructure, resources) that are addressing our top health issues?

(These cards were not dotted.)

Preventative – Parents as Teachers
Preventative – Teen Fair
Preventative – Area health departments
Preventative – Hannibal Regional Hospital
Harvest Outreach – sober living houses
Free Clinic
Balance of State (Housing) top notch communication
Project Community Connect
Social Service agencies work very closely together
Increased outreach efforts which is increasing general public involvement
We're talking about things we never did before
Trauma-informed programs that are helping in schools, in community
Social Services Providers – Ministerial Alliance
Stigma removed over mental health needs – schools slowly moving the needle
Free clinic
County Health Departments
Project Community Connect (PCC) annual resource activity
Having an independent non-profit healthcare system available to provide services in this area
Establishment of 988 access to crisis resources
Development of an HPD Resource Card – scan QR code to see available services
The growth and development of Clarity Health and the services they offer
Opening of the Mark Twain Behavioral Health Crisis Stabilization Unit (CSU) [Voluntary 23-Hour Crisis Chair]
Local school systems doing a good job with job awareness/shadow programs
CIT (Crisis Intervention Team) Council and the valuable training they offer the region's field responders
Addition of CIT-Trained Paramedics to the Region's EMS services (Crisis Intervention Team)
United Way Community Resource Line (phone calls)
EMS and local law enforcement and triage efforts for mental health patients
Increased number of adult mental health providers
City has grown the number of outdoor fitness opportunities

Healthcare showcases and expo events that educate communities
Health department outreach and education has increased
Multiple inter-agency collaborations
Care coordination
Coordinated Entry at Preferred - Housing
Mark Twain Behavioral Health – Crisis Stabilization Unit – point of entry for care coordination
United Way Community Helpline and 211 and 988
Harvest House, Care Coordination
Salvation Army
Project Community Connect, Care Coordination
Clone Denise Damron
Preventative – Project Community Connect
Public School Systems
Marion County Health Department Community Health Education – Preventative
Local Health Departments
Preventative – Juneteenth
Housing
Hannibal Housing Authority
NECAC
Hannibal Workforce Development
Housing Taskforce with NECAC – Affordable Housing
Local nonprofits
Hannibal Regional Hospital
Law enforcement
CSU (Crisis Stabilization Unit) – provide transportation now
United Way
FACT
Shelby County Cares – preventative care, therapy services, ABA (applied behavior analysis - youth behavior, IEPs, 504s)
More mental health – Mark Twain Behavioral Health, Preferred/Clarity
Hannibal Regional Hospital ER for psych transfers
Mark Twain Recovery

Faith Based Organizations
Federally Qualified health centers
Douglass Community Center
Clarity
Mark Twain Behavioral Health
Preferred Healthcare
Mental Health Awareness

Strategies

What's working now? Where are we seeing areas of promise around our top health issues?

(Column 2 = # of Dots; Individual cards are separated by a /)

Breaking generational poverty – parent education for all ages / Breaking the generational cycle / Breaking generational cycle of food and exercise perspective / Resources to break generational cycles that cause issues / Communities more aware of need to break generational cycle and focus efforts on kids	**34**
Centralized location to act as hub for all available resources / Community Center – downtown preferably that has representation from each agency "one stop shop" / A single resource center / Community liaison – one stop shop for where to go (as a person in need, as an employer) / Mechanism to see person for all needs – housing, meds, transportation, etc. / Independent "Community Worker" to meet people where they are and direct / 24/7 "Care Coordinator" access to a system like Project Community Connect / Community gatekeeper	**30**
Agency Collaboration / Collaborations with agencies / More collaboration across agencies and nonprofits / Community Collaboration / Collaboration across agencies to get resources to right person/place	**28**
Crisis Intervention Team (St. Avenue's) with holistic view of the person in crisis – new since last CHNA	9
Project Community Connect – create relationships / Collaboration and streamline services Project Community Connect / Increased events and opportunities for example Project Community Connect	9
Passionate caregivers	6
School system more open to new opportunities	5
Care Navigator and social worker job positions created	5
Schools increased communications with parents about resources available	4
Recovery centers have increased	4
Crisis Intervention Team (CIT) now available / CIT Training is helping	4
Public school systems providing trauma informed care	2
Community Behavioral Health liaisons are being effective	2
Telehealth for mental health services is helping patients – specifically at Pike County Health Department	2
More community meetings to bring awareness / Outreach and educating the community	2
Specialty care physicians are available	1
Reintroducing children with tech programs	1

Culver Stockton Masters in Counseling program	1
Shelby County Cares is seeing success with many of their free programs and outreach	1
Number of health care providers / More physicians in community, yet not enough	1
Addressing whole picture (holistic care)	
Mark Twain Behavioral Health providing services to schools	
Meet people where they are for services	
Referrals from Health Department to others	
New Mark Twain Behavioral Health building has brought more attention to growing need	
More services are provided by Clarity/Mark Twain Behavioral Health	
Chronic disease is not as high an issue as past years	
Crisis Unit now available, Mark Twain Behavioral Health Resource Center	

Gaps

Where are the gaps? Where do we need to focus our energy and resources to improve our top health issues?

(Column 2 = # of Dots; Individual cards are separated by a /)

Affordable Housing, rent prices and shelters / Housing as urgent/root cause / Access to affordable/available units / Affordable safe housing	**21**
Public transportation / Money for transportation / Transportation to and from services and meetings (i.e. AA) / Transportation that is accessible and affordable to get patients to resources / Transportation in rural areas to access healthcare	**15**
Inpatient mental health locally / Number of inpatient mental health beds	**15**
Awareness and Access - Patients who need services may know what services, but not know ho to access them. Who to contact, etc.	**11**
Starting younger – before crisis occurs	11
Solutions for generational issues	11
Inter-agency education and tours	8
Financial Literacy for low-income clients	7
Shelter - emergency	5
Mental health providers	4
Extend Parents as Teachers (or alternative) to adulthood to support Parent Education	2
Help people get from “I recognize need, but I’m not ready”	2
Improving communication and trust to the people seeking services	2
It’s all about money. Issues are ID’d, but no funds to support	2
Limited Providers at every level, health/social/emergency	1
Completing final step in getting resources to the client (the client coordinator person)	1
Recruit and engage a broader segment of the community to be involved	1
Trained volunteer for “free” outreach/support to those in need remote/lonely (Senior Companion AmeriCorp**s** AKA Stephens Ministry	1
Education/training between law enforcement, EMS, dealing with mental illness and developmentally disabled	1
Limited Funding – grants that discontinue, certain funds only available for limited use	
How to get donated items distributed to those who could benefit from them	
Price disparity between health and unhealthy foods	
Mental healthcare access in jails	

Cost of mental healthcare makes access difficult for Medicaid/Medicare populations	
Educate policy makers – big pharma, does v/s our needs	
Community engagement to change perception of community providers/leaders	
Case workers for individuals with no payment source (non-Medicaid)	
Support system for K-12 Parents for behavioral issues	
Faith based community more unified, involvement	
Support for non-English speaking	
Co-responder for crisis support (team approach)	
Quality provider recruitment into field and to work here	
Stigma	

What's the single greatest thing we can do, that if we do it well, will help everything else?

(Column 2 = # of Dots; Individual cards are separated by a /)

Effective education for youth, parents, adults – boundaries, lifestyle, healthy food, resources	**10**
Rural public transportation	**8**
Affordable, safe housing / affordable housing / low cost, energy efficient housing / housing – money to build houses	**8**
"Neighborhood Watch" – Active Community/Community Action to be a good neighbor for health, education	5
Access to safe childcare	5
Homeless shelters (with community worker visits) / homeless/emergency shelter	4
Money and support from state and federal to address mental health	3
Workforce development efforts	3
Community paramedic to come in and do assessment and referral to services, including utility assistance, medication, more services like mental health, handicap, meals *Done on discharge	2
Get people to want the help!	1
Build empathy and understanding	1
Access to health food – brainstorm new options	1
Insurance for all	1
Building relationships – community paramedic community, healthcare worker	
Breakdown barriers	
Regain community's trust	
Take care of ourselves	
Employer education (*managers, HR, employee) on agencies available *First ones to hear he employee can't come in – care broke down, no childcare, etc	
Good foundation of education of issues	
Increase everyone's access to healthcare	
Increase number of resources (all types)	
Bring services to the people (more mobile options)	

What absolutely has to happen for us to be happy with our progress in three years?

(These cards were not dotted.)

Sustainability – financial stability, grant funding to become permanent
Engaging more partners beyond the usual in this room. 80/20 rule
Utilize the Hannibal Regional Hospital "Hub and Spoke" process to build out services to all 6 counties
Increased mental health resources
Increased community awareness of those mental health resources
Some type of shelter available/built for homeless
Wheels in motion for Project Community Connect to be available all year round
Investments in housing solutions
Increased mental health services in schools
Drastically reduce the mental health provider ratio listed in the snapshot
Resource development - collaborative effort to attract more resources (people and money)
Identify a "permanent" position for a leader/coordinator of all agencies to also expand/incentivize right/onoing active community leader support
Expand "Council of Agencies" to include people at this meeting /meet periodically to share and support community-wide needs in support of priorities of CHNA (how to make it important enough to attend/host – make it I "want to" attend and take action, figure out the "reward" for involvement, start with a small team)
Action has to be backing the collaboration
Establish a centrally located PCC building, ideally each county
Keep people here for services – earn their trust and service them here
Implement programs to help with current problems – resources, gatekeeper
Decrease in preventable hospitalizations
Successful client progression in programs
Increased vaccination rates
Creation of community center to network services
Stretch goal: Land Bank
Maintain existence to be able to move forward
Inpatient mental health beds in our local community
Increased funding – other sources?
Legislative support for most vulnerable
Decreased unemployment rate

Some type of one-stop-shop for coordination of care
Reduce children in poverty numbers
Utilize the resources and collaborate so not duplicating (ex) social providers come together and conquer and divide

SESSION DEBRIEF

What went well?

- Engaged participants
- Fast paced, churned best ideas/solutions
- Fast-moving, engaging process
- Agency participation
- Everyone on the same page
- Forced to prioritize
- Survey response set groundwork/background
- Food, space, all great at Hannibal Regional Hospital
- Unity
- Varied points of view and perspective

What would we change for next time?

- Know the growth or changes from the last CHNA
- More input from those who need the services/support
- Have some of those who utilize the services
- Put cost of living in context of national averages for costs
- County ratios
- Resources/organizations not in the room
- The dots!

Lessons Learned.

- Good energy in the room. Momentum
- Crisis Intervention Training (some participants didn't know about this)
- United Way hotline (some participants didn't know about this)
- Project Community Connect is well-recognized and appreciated
- Clone Denise! Energy, heart, empathy, connections
- People in our region showed up and were engaged